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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0046169

Facility Name: Lakewood Nursing & Rehab Center, Llc

Address: 1112 North Eastern Avenue (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 01/01/17 to 12/31/17 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, 9 Parkway North, Suite 200 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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	47,815	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	47,815	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	17,509	9,324	14,706	41,539	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,509	9,324	14,706	41,539	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.87%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 8,141

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: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	323,529	85,174	20,985	429,688		429,688	8,358	438,046			1
2	Food Purchase		282,531		282,531		282,531	(708)	281,823			2
3	Housekeeping	180,769	42,757		223,526		223,526	1,042	224,568			3
4	Laundry	56,742	20,553		77,295		77,295		77,295			4
5	Heat and Other Utilities			185,703	185,703		185,703	1,277	186,980			5
6	Maintenance	132,037		314,402	446,439		446,439	6,861	453,300			6
7	Other (specify):*							4,202	4,202			7
8	TOTAL General Services	693,077	431,015	521,090	1,645,182		1,645,182	21,032	1,666,214			8
	B. Health Care and Programs											
9	Medical Director			27,600	27,600		27,600		27,600			9
10	Nursing and Medical Records	2,900,064	349,341	374,176	3,623,581		3,623,581	34,311	3,657,892			10
10a	Therapy	252,197		561	252,758		252,758		252,758			10a
11	Activities	146,453	38,220		184,673		184,673		184,673			11
12	Social Services	215,898			215,898		215,898	29,540	245,438			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*	23,042			23,042		23,042	9,319	32,361			15
16	TOTAL Health Care and Programs	3,537,654	387,561	402,337	4,327,552		4,327,552	73,170	4,400,722			16
	C. General Administration											
17	Administrative	97,839			97,839		97,839	88,407	186,246			17
18	Directors Fees											18
19	Professional Services			590,642	590,642		590,642	(478,125)	112,517			19
20	Dues, Fees, Subscriptions & Promotions			122,191	122,191		122,191	(38,118)	84,073			20
21	Clerical & General Office Expenses	122,125	40,972	351,037	514,134		514,134	(148,054)	366,080			21
22	Employee Benefits & Payroll Taxes			818,006	818,006		818,006	(13,949)	804,057			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,543	3,543		3,543	1,096	4,639			24
25	Other Admin. Staff Transportation			11,708	11,708		11,708	766	12,474			25
26	Insurance-Prop.Liab.Malpractice			222,635	222,635		222,635	1,930	224,565			26
27	Other (specify):*							34,209	34,209			27
28	TOTAL General Administration	219,964	40,972	2,119,762	2,380,698		2,380,698	(551,837)	1,828,861			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,450,695	859,548	3,043,189	8,353,432		8,353,432	(457,636)	7,895,796			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 Nursing & Rehab Center, Llc #0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			82,447	82,447		82,447	378,951	461,398			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			542	542		542	278,647	279,189			32
33	Real Estate Taxes			99,489	99,489		99,489	3,885	103,374			33
34	Rent-Facility & Grounds			961,095	961,095		961,095	(960,000)	1,095			34
35	Rent-Equipment & Vehicles			3,708	3,708		3,708	847	4,555			35
36	Other (specify):*			924	924		924	(924)				36
37	TOTAL Ownership			1,148,205	1,148,205		1,148,205	(298,594)	849,611			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		94,942	1,312,573	1,407,515		1,407,515	(26,804)	1,380,711			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			271,152	271,152		271,152		271,152			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		94,942	1,583,725	1,678,667		1,678,667	(26,804)	1,651,863			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,450,695	954,490	5,775,119	11,180,304		11,180,304	(783,034)	10,397,270			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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(119)	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	64,279	30		9
10	Interest and Other Investment Income	(48,921)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(622)	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	(251,524)	21		24
25	Fund Raising, Advertising and Promotional	(32,693)	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	(50,864)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (320,464)		$	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)	(462,570)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (462,570)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (783,034)		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 Nursing & Rehab Center, Llc

ID# 0046169

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (414)	02	1
2	Patient Clothing	(120)	10	2
3	Charitable Donations	(75)	20	3
4	Theft Loss	(509)	21	4
5	Collection Expense	(7,334)	21	5
6	Amortization	(924)	36	6
7	Pac Dues	(5,850)	20	7
8	Joliet Chamber of Commerce Dues	(810)	20	8
9	Non Allowable Legal Fees	(16,835)	19	9
10	Capitalized R&M	(3,297)	06	10
11	Bldg Co. - Management Fee	(6,600)	17	11
12	Bldg Co. - Misc. Admin Expense	(250)	21	12
13	Bldg Co. - Bank Service Charge	(94)	21	13
14	Bldg Co. - Amortization	(7,502)	36	14
15	Annual Report	(250)	20	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				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**	(50,864)		49

Lakewood Nursing & Rehab Center, Llc

ID# 0046169

Report Period Beginning: 01/01/17

Ending: 12/31/17

	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 Nursing & Rehab Center, Llc # 0046169 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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			153		8,205							8,358	1
2	Food Purchase	(1,155)		447									(708)	2
3	Housekeeping			926		116							1,042	3
4	Laundry													4
5	Heat and Other Utilities			1,147		130							1,277	5
6	Maintenance	(3,297)		3,158	6,776	224							6,861	6
7	Other (specify):*				3,053	1,149							4,202	7
8	**TOTAL General Services**	(4,452)		5,831	9,829	9,824							21,032	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(120)				37,003		(2,572)					34,311	10
10a	Therapy													10a
11	Activities													11
12	Social Services					29,540							29,540	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					9,319							9,319	15
16	**TOTAL Health Care and Programs**	(120)				75,862		(2,572)					73,170	16
	C. General Administration													
17	Administrative	(6,600)	6,600	2,363	13,588	72,456							88,407	17
18	Directors Fees													18
19	Professional Services	(16,835)		(345,754)		(115,579)		43					(478,125)	19
20	Fees, Subscriptions & Promotions	(39,678)		687		873							(38,118)	20
21	Clerical & General Office Expenses	(259,711)	344	6,791	84,989	19,533							(148,054)	21
22	Employee Benefits & Payroll Taxes				(13,949)								(13,949)	22
23	Inservice Training & Education													23
24	Travel and Seminar			29		1,067							1,096	24
25	Other Admin. Staff Transportation			766									766	25
26	Insurance-Prop.Liab.Malpractice			1,382		548							1,930	26
27	Other (specify):*				21,530	12,679							34,209	27
28	**TOTAL General Administration**	(322,824)	6,944	(333,736)	106,158	(8,423)		43					(551,837)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(327,396)	6,944	(327,905)	115,987	77,263		(2,529)					(457,636)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc **#** 0046169 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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	64,279	312,319	1,965		388							378,951	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(48,921)	315,118	12,309		141							278,647	32
33	Real Estate Taxes			3,454		431							3,885	33
34	Rent-Facility & Grounds		(960,000)										(960,000)	34
35	Rent-Equipment & Vehicles			847									847	35
36	Other (specify):*	(8,426)	7,502										(924)	36
37	**TOTAL Ownership**	6,932	(325,061)	18,575		960							(298,594)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(26,804)					(26,804)	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**							(26,804)					(26,804)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(320,464)	(318,117)	(309,330)	115,987	78,223		(29,333)					(783,034)	45

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 960,000	Lakewood Plainfield Property LLC	100.00%	$	$ (960,000)	1
2	V	17	Management Fee		Lakewood Plainfield Property LLC	100.00%	6,600	6,600	2
3	V	30	Depreciation		Lakewood Plainfield Property LLC	100.00%	312,319	312,319	3
4	V	36	Amortization		Lakewood Plainfield Property LLC	100.00%	7,502	7,502	4
5	V	32	Interest Expense		Lakewood Plainfield Property LLC	100.00%	315,118	315,118	5
6	V	21	Misc Admin Expense		Lakewood Plainfield Property LLC	100.00%	250	250	6
7	V	21	Bank Service Charge		Lakewood Plainfield Property LLC	100.00%	94	94	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 960,000			$ 641,883	$ * (318,117)	14

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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%	$ 153	$ 153	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	447	447	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	926	926	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,147	1,147	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	3,158	3,158	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	2,363	2,363	20
21	V	19	Professional Fees	348,792	Extended Care Consulting, LLC	100.00%	3,038	(345,754)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	687	687	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	6,791	6,791	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	29	29	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	766	766	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,382	1,382	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	1,965	1,965	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	12,309	12,309	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	3,454	3,454	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	847	847	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			$ 39,462	$ * (309,330)	39

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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%	6,776	$ 6,776	15
16	V	06	Maintenance (Direct)	15,351	Extended Care Consulting, LLC	100.00%	15,351		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	628	628	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	2,425	2,425	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	13,588	13,588	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	84,989	84,989	22
23	V	21	Office and Clerical (Direct)	31,146	Extended Care Consulting, LLC	100.00%	31,146		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	19,047	19,047	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	2,483	2,483	25
26	V	22	Employee Benefits	13,949	Extended Care Consulting, LLC	100.00%		(13,949)	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			$ 60,446			$ 176,433	$ * 115,987	39

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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%	$ 116	$ 116	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	130	130	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	224	224	17
18	V	19	Professional Fees	116,268	Extended Care Clinical, LLC	100.00%	689	(115,579)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	873	873	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	1,451	1,451	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,067	1,067	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	548	548	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	388	388	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	141	141	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	431	431	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	8,205	8,205	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,149	1,149	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	37,003	37,003	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	29,540	29,540	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	9,319	9,319	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	72,456	72,456	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	18,082	18,082	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	12,679	12,679	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 116,268			$ 194,491	$ * 78,223	39

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,980	Vent Lease LLC	100.00%	1,980	$	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			$ 1,980			$ 1,980	$ *	39

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	31,142	MAC Rx, LLC	100.00%	28,570	(2,572)	15
16	V	10A	Therapy		MAC Rx, LLC	100.00%			16
17	V	19	Professional Services	(525)	MAC Rx, LLC	100.00%	(482)	43	17
18	V	21	Clerical & General Office Expenses		MAC Rx, LLC	100.00%			18
19	V	22	Employee Benefits		MAC Rx, LLC	100.00%			19
20	V	39	Ancillary	324,500	MAC Rx, LLC	100.00%	297,696	(26,804)	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			$ 355,117			$ 325,784	$ * (29,333)	39

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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%	$ 298,241	$ 298,241	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	298,241	CCS Employee Benefits Group	100.00%		(298,241)	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			$ 298,241			$ 298,241	$ *	39

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 PROF	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 COMPANY	4
5			GRASMERE PLACE, LLC	CHICAGO	VENT LEASE LLC	EVANSTON	NURSING EQUIPMENT	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			LITTLE VILLAGE NURSING & REHABILITATION CENTER, L.L.C.	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			SPRING MILL HEALTH CAMPUS	MERRIVILLE, IN				21
22			ST. JAMES WELLNESS REHAB VILLAS	CRETE				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			THE PARC AT JOLIET	JOLIET				24
25			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				25
26			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				26
27			WHEATON CARE CENTER	WHEATON				27
28								28
29								29
30								30

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		See Attached	2.33	4.24%	Alloc Sal/Fee	$ 8,491	17-7	1
2	David Aronin	Relative	Administrative		See Attached	1.13	1.98%	Alloc Salary	2,838	17-7	2
3	Adam Vales	Relative	Clerical		See Attached	1.32	3.30%	Alloc Salary	2,292	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	$ 13,621		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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,476,506	37	$ 5,451	$	41,539	$ 153	1
2	02	Food	Patient Days	1,476,506	37	15,903		41,539	447	2
3	03	Housekeeping	Patient Days	1,476,506	37	32,901		41,539	926	3
4	05	Utilities	Patient Days	1,476,506	37	40,755		41,539	1,147	4
5	06	Maintenance	Patient Days	1,476,506	37	112,249		41,539	3,158	5
6	17	Administrative	Patient Days	1,476,506	37	84,000		41,539	2,363	6
7	19	Professional Fees	Patient Days	1,476,506	37	107,994		41,539	3,038	7
8	20	Dues and Subscriptions	Patient Days	1,476,506	37	24,409		41,539	687	8
9	21	Office and Clerical	Patient Days	1,476,506	37	241,371		41,539	6,791	9
10	24	Seminar and Travel	Patient Days	1,476,506	37	1,048		41,539	29	10
11	25	Other Staff Admin. Trans.	Patient Days	1,476,506	37	27,239		41,539	766	11
12	26	Insurance	Patient Days	1,476,506	37	49,139		41,539	1,382	12
13	30	Depreciation	Patient Days	1,476,506	37	69,861		41,539	1,965	13
14	32	Interest	Patient Days	1,476,506	37	437,528		41,539	12,309	14
15	33	Real Estate Taxes	Patient Days	1,476,506	37	122,769		41,539	3,454	15
16	35	Rent - Equipment & Auto	Patient Days	1,476,506	37	30,092		41,539	847	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,402,709	$		$ 39,462	25

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,476,506	37	240,841	240,841	41,539	6,776	1
2	06	Maintenance (Direct)	Direct		21	358,056	358,056		15,351	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,476,506	37	22,330		41,539	628	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		21	51,193			2,425	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,476,506	37	483,002	483,002	41,539	13,588	7
8	21	Office and Clerical (Pooled)	Patient Days	1,476,506	37	3,020,951	3,020,951	41,539	84,989	8
9	21	Office and Clerical (Direct)	Direct		28	498,631	498,631		31,146	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,476,506	37	677,040		41,539	19,047	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		28	74,203			2,483	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					$ 5,426,248	$ 4,601,481		$ 176,433	25

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	781,509	20	$ 2,174	$	41,539	$ 116	1
2	05	Utilities	Patient Days	781,509	20	2,440		41,539	130	2
3	06	Maintenance	Patient Days	781,509	20	4,212		41,539	224	3
4	19	Professional Fees	Patient Days	781,509	20	12,959		41,539	689	4
5	20	Dues and Subscriptions	Patient Days	781,509	20	16,422		41,539	873	5
6	21	Office & Clerical	Patient Days	781,509	20	27,302		41,539	1,451	6
7	24	Travel and Seminar	Patient Days	781,509	20	20,068		41,539	1,067	7
8	26	Insurance	Patient Days	781,509	20	10,303		41,539	548	8
9	30	Depreciation	Patient Days	781,509	20	7,302		41,539	388	9
10	32	Interest	Patient Days	781,509	20	2,656		41,539	141	10
11	33	Real Estate Taxes	Patient Days	781,509	20	8,112		41,539	431	11
12	01	Dietary Salary	Patient Days	781,509	20	154,359	154,359	41,539	8,205	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	781,509	20	21,616		41,539	1,149	13
14	10	Nursing Salary	Patient Days	781,509	20	696,174	696,174	41,539	37,003	14
15	12	Social Service Salary	Patient Days	781,509	20	555,767	555,767	41,539	29,540	15
16	15	Emp. Ben. - Healthcare	Patient Days	781,509	20	175,320		41,539	9,319	16
17	17	Administration Salary	Patient Days	781,509	20	1,363,182	1,363,182	41,539	72,456	17
18	21	Office Salary	Patient Days	781,509	20	340,193	340,193	41,539	18,082	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	781,509	20	238,538		41,539	12,679	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,659,098	$ 3,109,674		$ 194,491	25

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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						1,980	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					$	$		$ 1,980	25

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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						28,570	1
2	10A	Therapy	Direct Allocation							2
3	19	Professional Services	Direct Allocation						(482)	3
4	21	Clerical & General Office Expense	Direct Allocation							4
5	22	Employee Benefits	Direct Allocation							5
6	39	Ancillary	Direct Allocation						297,696	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					$	$		$ 325,784	25

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			$	$		$ 298,241	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					$	$		$ 298,241	25

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			$	$ 7,589,634			$ 315,660	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Allocated from EC Consulting	X									12,309	6
7	Allocated from EC Clinical	X									141	7
8												8
9	TOTAL Facility Related						$	$ 7,589,634			$ 328,110	9
	B. Non-Facility Related*											
10	Interest Income		X								(48,921)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (48,921)	14
15	TOTALS (line 9+line14)						$	$ 7,589,634			$ 279,189	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 Nursing & Rehab Center, Llc **#** 0046169 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 115,156	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.)		$ 108,590	2
3. Under or (over) accrual (line 2 minus line 1).		$ (6,566)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 109,940	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.)		$	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.		$ 103,374	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	123,404	8
	2013	119,716	9
	2014	121,149	10
	2015	109,672	11
	2016	104,705	12

2017 Accrual = $104,705 x 1.05 = $109,940

Allocated from Extended Care Consulting - $3,454

Allocated from Extended Care Clinical - $431

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lakewood Nursing & Rehab Center, Llc COUNTY Will

FACILITY IDPH LICENSE NUMBER 0046169

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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	$ 104,705.12	$ 104,705.12
2.	See Attached	Home Office Allocation	$ 181,041.32	$ 3,885.08
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 285,746.44	$ 108,590.20

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 2016 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 2016 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2016.

Please complete the Real Estate Tax Statement below and include it in the 2017 cost report along with a copy of your 2016 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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lakewood Nursing & Rehab Center, Llc COUNTY Will

FACILITY IDPH LICENSE NUMBER 0046169

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Care Center Building			17,597	2
3	TOTALS	273,121		$ 254,976	3

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 312,319	39	$ 53,837	$ (258,482)	$ 750,777	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2003	11,804		20	83	83	11,329	9
10	Various			2004	41,672		20	1,819	1,819	29,588	10
11	Various			2005	14,592		20	430	430	11,375	11
12	Various			2006	66,264		20	600	600	65,964	12
13	Various			2007	40,549		20	1,177	1,177	30,000	13
14	Various			2008	65,346		20	1,169	1,169	53,028	14
15	Various			2009	41,805		20	737	737	33,126	15
16	Various			2010	10,259		20	513	513	3,793	16
17	Various			2011	76,043		20	1,810	1,810	19,939	17
18	Various			2012	54,671		20	2,734	2,734	14,597	18
19	Various			2013	76,999		20	4,360	4,360	18,541	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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	3,822,460	67
68	Related Party Allocations (Pages 12H & 12I)		86,059	1,285		1,285		57,679	68
69	Financial Statement Depreciation			82,447			(82,447)		69
70	TOTAL (lines 4 thru 69)		$ 9,017,949	$ 396,051		$ 387,165	$ (8,886)	$ 4,922,195	70

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 9,017,949	$ 396,051		$ 387,165	$ (8,886)	$ 4,922,195	1
2	Communication System	2014	35,000		20	7,000	7,000	28,000	2
3	Roofing	2014	6,800		20	340	340	1,332	3
4	Parking Lot	2014	152,000		20	15,200	15,200	54,467	4
5	Hot Water Tank & Piping	2015	3,520		20	176	176	367	5
6	Sprinkler System Upgrade	2015	2,689		20	134	134	381	6
7	Roof Sections 1, 2, 3	2016	17,000		20	850	850	1,488	7
8	Plumbing Re-Route - Remove Fill From Grease Trap Area	2016	17,037		20	852	852	1,207	8
9	Plumbing Re-Route At North East Part Of Building	2016	61,000		20	3,050	3,050	3,304	9
10	Concrete Work (Post Plumbing Work) At East Wing Of Building	2016	4,700		20	235	235	255	10
11	Additional Roof Work	2016	2,500		20	125	125	156	11
12	Flooring Work - Corridor	2017	12,500		20	2,292	2,292	2,292	12
13	Basement Door Replacement	2017	2,500		20	375	375	375	13
14	Water Heater 100 Gal, 160000 Btuh Manufacturer	2017	5,616		20	140	140	140	14
15	Fire Sprinkler System Repair	2017	3,297		20	165	165	165	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)		$ 9,344,107	$ 396,051		$ 418,099	$ 22,048	$ 5,016,122	34

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 9,344,107	$ 396,051		$ 418,099	$ 22,048	$ 5,016,122	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)		$ 9,344,107	$ 396,051		$ 418,099	$ 22,048	$ 5,016,122	34

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 9,344,107	$ 396,051		$ 418,099	$ 22,048	$ 5,016,122	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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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)		$ 9,344,107	$ 396,051		$ 418,099	$ 22,048	$ 5,016,122	34

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 9,344,107	$ 396,051		$ 418,099	$ 22,048	$ 5,016,122	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
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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)		$ 9,344,107	$ 396,051		$ 418,099	$ 22,048	$ 5,016,122	34

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Construction Project	2005	1,354,202		20	67,710	67,710	883,054	9
10	Construction Project	2006	4,978,055		20	248,903	248,903	2,939,406	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)		$ 6,332,257	$		$ 316,613	$ 316,613	$ 3,822,460	34

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$	$ 3,822,460	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
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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	$	$ 3,822,460	34

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Extended Care Consulting-Care Center Bldg	2002	21,558	553	35	553		8,453	3
4	Allocated from Extended Care Consulting - Dyer Building	2007	6,752	150	35	150		1,570	4
5	Allocated from Extended Care Clinical - Care Center Bldg	2002	2,691	69	35	69		1,055	5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting-Care Center Bldg	2002	17,809		20			17,809	9
10	Allocated from Extended Care Consulting-Care Center Bldg	2003	20,987		20			20,987	10
11	Allocated from Extended Care Consulting-Care Center Bldg	2005	1,043		20			1,043	11
12	Allocated from Extended Care Consulting-Care Center Bldg	2009	188	9	20	9		85	12
13	Allocated from Extended Care Consulting-Care Center Bldg	2014	1,806	90	20	90		361	13
14	Allocated from Extended Care Consulting-Care Center Bldg	2015	297	15	20	15		96	14
15	Allocated from Extended Care Consulting-Care Center Bldg	2016	1,172	59	20	59		117	15
16	Allocated from Extended Care Consulting-Care Center Bldg	2017	2,033	102	20	102		102	16
17									17
18	Allocated from Extended Care Consulting	2007	129	6	20	6		71	18
19	Allocated from Extended Care Consulting	2009	77	4	20	4		35	19
20	Allocated from Extended Care Consulting	2010	759	38	20	38		304	20
21	Allocated from Extended Care Consulting	2011	273	14	20	14		96	21
22	Allocated from Extended Care Consulting	2012	90	5	20	5		27	22
23	Allocated from Extended Care Consulting	2014	1,248	62	20	62		250	23
24	Allocated from Extended Care Consulting	2016	1,496	75	20	75		150	24
25									25
26	Allocated from Extended Care Clinical - Care Center Bldg	2002	2,223		20			2,223	26
27	Allocated from Extended Care Clinical - Care Center Bldg	2003	2,620		20			2,620	27
28	Allocated from Extended Care Clinical - Care Center Bldg	2005	130		20			130	28
29	Allocated from Extended Care Clinical - Care Center Bldg	2009	23	1	20	1		11	29
30	Allocated from Extended Care Clinical - Care Center Bldg	2014	218	11	20	11		44	30
31	Allocated from Extended Care Clinical - Care Center Bldg	2015	37	2	20	2		12	31
32	Allocated from Extended Care Clinical - Care Center Bldg	2016	146	7	20	7		15	32
33	Allocated from Extended Care Clinical - Care Center Bldg	2017	254	13	20	13		13	33
34	TOTAL (lines 1 thru 33)		$ 86,059	$ 1,285		$ 1,285	$	$ 57,679	34

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 86,059	$ 1,285		$ 1,285	$	$ 57,679	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
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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)		$ 86,059	$ 1,285		$ 1,285	$	$ 57,679	34

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 222,332	$ 641	$ 41,811	$ 41,170	10	$ 158,115	71
72	Current Year Purchases	6,371		1,062	1,062	10	1,062	72
73	Fully Depreciated Assets	637,864				10	637,864	73
74								74
75	TOTALS	$ 866,567	$ 641	$ 42,872	$ 42,231		$ 797,042	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 Extended Care Consulting		$ 5,077	$ 143	$ 143	$	5	$ 4,934	76
77		Allocated from Extended Care Clinical		2,731	285	285		5	2,731	77
78										78
79										79
80	TOTALS			$ 7,808	$ 428	$ 428	$		$ 7,665	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)	$ 10,473,458	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 397,120	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 461,399	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 64,279	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,820,829	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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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				1,095			5
6								6
7	TOTAL				$ 1,095 **			7

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: *

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: $ 4,555 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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$		$ 491,796	$		$ 491,796	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			209,093			209,093	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			545,721			545,721	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				9,073		9,073	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					65,963	85,869		151,832	13
14	TOTAL			$		$ 1,312,573	$ 94,942		$ 1,407,515	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.

STATE OF ILLINOIS

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc **#** 0046169 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(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	$ 9,631	$ 130,182	1
2	Cash-Patient Deposits	21,924	21,924	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	952,790	952,790	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	85,760	85,760	6
7	Other Prepaid Expenses	1,161	1,161	7
8	Accounts Receivable (owners or related parties)	350,855	3,466,340	8
9	Other(specify): See Attached Schedule	3,375,631	3,375,631	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,797,752	$ 8,033,788	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	673,689	5,698,794	15
16	Equipment, at Historical Cost	688,294	688,294	16
17	Accumulated Depreciation (book methods)	(983,462)	(5,502,349)	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	1,309	28,624	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 379,830	$ 5,235,124	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,177,582	$ 13,268,912	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 549,174	$ 549,174	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,126	16,126	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	278,499	278,499	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,013	15,013	31
32	Accrued Real Estate Taxes(Sch.IX-B)	109,940	109,940	32
33	Accrued Interest Payable		795,140	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	29,834	692,635	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 998,586	$ 2,456,527	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,589,634	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)**	$	$ 7,589,634	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 998,586	$ 10,046,161	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,178,996	$ 3,222,751	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,177,582	$ 13,268,912	48

***(See instructions.)**

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,552,909	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,552,909	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	626,087	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)**	$ 626,087	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)**	$ 4,178,996	24 *

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 11,393,392	1
2	Discounts and Allowances for all Levels	(4,509,904)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,883,488	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,300,529	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,300,529	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	1,034	13
14	Non-Patient Meals	119	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	341,231	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	120,204	19
20	Radiology and X-Ray	49,215	20
21	Other Medical Services	61,236	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 573,039	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	48,921	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 48,921	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	414	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 414	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,806,391	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,645,182	31
32	Health Care	4,327,552	32
33	General Administration	2,380,698	33
	B. Capital Expense		
34	Ownership	1,148,205	34
	C. Ancillary Expense		
35	Special Cost Centers	1,407,515	35
36	Provider Participation Fee	271,152	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,180,304	40
41	**Income before Income Taxes (line 30 minus line 40)****	626,087	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 626,087	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,351,935	44
45	Private Pay - Net Inpatient Revenue	2,311,311	45
46	Medicare - Net Inpatient Revenue	816,800	46
47	Other-(specify) Hospice	388,492	47
48	Other-(specify) Insurance	14,950	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,883,488	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.**

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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	1,853	2,100	$ 95,094	$ 45.28	1
2	Assistant Director of Nursing	1,915	2,142	91,939	42.92	2
3	Registered Nurses	26,809	29,387	963,364	32.78	3
4	Licensed Practical Nurses	25,797	27,851	789,137	28.33	4
5	CNAs & Orderlies	60,507	65,648	876,469	13.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,093	13,021	252,197	19.37	8
9	Activity Director	1,832	2,033	37,286	18.34	9
10	Activity Assistants	9,297	10,212	109,167	10.69	10
11	Social Service Workers	8,141	8,880	215,898	24.31	11
12	Dietician					12
13	Food Service Supervisor	1,911	2,128	58,866	27.66	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,615	5,899	94,956	16.10	15
16	Dishwashers	15,117	16,565	169,707	10.25	16
17	Maintenance Workers	5,488	6,147	132,037	21.48	17
18	Housekeepers	14,505	16,188	180,769	11.17	18
19	Laundry	5,205	5,739	56,742	9.89	19
20	Administrator	2,021	2,121	97,839	46.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,065	7,665	122,125	15.93	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	1,980	2,236	53,445	23.90	31
32	Other Health Care(specify)					32
33	Other(specify)	3,806	4,184	53,656	12.83	33
34	TOTAL (lines 1 - 33)	210,955	230,147	$ 4,450,693 *	$ 19.34	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	400	$ 20,985	01-03	35
36	Medical Director	Monthly	27,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,936	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	per visit	468	10a-03	42
43	Speech Therapy Consultant	per visit	93	10a-03	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	400	$ 53,082		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	12,976	370,240	10-03	52
53	TOTAL (lines 50 - 52)	12,976	$ 370,240		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Marjorie Thompson	Administrator	0	$ 97,839
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 97,839

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 fees	$ 37,443
Marcum LLP	Accounting	25,714
Extended Care Consulting	Home Office Expense	348,792
Extended Care Clinical	Home Office Expense	116,268
Personnel Planners	Unemployment Consulting	1,305
DAIWA	Line of Credit Audit	4,682
Achieve	Data Processing	13,825
Access One, Inc	Managed IT Services	952
Pro Payroll Solutions	Payroll Services	26,034
IIT/Soutcetech	Data Processing	605
Ability Network	Medicare Billing	5,793
See Supplemental Schedule		9,229
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 590,643

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 173,273
Unemployment Compensation Insurance	73,571
FICA Taxes	340,478
Employee Health Insurance	208,554
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	1,002
Other Employee Welfare	1,650
Holiday Expense	5,529
TOTAL (agree to Schedule V, line 22, col.8)	$ 804,057

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	47,712
Health Care Worker Background Check	3,660
(Indicate # of checks performed 280)	
Patient Background Checks	
Dues & Subscriptions	19,049
Licenses & Fees	10,103
Allocated from Extended Care Consulting	687
Allocated from Extended Care Clinical	873
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 84,074

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,543
See Supplemental Schedule	1,096
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,639

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 $11,699.4**

(3) Did the nursing home make political contributions or payments to a political 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. $ **64,431** 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 for 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 Department during this cost report period. $ **271,152**
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 to the Department, in addition to the daily rate, been properly classified 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 for 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. $ **119**

(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 for 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 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