		FOR BHF USE					

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0046169

Facility Name: Lakewood Nrsg & Rehab Center

Address: 14716 S Eastern Ave (Number) Plainfield (City) 60544 (Zip Code)

County: Will

Telephone Number: (815) 436-3400 **Fax #** (815) 436-1357

HFS ID Number:

Date of Initial License for Current Owners: 2/1/2003

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) * (Date)
** Subject to the attached Accountants Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	131	Skilled (SNF)	131	47,946	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	131	TOTALS	131	47,946	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	19,390	11,329	11,778	42,497	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,390	11,329	11,778	42,497	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.64%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/2003

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/2003 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 131 and days of care provided 8,820

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/16 Fiscal Year: 12/31/16

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	319,870	72,164	21,843	413,877		413,877	8,523	422,400			1
2	Food Purchase		263,571		263,571		263,571	(1,253)	262,318			2
3	Housekeeping	186,131	45,987		232,118		232,118	982	233,100			3
4	Laundry	54,947	21,688		76,635		76,635		76,635			4
5	Heat and Other Utilities			181,722	181,722		181,722	1,358	183,080			5
6	Maintenance	140,014		297,072	437,086		437,086	4,710	441,796			6
7	Other (specify):*							2,247	2,247			7
8	TOTAL General Services	700,962	403,410	500,637	1,605,009		1,605,009	16,567	1,621,576			8
	B. Health Care and Programs											
9	Medical Director			26,100	26,100		26,100		26,100			9
10	Nursing and Medical Records	3,164,280	358,028	9,120	3,531,428		3,531,428	32,288	3,563,716			10
10a	Therapy	251,186			251,186		251,186		251,186			10a
11	Activities	144,322	33,697		178,019		178,019		178,019			11
12	Social Services	212,765	187		212,952		212,952	20,251	233,203			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*	31,308			31,308		31,308	7,604	38,912			15
16	TOTAL Health Care and Programs	3,803,861	391,912	35,220	4,230,993		4,230,993	60,143	4,291,136			16
	C. General Administration											
17	Administrative	98,331			98,331		98,331	85,061	183,392			17
18	Directors Fees											18
19	Professional Services			620,336	620,336	(878)	619,458	(471,377)	148,081			19
20	Dues, Fees, Subscriptions & Promotions			96,709	96,709		96,709	(31,416)	65,293			20
21	Clerical & General Office Expenses	111,769	41,705	281,049	434,523		434,523	(82,199)	352,324			21
22	Employee Benefits & Payroll Taxes			874,491	874,491		874,491	(7,094)	867,397			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,128	2,128		2,128	768	2,896			24
25	Other Admin. Staff Transportation			6,694	6,694		6,694	894	7,588			25
26	Insurance-Prop.Liab.Malpractice			199,572	199,572		199,572	2,078	201,650			26
27	Other (specify):*							31,892	31,892			27
28	TOTAL General Administration	210,100	41,705	2,080,979	2,332,784	(878)	2,331,906	(471,393)	1,860,513			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,714,923	837,027	2,616,836	8,168,786	(878)	8,167,908	(394,683)	7,773,225			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lakewood Nrsg & Rehab Center #0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			76,015	76,015		76,015	380,577	456,592			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							391,997	391,997			32
33	Real Estate Taxes			115,037	115,037	878	115,915	3,998	119,913			33
34	Rent-Facility & Grounds			800,517	800,517		800,517	(798,000)	2,517			34
35	Rent-Equipment & Vehicles			3,892	3,892		3,892	845	4,737			35
36	Other (specify):*			539	539		539	(539)				36
37	**TOTAL Ownership**			996,000	996,000	878	996,878	(21,122)	975,756			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		478,469	1,327,782	1,806,251		1,806,251	(27,987)	1,778,264			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			269,870	269,870		269,870		269,870			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		478,469	1,597,652	2,076,121		2,076,121	(27,987)	2,048,134			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,714,923	1,315,496	5,210,488	11,240,907		11,240,907	(443,792)	10,797,115			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(447)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	377,892	30		9
10	Interest and Other Investment Income	(28,770)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(687)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(177,066)	21		24
25	Fund Raising, Advertising and Promotional	(26,672)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(61,735)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 82,515		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(526,307)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (526,307)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (443,792)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Lakewood Nrsg & Rehab Center

ID# 0046169

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (464)	02	1
2	Other Income	(706)	21	2
3	Patient Clothing	(702)	10	3
4	Charitable Donations	(1,357)	20	4
5	Theft Loss	(17)	21	5
6	Collection Expense	(6,367)	21	6
7	Amortization	(539)	36	7
8	Pac Dues	(4,283)	20	8
9	Joliet Chamber of Commerce Dues	(405)	20	9
10	Plainfield Chamber of Commerce Dues	(250)	20	10
11	Lobbying	(1,977)	21	11
12	Bldg Co. - Management Fee	(6,600)	17	12
13	Bldg Co. - Filing Fees	(250)	20	13
14	Bldg Co. - Amortization	(19,502)	31	14
15	Bldg Co. - Bank Service Charges	(120)	21	15
16	Non Allowable Legal Fees	(12,108)	19	16
17	Annual Report	(250)	20	17
18	Capitalized R&M	(5,838)	06	18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(61,735)		49

Lakewood Nrsg & Rehab Center

ID# 0046169

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			160		8,363							8,523	1
2	Food Purchase	(1,598)		345									(1,253)	2
3	Housekeeping			886		96							982	3
4	Laundry													4
5	Heat and Other Utilities			1,236		122							1,358	5
6	Maintenance	(5,838)		2,583	7,739	226							4,710	6
7	Other (specify):*				1,092	1,155							2,247	7
8	**TOTAL General Services**	(7,436)		5,210	8,831	9,962							16,567	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(702)				34,794	(1,434)		(350)	(19)			32,288	10
10a	Therapy													10a
11	Activities													11
12	Social Services					20,251							20,251	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					7,604							7,604	15
16	**TOTAL Health Care and Programs**	(702)				62,649	(1,434)		(350)	(19)			60,143	16
	C. General Administration													
17	Administrative	(6,600)	6,600	2,585	14,717	67,759							85,061	17
18	Directors Fees													18
19	Professional Services	(12,108)		(343,631)		(115,638)							(471,377)	19
20	Fees, Subscriptions & Promotions	(33,467)	250	839		962							(31,416)	20
21	Clerical & General Office Expenses	(186,253)	120	5,209	82,016	16,709							(82,199)	21
22	Employee Benefits & Payroll Taxes				(7,094)								(7,094)	22
23	Inservice Training & Education													23
24	Travel and Seminar			132		636							768	24
25	Other Admin. Staff Transportation			894									894	25
26	Insurance-Prop.Liab.Malpractice			1,548		530							2,078	26
27	Other (specify):*				20,568	11,324							31,892	27
28	**TOTAL General Administration**	(238,428)	6,970	(332,424)	110,207	(17,718)							(471,393)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(246,566)	6,970	(327,214)	119,038	54,893	(1,434)		(350)	(19)			(394,683)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	377,892		2,063		622							380,577	30
31	Amortization of Pre-Op. & Org.	(19,502)	19,502											31
32	Interest	(28,770)	413,097	7,491		179							391,997	32
33	Real Estate Taxes			3,608		390							3,998	33
34	Rent-Facility & Grounds		(798,000)										(798,000)	34
35	Rent-Equipment & Vehicles			845									845	35
36	Other (specify):*	(539)											(539)	36
37	**TOTAL Ownership**	329,081	(365,401)	14,007		1,191							(21,122)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(27,987)						(27,987)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**						(27,987)						(27,987)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	82,515	(358,431)	(313,207)	119,038	56,084	(29,421)		(350)	(19)			(443,792)	45

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 798,000	Lakewood Plainfield Property LLC	100.00%	$	$ (798,000)	1
2	V	17	Management Fee		Lakewood Plainfield Property LLC	100.00%	6,600	6,600	2
3	V	21	Bank Service Charges		Lakewood Plainfield Property LLC	100.00%	120	120	3
4	V	20	Filing Fees		Lakewood Plainfield Property LLC	100.00%	250	250	4
5	V	31	Amortization		Lakewood Plainfield Property LLC	100.00%	19,502	19,502	5
6	V	32	Interest Expense		Lakewood Plainfield Property LLC	100.00%	413,097	413,097	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 798,000			$ 439,569	$ * (358,431)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Extended Care Consulting, LLC	100.00%	$ 160	$ 160	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	345	345	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	886	886	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,236	1,236	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	2,583	2,583	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	2,585	2,585	20
21	V	19	Professional Fees	348,792	Extended Care Consulting, LLC	100.00%	5,161	(343,631)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	839	839	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	5,209	5,209	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	132	132	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	894	894	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,548	1,548	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	2,063	2,063	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	7,491	7,491	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	3,608	3,608	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	845	845	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 348,792			$ 35,585	$ * (313,207)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	7,739	$ 7,739	15
16	V	06	Maintenance (Direct)	4,465	Extended Care Consulting, LLC	100.00%	4,465		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	725	725	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	367	367	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	14,717	14,717	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	89,184	89,184	22
23	V	21	Office and Clerical (Direct)	26,349	Extended Care Consulting, LLC	100.00%	19,181	(7,168)	23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	19,003	19,003	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,565	1,565	25
26	V	22	Employee Benefits	7,094	Extended Care Consulting, LLC	100.00%		(7,094)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 37,908			$ 156,946	$ * 119,038	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	03	Housekeeping	$	Extended Care Clinical, LLC	100.00%	$ 96	$ 96	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	122	122	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	226	226	17
18	V	19	Professional Fees	116,268	Extended Care Clinical, LLC	100.00%	630	(115,638)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	962	962	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	2,500	2,500	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	636	636	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	530	530	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	622	622	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	179	179	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	390	390	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	8,363	8,363	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,155	1,155	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	34,794	34,794	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	20,251	20,251	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	7,604	7,604	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	67,759	67,759	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	14,209	14,209	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	11,324	11,324	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 116,268			$ 172,352	$ * 56,084	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	$ 19,910	MAC Rx, LLC	100.00%	$ 18,476	$ (1,434)	15
16	V	21	Clerical & General Office Expenses		MAC Rx, LLC	100.00%			16
17	V	22	Employee Benefits		MAC Rx, LLC	100.00%			17
18	V	39	Ancillary	388,596	MAC Rx, LLC	100.00%	360,609	(27,987)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 408,506			$ 379,085	$ * (29,421)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 288,968	$ 288,968	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	288,968	CCS Employee Benefits Group	100.00%		(288,968)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 288,968			$ 288,968	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Various Equipment	6,020	Vent Lease LLC	100.00%	5,670	$ (350)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 6,020			$ 5,670	$ * (350)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing Equipment Rental	1,450	Reliable Medical of the Midwest, LLC	100.00%	1,431	$ (19)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,450			$ 1,431	$ * (19)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ROTHNER HEALTH VENTURES G II, LLC	100.00%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	LAKEWOOD PLAINFIELD PROI	PLAINFIELD	BUILDING CO.	1
2			BRIAR PLACE LTD.	INDIAN HEAD PARK	EXTENDED CARE CONSULTING	EVANSTON	MGMT/BOOKKEEPING	2
3			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	3
4			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CARE CENTERS BUILDING	EVANSTON	BUILDING CO.	4
5			GRASMERE PLACE, LLC	CHICAGO	VENT LEASE LLC	EVANSTON	VENTILATOR EQIP	5
6			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7			MAJOR HOSPITAL DYER	DYER, IN	MAC RX	DES PLAINES	PHARMACY	7
8			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN	RELIABLE MEDICAL SUPPLY	DES PLAINES	MEDICAL SUPPLIES	8
9			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				9
10			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				10
11			MAJOR HOSPITAL SEBOS	HOBART, IN				11
12			MCKINLEY HEALTH CARE CENTER	CANTON, OH				12
13			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				13
14			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				14
15			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				15
16			RAINBOW BEACH QOC, L.L.C.	CHICAGO				16
17			SHEFFIELD MANOR	DYER, IN				17
18			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				18
19			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				19
20			SPRING CREEK NURSING & REHAB CENTER	JOLIET				20
21			ST. JAMES WELLNESS REHAB VILLAS	CRETE				21
22			THE ESTATES OF HYDE PARK	CHICAGO				22
23			THE PARC AT JOLIET	JOLIET				23
24			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				24
25			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				25
26			WHEATON CARE CENTER	WHEATON				26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Steinberg	Relative	Administrative	0.00%	See Attached	2.45	4.46%	Alloc Sal/Fee	$ 8,886	17-7	1
2	Kimberly Rudolph	Relative	Clerical	0.00%	See Attached	0.23	3.08%	Alloc Salary	72	21-7	2
3	Adam Vales	Relative	Clerical		See Attached	1.47	3.67%	Alloc Salary	2,693	22-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 11,651		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,380,761	34	$ 5,206	$	42,497	$ 160	1
2	02	Food	Patient Days	1,380,761	34	11,203		42,497	345	2
3	03	Housekeeping	Patient Days	1,380,761	34	28,798		42,497	886	3
4	05	Utilities	Patient Days	1,380,761	34	40,168		42,497	1,236	4
5	06	Maintenance	Patient Days	1,380,761	34	83,922		42,497	2,583	5
6	17	Administrative	Patient Days	1,380,761	34	84,000		42,497	2,585	6
7	19	Professional Fees	Patient Days	1,380,761	34	167,697		42,497	5,161	7
8	20	Dues and Subscriptions	Patient Days	1,380,761	34	27,266		42,497	839	8
9	21	Office and Clerical	Patient Days	1,380,761	34	169,235		42,497	5,209	9
10	24	Seminar and Travel	Patient Days	1,380,761	34	4,279		42,497	132	10
11	25	Other Staff Admin. Trans.	Patient Days	1,380,761	34	29,053		42,497	894	11
12	26	Insurance	Patient Days	1,380,761	34	50,289		42,497	1,548	12
13	30	Depreciation	Patient Days	1,380,761	34	67,038		42,497	2,063	13
14	32	Interest	Patient Days	1,380,761	34	243,379		42,497	7,491	14
15	33	Real Estate Taxes	Patient Days	1,380,761	34	117,233		42,497	3,608	15
16	35	Rent - Equipment & Auto	Patient Days	1,380,761	34	27,451		42,497	845	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,156,218	$		$ 35,585	25

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance (Pooled)	Patient Days	1,380,761	34	251,431	251,431	42,497	7,739	1
2	06	Maintenance (Direct)	Direct		20	373,682	373,682		4,465	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,380,761	34	23,565		42,497	725	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		20	46,748			367	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,380,761	34	478,172	478,172	42,497	14,717	7
8	21	Office and Clerical (Pooled)	Patient Days	1,380,761	34	2,897,656	2,897,656	42,497	89,184	8
9	21	Office and Clerical (Direct)	Direct		24	460,382	460,382		19,181	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,380,761	34	617,434		42,497	19,003	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		24	73,413			1,565	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,222,483	$ 4,461,323		$ 156,946	25

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Extended Care Clinical, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	03	Housekeeping	Patient Days	818,091	19	$ 1,844	$	42,497	$ 96	1
2	05	Utilities	Patient Days	818,091	19	2,355		42,497	122	2
3	06	Maintenance	Patient Days	818,091	19	4,352		42,497	226	3
4	19	Professional Fees	Patient Days	818,091	19	12,122		42,497	630	4
5	20	Dues and Subscriptions	Patient Days	818,091	19	18,512		42,497	962	5
6	21	Office & Clerical	Patient Days	818,091	19	48,124		42,497	2,500	6
7	24	Travel and Seminar	Patient Days	818,091	19	12,239		42,497	636	7
8	26	Insurance	Patient Days	818,091	19	10,196		42,497	530	8
9	30	Depreciation	Patient Days	818,091	19	11,978		42,497	622	9
10	32	Interest	Patient Days	818,091	19	3,446		42,497	179	10
11	33	Real Estate Taxes	Patient Days	818,091	19	7,506		42,497	390	11
12	01	Dietary Salary	Patient Days	818,091	19	160,997	160,997	42,497	8,363	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	818,091	19	22,241		42,497	1,155	13
14	10	Nursing Salary	Patient Days	818,091	19	669,803	669,803	42,497	34,794	14
15	12	Social Service Salary	Patient Days	818,091	19	389,842	389,842	42,497	20,251	15
16	15	Emp. Ben. - Healthcare	Patient Days	818,091	19	146,386		42,497	7,604	16
17	17	Administration Salary	Patient Days	818,091	19	1,304,395	1,304,395	42,497	67,759	17
18	21	Office Salary	Patient Days	818,091	19	273,525	273,525	42,497	14,209	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	818,091	19	217,984		42,497	11,324	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,317,844	$ 2,798,561		$ 172,352	25

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MAC Rx, LLC
Street Address: 2307 S. Mount Prospect Road
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (224)220-2700
Fax Number: (224)220-2730

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing And Medical Records	Direct Allocation			$	$		$ 18,476	1
2	21	Clerical & General Office Expense	Direct Allocation							2
3	22	Employee Benefits	Direct Allocation							3
4	39	Ancillary	Direct Allocation						360,609	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 379,085	25

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS Employee Benefits Group, Inc.
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation			$	$		$ 288,968	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 288,968	25

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Vent Lease, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Various Equipment	Direct Allocation						5,670	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 5,670	25

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Reliable Medical of the Midwest, LLC
Street Address: 200 Howard Avenue
City / State / Zip Code: Des Plaines, Illinois 60018-5909
Phone Number: (847) 566-0800
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing Equipment Rental	Direct Allocation						1,431	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 1,431	25

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Citizens FNB		X	Mortgage			$	$ 7,992,956			$ 413,097	1
2												2
3												3
4												4
5					-							5
	Working Capital											
6	Allocated - EC Consulting	X									7,491	6
7	Allocated - EC Clinical	X									179	7
8					-							8
9	TOTAL Facility Related						$	$ 7,992,956			$ 420,767	9
	B. Non-Facility Related*											
10	Interest Income		X								(28,770)	10
11												11
12												12
13					-							13
14	TOTAL Non-Facility Related						$	$			$ (28,770)	14
15	TOTALS (line 9+line14)						$	$ 7,992,956			$ 391,997	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 109,791	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 113,670	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,879	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 115,156	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$ 878	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 119,913	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	112,723	8
	2012	123,404	9
	2013	119,716	10
	2014	121,149	11
	2015	109,672	12

2016 Accrual = $109,672 x 1.05 = $115,156

Allocated from Extended Care Consulting - $3,608

Allocated from Extended Care Clinical - $390

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** This denial must be no more than four years old at the time the cost report is filed.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lakewood Nrsg & Rehab Center COUNTY Will

FACILITY IDPH LICENSE NUMBER 0046169

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-03-10-312-003-0000	Long Term Care Property	$ 109,671.94	$ 109,671.94
2.	See Attached	Allocated from EC Consulting	$ 117,233.57	$ 3,608.21
3.	See Attached	Allocated from EC Clinical	$ 7,506.21	$ 389.92
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 234,411.72	$ 113,670.07

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lakewood Nrsg & Rehab Center COUNTY Will

FACILITY IDPH LICENSE NUMBER 0046169

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation***. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 15,925 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	273,121	2003	$ 237,379	1
2	Allocated from Extended Care Consulting			19,571	2
3	TOTALS	273,121		$ 256,950	3

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	131			1971	$ 2,099,630	$	39	$ 53,837	$ 53,837	$ 696,940	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2003	11,804		20	83	83	11,247	9
10	Various			2004	41,672		20	1,899	1,899	27,769	10
11	Various			2005	14,592		20	430	430	10,945	11
12	Various			2006	66,264		20	2,024	2,024	65,364	12
13	Various			2007	40,549		20	1,406	1,406	28,823	13
14	Various			2008	65,346		20	1,169	1,169	51,859	14
15	Various			2009	41,805		20	737	737	32,389	15
16	Various			2010	10,259		20	513	513	3,280	16
17	Various			2011	76,043		20	2,073	2,073	18,129	17
18	Various			2012	54,671		20	2,734	2,734	11,864	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		6,332,257			316,613	316,613	3,505,847	67
68	Related Party Allocations (Pages 12H & 12I)		92,912	1,294		1,294		62,605	68
69	Financial Statement Depreciation			76,015			(76,015)		69
70	TOTAL (lines 4 thru 69)		$ 8,947,803	$ 77,309		$ 384,810	$ 307,501	$ 4,527,060	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 8,947,803	$ 77,309		$ 384,810	$ 307,501	$ 4,527,060	1
2	Corridor Double Egress Doors & Metal Doors	2013	5,870		20	294	294	1,150	2
3	Replace Concrete In Front Of Building	2013	11,760		20	588	588	1,960	3
4	Install 16 Outlets & Cable Lines In Resident Rooms, Therapy Roo	2013	3,400		20	680	680	2,210	4
5	Pt Remodel-Shoring Structure,Remove Wall,Relocate Fire Sprink	2013	55,969		20	2,798	2,798	8,862	5
6	Communication System	2014	35,000		20	7,000	7,000	21,000	6
7	Roofing	2014	6,800		20	340	340	992	7
8	Parking Lot	2014	152,000		20	15,200	15,200	39,267	8
9	Hot Water Tank & Piping	2015	3,520		20	176	176	191	9
10	Sprinkler System Upgrade	2015	2,689		20	134	134	246	10
11	Roof Sections 1, 2, 3	2016	17,000		20	638	638	638	11
12	Plumbing Re-Route, Remove Fill From Grease Trap Area	2016	17,037		20	355	355	355	12
13	Plumbing Re-Route At North East Part Of Building	2016	61,000		20	254	254	254	13
14	Concrete Work (Post Plumbing Work) At East Wing Of Building	2016	4,700		20	20	20	20	14
15	Additional Roof Work	2016	2,500		20	31	31	31	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,327,047	$ 77,309		$ 413,318	$ 336,009	$ 4,604,234	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,327,047	$ 77,309		$ 413,318	$ 336,009	$ 4,604,234	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,327,047	$ 77,309		$ 413,318	$ 336,009	$ 4,604,234	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 9,327,047	$ 77,309		$ 413,318	$ 336,009	$ 4,604,234	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,327,047	$ 77,309		$ 413,318	$ 336,009	$ 4,604,234	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 9,327,047	$ 77,309		$ 413,318	$ 336,009	$ 4,604,234	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,327,047	$ 77,309		$ 413,318	$ 336,009	$ 4,604,234	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11	Construction Project	2005	1,354,202		20	67,710	67,710	815,344	11
12	Construction Project	2006	4,978,055		20	248,903	248,903	2,690,503	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,332,257	$		$ 316,613	$ 316,613	$ 3,505,847	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 6,332,257	$		$ 316,613	$ 316,613	$ 3,505,847	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,332,257	$		$ 316,613	$ 316,613	$ 3,505,847	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from EC Consulting - Dyer Building	2007	7,387	164	35	164		1,554	3
4	Allocated from EC Consulting, LLC	2002	24,339	624	39	624		8,919	4
5	Allocated from EC Clinical, LLC	2002	2,630	67	39	67		964	5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting, LLC	2002	20,106		20			20,106	9
10	Allocated from Extended Care Consulting, LLC	2003	23,694		20			23,694	10
11	Allocated from Extended Care Consulting, LLC	2005	1,177	2	20	2		1,177	11
12	Allocated from Extended Care Consulting, LLC	2007	142	7	20	7		71	12
13	Allocated from Extended Care Consulting, LLC	2009	212	11	20	11		85	13
14	Allocated from Extended Care Consulting, LLC	2009	85	4	20	4		34	14
15	Allocated from Extended Care Consulting, LLC	2010	830	42	20	42		291	15
16	Allocated from Extended Care Consulting, LLC	2011	299	15	20	15		90	16
17	Allocated from Extended Care Consulting, LLC	2012	98	5	20	5		25	17
18	Allocated from Extended Care Consulting, LLC	2014	1,976	99	20	99		296	18
19	Allocated from Extended Care Consulting, LLC	2014	1,365	68	20	68		205	19
20	Allocated from Extended Care Consulting, LLC	2015	335	17	20	17		33	20
21	Allocated from Extended Care Consulting, LLC	2016	1,323	66	20	66		66	21
22	Allocated from Extended Care Consulting, LLC	2016	1,637	82	20	82		82	22
23									23
24	Allocated from Extended Care Clinical, LLC	2002	2,173		20			2,173	24
25	Allocated from Extended Care Clinical, LLC	2003	2,561		20			2,561	25
26	Allocated from Extended Care Clinical, LLC	2005	127		20			127	26
27	Allocated from Extended Care Clinical, LLC	2009	23	1	20	1		9	27
28	Allocated from Extended Care Clinical, LLC	2014	214	11	20	11		32	28
29	Allocated from Extended Care Clinical, LLC	2015	36	2	20	2		4	29
30	Allocated from Extended Care Clinical, LLC	2016	143	7	20	7		7	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 92,912	$ 1,294		$ 1,294	$	$ 62,605	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 92,912	$ 1,294		$ 1,294	$	$ 62,605	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 92,912	$ 1,294		$ 1,294	$	$ 62,605	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 227,402	$ 702	$ 42,001	$ 41,299	10	$ 126,674	71
72	Current Year Purchases	5,838		584	584	10	584	72
73	Fully Depreciated Assets	635,807				10	635,807	73
74								74
75	TOTALS	$ 869,047	$ 702	$ 42,585	$ 41,883		$ 763,065	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from EC Consulting, L	2016	$ 5,554	$ 157	$ 157	$	5	$ 5,241	76
77		Allocated from EC Clinical, LLC	2016	2,669	534	534		5	2,390	77
78										78
79										79
80	TOTALS			$ 8,223	$ 691	$ 691	$		$ 7,631	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,461,268	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 78,702	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 456,594	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 377,892	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,374,930	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Off Site Storage Rental				2,517			5
6								6
7	TOTAL				$ 2,517 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 4,737 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$ -	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 583,080	$		$ 583,080	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			191,221			191,221	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			531,431			531,431	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				388,596		388,596	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					22,050	89,873		111,923	13
14	TOTAL			$		$ 1,327,782	$ 478,469		$ 1,806,251	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Lakewood Nrsg & Rehab Center **#** 0046169 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,961	$ 272,427	1
2	Cash-Patient Deposits	23,423	23,423	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,230,839	1,230,839	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	317,391	317,391	6
7	Other Prepaid Expenses	5,918	5,918	7
8	Accounts Receivable (owners or related parties)	627,060	3,360,574	8
9	Other(specify): See Attached Schedule	2,676,026	2,676,026	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,883,618	$ 7,886,598	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		237,379	13
14	Buildings, at Historical Cost		4,084,382	14
15	Leasehold Improvements, at Historical Cost	661,189	5,686,294	15
16	Equipment, at Historical Cost	673,807	673,807	16
17	Accumulated Depreciation (book methods)	(901,015)	(4,795,199)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	2,233	37,050	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 436,214	$ 5,923,713	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,319,832	$ 13,810,311	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,337,082	$ 1,337,081	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,257	16,257	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	278,627	278,627	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,547	15,547	31
32	Accrued Real Estate Taxes(Sch.IX-B)	115,156	115,156	32
33	Accrued Interest Payable		796,700	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	4,254	2,132,751	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,766,923	$ 4,692,119	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,992,956	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 7,992,956	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,766,923	$ 12,685,075	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,552,909	$ 1,125,236	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,319,832	$ 13,810,311	48

***(See instructions.)**

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,837,215	1
2	Restatements (describe):		2
3	**Rounding**	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,837,216	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	715,693	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 715,693	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,552,909	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,559,823	1
2	Discounts and Allowances for all Levels	(4,871,755)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,688,068	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,650,004	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,650,004	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	919	13
14	Non-Patient Meals	447	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	385,704	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	111,571	19
20	Radiology and X-Ray	49,222	20
21	Other Medical Services	40,725	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 588,588	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	28,770	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 28,770	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	1,170	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,170	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,956,600	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,605,009	31
32	Health Care	4,230,993	32
33	General Administration	2,332,784	33
	B. Capital Expense		
34	Ownership	996,000	34
	C. Ancillary Expense		
35	Special Cost Centers	1,806,251	35
36	Provider Participation Fee	269,870	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,240,907	40
41	**Income before Income Taxes (line 30 minus line 40)****	715,693	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 715,693	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,443,518	44
45	Private Pay - Net Inpatient Revenue	2,435,695	45
46	Medicare - Net Inpatient Revenue	639,572	46
47	Other-(specify) Hospice	195,606	47
48	Other-(specify) Insurance	(26,323)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,688,068	49

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,181	2,354	$ 105,629	$ 44.87	1
2	Assistant Director of Nursing	2,078	2,279	89,263	39.17	2
3	Registered Nurses	28,207	31,390	1,003,372	31.96	3
4	Licensed Practical Nurses	26,997	29,429	819,678	27.85	4
5	CNAs & Orderlies	75,349	81,240	1,059,564	13.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,747	13,840	251,186	18.15	8
9	Activity Director	2,361	2,644	45,917	17.37	9
10	Activity Assistants	9,113	9,920	98,405	9.92	10
11	Social Service Workers	8,440	9,145	212,765	23.27	11
12	Dietician					12
13	Food Service Supervisor	2,122	2,302	64,206	27.89	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,639	5,989	93,772	15.66	15
16	Dishwashers	14,603	15,806	161,892	10.24	16
17	Maintenance Workers	5,966	6,670	140,014	20.99	17
18	Housekeepers	14,994	16,803	186,131	11.08	18
19	Laundry	5,224	5,700	54,947	9.64	19
20	Administrator	2,065	2,184	98,331	45.02	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,514	1,581	22,990	14.54	23
24	Clerical	5,465	5,642	88,779	15.74	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,003	2,243	52,437	23.38	31
32	Other Health Care(specify)					32
33	Other(specify)	5,136	5,675	65,644	11.57	33
34	TOTAL (lines 1 - 33)	232,204	252,836	$ 4,714,922 *	$ 18.65	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	416	$ 21,843	01-03	35
36	Medical Director	Monthly	26,100	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,120	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	416	$ 57,063		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Majorie Thompson	Administrator	0	$ 98,331
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 98,331

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 64,877
Marcum LLP	Accounting	24,776
Extended Care Consulting	Home Office Expense	348,792
Extended Care Clinical	Home Office Expense	116,268
Personnel Planners	Unemployment Consulting	1,965
E-Health Data Solutions	MDS Software	1,960
Achieve	Data Processing	15,160
Access One, Inc	Managed IT Services	444
Pro Payroll Solutions	Payroll Services	27,907
IIT/Soutcetech	Data Processing	440
Ability Network	Medicare Billing	3,898
See Supplemental Schedule		13,848
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 620,335

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 205,760
Unemployment Compensation Insurance	120,184
FICA Taxes	351,864
Employee Health Insurance	168,324
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	1,055
Other Employee Welfare	14,017
Holiday Expense	6,193
TOTAL (agree to Schedule V, line 22, col.8)	$ 867,397

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	39,301
Health Care Worker Background Check	3,317
(Indicate # of checks performed 240)	
Patient Background Checks	
Dues & Subscriptions	14,801
Licenses & Fees	4,083
Allocated from EC Consulting	839
Allocated from EC Clinical	962
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 65,293

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,128
Allocated from EC Consulting	132
Allocated from EC Clinical	636
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,896

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/16 Ending: 12/31/16

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC $12,979**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **Yes** If YES, have these costs
been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **64,889** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **269,870**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services fo
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **447**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **N/A** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees