		FOR BHF USE					

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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.

I. IDPH License ID Number: 0046169

Facility Name: Lakewood Nrsg & Rehab Center

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

County: Will

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/20 to 12/31/20 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 Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	20,832	2,925	11,484	35,241	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,832	2,925	11,484	35,241	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.50%

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 2/1/2003

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/2003 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 8,048

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: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	324,212	61,944	21,608	407,764		407,764	623	408,387			1
2	Food Purchase		252,619		252,619		252,619	(304)	252,315			2
3	Housekeeping	109,696	37,881		147,577		147,577	1,142	148,719			3
4	Laundry	55,643	12,131		67,774		67,774		67,774			4
5	Heat and Other Utilities			188,035	188,035		188,035	(15,823)	172,212			5
6	Maintenance	91,722		217,186	308,908		308,908	(34,492)	274,416			6
7	Other (specify):*							3,109	3,109			7
8	TOTAL General Services	581,273	364,575	426,829	1,372,677		1,372,677	(45,745)	1,326,932			8
	B. Health Care and Programs											
9	Medical Director			19,500	19,500		19,500		19,500			9
10	Nursing and Medical Records	2,724,305	384,237	375,413	3,483,955		3,483,955	12,996	3,496,951			10
10a	Therapy	159,154		591	159,745		159,745		159,745			10a
11	Activities	78,207	4,917		83,124		83,124		83,124			11
12	Social Services	173,034			173,034		173,034	13,321	186,355			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*	5,046			5,046		5,046	6,183	11,229			15
16	TOTAL Health Care and Programs	3,139,746	389,154	395,504	3,924,404		3,924,404	32,500	3,956,904			16
	C. General Administration											
17	Administrative	12,887			12,887		12,887	99,258	112,145			17
18	Directors Fees											18
19	Professional Services			638,969	638,969	(13)	638,956	(502,761)	136,195			19
20	Dues, Fees, Subscriptions & Promotions			219,243	219,243		219,243	(18,289)	200,954			20
21	Clerical & General Office Expenses	111,107	23,535	356,108	490,750		490,750	(129,997)	360,753			21
22	Employee Benefits & Payroll Taxes			610,289	610,289		610,289	(18,328)	591,961			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,766	3,766		3,766	639	4,405			24
25	Other Admin. Staff Transportation			809	809		809	577	1,386			25
26	Insurance-Prop.Liab.Malpractice			284,609	284,609		284,609	1,580	286,189			26
27	Other (specify):*							39,905	39,905			27
28	TOTAL General Administration	123,994	23,535	2,113,793	2,261,322	(13)	2,261,309	(527,416)	1,733,893			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,845,013	777,264	2,936,126	7,558,403	(13)	7,558,390	(540,661)	7,017,729			29

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center #0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			56,140	56,140		56,140	354,542	410,682			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							233,501	233,501			32
33	Real Estate Taxes			95,654	95,654	13	95,667	4,377	100,044			33
34	Rent-Facility & Grounds			960,832	960,832		960,832	(960,000)	832			34
35	Rent-Equipment & Vehicles			12,740	12,740		12,740	211	12,951			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,125,366	1,125,366	13	1,125,379	(367,369)	758,010			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		335,598	971,993	1,307,591		1,307,591	(25,056)	1,282,535			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			253,619	253,619		253,619		253,619			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		335,598	1,225,612	1,561,210		1,561,210	(25,056)	1,536,154			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,845,013	1,112,862	5,287,104	10,244,979		10,244,979	(933,086)	9,311,893			45

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(17,058)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	50,806	30		9
10	Interest and Other Investment Income	(37,808)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(207)	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	(500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(254,449)	21		24
25	Fund Raising, Advertising and Promotional	(12,926)	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	(46,183)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (318,325)		$	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)	(614,761)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (614,761)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (933,086)		37

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

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

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

Lakewood Nrsg & Rehab Center
ID# 0046169
Report Period Beginning: 01/01/20
Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (181)	02	1
2	Patient Clothing	(54)	10	2
3	Collection Expense	(4,533)	21	3
4	PAC Dues	(7,352)	20	4
5	Building Company - Management Fee	(6,600)	21	5
6	Building Company - Filing Fees	(75)	21	6
7	Building Company - Amortization	(7,502)	36	7
8	Capitalized R&M	(16,403)	6	8
9	Chamber of Commerce Dues	(363)	20	9
10	Duplicate Expense	(3,120)	21	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				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**	(46,183)		49

Detail lines 29 and 35 of Page 5 starting in C12. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 5B**

Lakewood Nrsg & Rehab Center

IDF 00463169

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		b		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

Reference 1 Reference 2 Reference 3 Reference 4 Reference 5 Reference 6 Reference 7 Reference 9 Reference 10 Reference 10a Reference 11 Reference 12 Reference 13 Reference 14 Reference 15 Reference 17 Reference 18 Reference 19 Reference 20 Reference 21 Reference 22 Reference 23 Reference 24 Reference 25 Reference 26 Reference 27 Reference 30 Reference 31 Reference 32 Reference 33 Reference 34 Reference 35 Reference 36 Reference 38 Reference 39 Reference 40 Reference 41 Reference 42 Reference 43

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			115	508								623	1
2	Food Purchase	(388)		84									(304)	2
3	Housekeeping			1,007	135								1,142	3
4	Laundry													4
5	Heat and Other Utilities	(17,058)		1,103	132								(15,823)	5
6	Maintenance	(16,403)		(18,222)	133								(34,492)	6
7	Other (specify):*			3,034	75								3,109	7
8	**TOTAL General Services**	(33,849)		(12,879)	983								(45,745)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(54)			29,496	(14,248)	(2,199)						12,996	10
10a	Therapy													10a
11	Activities													11
12	Social Services				13,321								13,321	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				6,183								6,183	15
16	**TOTAL Health Care and Programs**	(54)			49,000	(14,248)	(2,199)						32,500	16
	C. General Administration													
17	Administrative			14,421	84,837								99,258	17
18	Directors Fees													18
19	Professional Services			(387,671)	(115,090)								(502,761)	19
20	Fees, Subscriptions & Promotions	(21,141)		1,878	974								(18,289)	20
21	Clerical & General Office Expenses	(268,777)	6,675	87,799	44,306								(129,997)	21
22	Employee Benefits & Payroll Taxes			(18,328)									(18,328)	22
23	Inservice Training & Education													23
24	Travel and Seminar			306	333								639	24
25	Other Admin. Staff Transportation			577									577	25
26	Insurance-Prop.Liab.Malpractice			1,237	343								1,580	26
27	Other (specify):*			21,223	18,682								39,905	27
28	**TOTAL General Administration**	(289,918)	6,675	(278,558)	34,385								(527,416)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(323,821)	6,675	(291,437)	84,368	(14,248)	(2,199)						(540,661)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	50,806	301,672	1,941	123								354,542	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(37,808)	264,258	6,939	112								233,501	32
33	Real Estate Taxes		(1)	3,862	516								4,377	33
34	Rent-Facility & Grounds		(960,000)										(960,000)	34
35	Rent-Equipment & Vehicles			211									211	35
36	Other (specify):*	(7,502)	7,502											36
37	TOTAL Ownership	5,496	(386,569)	12,953	751								(367,369)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(25,056)						(25,056)	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						(25,056)						(25,056)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(318,325)	(379,894)	(278,484)	85,119	(14,248)	(27,255)						(933,086)	45

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Page 6-Supplemental		See Page 6-Supplemental		See Page 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		$	$ (960,000)	1
2	V	33	Real Estate Tax	95,654	Lakewood Plainfield Property LLC		95,653	(1)	2
3	V	21	Management Fee		Lakewood Plainfield Property LLC		6,600	6,600	3
4	V	21	Filing Fees		Lakewood Plainfield Property LLC		75	75	4
5	V	30	Depreciation		Lakewood Plainfield Property LLC		301,672	301,672	5
6	V	36	Amortization		Lakewood Plainfield Property LLC		7,502	7,502	6
7	V	32	Interest		Lakewood Plainfield Property LLC		264,258	264,258	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,055,654			$ 675,760	$ * (379,894)	14

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	LAKEWOOD PLAINFIELD PRO	PLAINFIELD	BUILDING COMPANY	1
2			BURBANK REHABILITATION CENTER	BURBANK	EXTENDED CARE CONSULTIN	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			ESTATES OF HIDDEN LAKE	ST. LOUIS, MO	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	MAC RX	DES PLAINES	PHARMACY	7
8			MAJOR HOSPITAL DYER	DYER, IN				8
9			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				9
10			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				10
11			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				11
12			MAJOR HOSPITAL SEBOS	HOBART, IN				12
13			MAJOR HOSPITAL SPRING MILL HEALTH CAMPUS	MERRIVILLE, IN				13
14			MCKINLEY HEALTH CARE CENTER	CANTON, OH				14
15			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				15
16			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				16
17			RAINBOW BEACH QOC, L.L.C.	CHICAGO				17
18			RUSHVILLE NURSING & REHABILITATION CENTER, LLC	RUSHVILLE				18
19			SHEFFIELD MANOR	DYER, IN				19
20			SOUTH HOLLAND MANOR HEALTH & REHAB CENTER	SOUTH HOLLAND				20
21			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				21
22			ST. JAMES WELLNESS REHAB VILLAS	CRETE				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				24
25			WESMONT MANOR HEALTH & REHAB CENTER	WESTMONT				25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 115	$ 115	15
16	V	02	Food		Extended Care Consulting, LLC		84	84	16
17	V	03	Housekeeping		Extended Care Consulting, LLC		1,007	1,007	17
18	V	05	Utilities		Extended Care Consulting, LLC		1,103	1,103	18
19	V	06	Maintenance		Extended Care Consulting, LLC		2,197	2,197	19
20	V	17	Administrative		Extended Care Consulting, LLC				20
21	V	19	Professional Fees	392,160	Extended Care Consulting, LLC		4,489	(387,671)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC		1,878	1,878	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC		9,887	9,887	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC		306	306	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC		577	577	25
26	V	26	Insurance		Extended Care Consulting, LLC		1,237	1,237	26
27	V	30	Depreciation		Extended Care Consulting, LLC		1,941	1,941	27
28	V	32	Interest		Extended Care Consulting, LLC		6,939	6,939	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC		3,862	3,862	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC		211	211	30
31	V	06	Maintenance Salaries	37,054	Extended Care Consulting, LLC		16,635	(20,419)	31
32	V	07	Emp. Ben. - Gen. Serv.		Extended Care Consulting, LLC		3,034	3,034	32
33	V	17	Administrative Salaries		Extended Care Consulting, LLC		14,421	14,421	33
34	V	21	Office and Clerical Salaries	24,039	Extended Care Consulting, LLC		101,951	77,912	34
35	V	27	Emp. Ben. - Gen. Admin.		Extended Care Consulting, LLC		21,223	21,223	35
36	V	22	Employee Benefits	18,328	Extended Care Consulting, LLC			(18,328)	36
37	V								37
38	V								38
39	Total			$ 471,581			$ 193,097	$ * (278,484)	39

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	1	Dietary Salary	$	Extended Care Clinical, LLC		$ 508	$ 508	15
16	V	3	Housekeeping		Extended Care Clinical, LLC		135	135	16
17	V	5	Utilities		Extended Care Clinical, LLC		132	132	17
18	V	6	Maintenance		Extended Care Clinical, LLC		133	133	18
19	V	7	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC		75	75	19
20	V	10	Nursing Salary		Extended Care Clinical, LLC		28,752	28,752	20
21	V	10	Nursing Expense		Extended Care Clinical, LLC		744	744	21
22	V	12	Social Service Salary		Extended Care Clinical, LLC		13,321	13,321	22
23	V	15	Emp. Ben, - Direct Alloc.		Extended Care Clinical, LLC				23
24	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC		6,183	6,183	24
25	V	17	Administration Salary		Extended Care Clinical, LLC		84,837	84,837	25
26	V	19	Professional Fees	116,268	Extended Care Clinical, LLC		1,178	(115,090)	26
27	V	19	Legal Fees - Direct Alloc.		Extended Care Clinical, LLC				27
28	V	20	Dues and Subscriptions		Extended Care Clinical, LLC		974	974	28
29	V	21	Office Salary		Extended Care Clinical, LLC		42,280	42,280	29
30	V	21	Office & Clerical Other		Extended Care Clinical, LLC		2,026	2,026	30
31	V	24	Travel and Seminar		Extended Care Clinical, LLC		333	333	31
32	V	26	Insurance		Extended Care Clinical, LLC		343	343	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC		18,682	18,682	33
34	V	30	Depreciation		Extended Care Clinical, LLC		123	123	34
35	V	32	Interest		Extended Care Clinical, LLC		112	112	35
36	V	33	Real Estate Taxes		Extended Care Clinical, LLC		516	516	36
37	V								37
38	V								38
39	Total			$ 116,268			$ 201,387	$ * 85,119	39

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	19,200	Vent Lease LLC		4,952	$ (14,248)	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			$ 19,200			$ 4,952	$ * (14,248)	39

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 23,525	MAC Rx, LLC		$ 21,327	$ (2,199)	15
16	V	39	Ancillary	268,102	MAC Rx, LLC		243,046	(25,056)	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			$ 291,627			$ 264,372	$ * (27,255)	39

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 302,489	$ 302,489	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	302,489	CCS Employee Benefits Group			(302,489)	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			$ 302,489			$ 302,489	$ *	39

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	Adam Vales	Relative	Clerical	0	See Attached	1.51	3.77%	Alloc. Salary	$ 2,689	22-7	1
2											2
3											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	$ 2,689		13

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

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	1,219,947	38	$ 3,992	$	35,241	$ 115	1
2	02	Food	Patient Days	1,219,947	38	2,910		35,241	84	2
3	03	Housekeeping	Patient Days	1,219,947	38	34,856		35,241	1,007	3
4	05	Utilities	Patient Days	1,219,947	38	38,173		35,241	1,103	4
5	06	Maintenance	Patient Days	1,219,947	38	76,040		35,241	2,197	5
6	17	Administrative	Patient Days	1,219,947	38			35,241		6
7	19	Professional Fees	Patient Days	1,219,947	38	155,408		35,241	4,489	7
8	20	Dues and Subscriptions	Patient Days	1,219,947	38	64,998		35,241	1,878	8
9	21	Office and Clerical	Patient Days	1,219,947	38	342,251		35,241	9,887	9
10	24	Seminar and Travel	Patient Days	1,219,947	38	10,602		35,241	306	10
11	25	Other Staff Admin. Trans.	Patient Days	1,219,947	38	19,988		35,241	577	11
12	26	Insurance	Patient Days	1,219,947	38	42,836		35,241	1,237	12
13	30	Depreciation	Patient Days	1,219,947	38	67,209		35,241	1,941	13
14	32	Interest	Patient Days	1,219,947	38	240,208		35,241	6,939	14
15	33	Real Estate Taxes	Patient Days	1,219,947	38	133,701		35,241	3,862	15
16	35	Rent - Equipment & Auto	Patient Days	1,219,947	38	7,304		35,241	211	16
17	06	Maintenance Salaries	Patient Days	1,219,947	38	575,856	575,856	35,241	16,635	17
18	07	Emp. Ben. - Gen. Serv.	Patient Days	1,219,947	38	105,021		35,241	3,034	18
19	17	Administrative Salaries	Patient Days	1,219,947	38	499,202	499,202	35,241	14,421	19
20	21	Office and Clerical Salaries	Patient Days	1,219,947	38	3,529,267	3,529,267	35,241	101,951	20
21	27	Emp. Ben. - Gen. Admin.	Patient Days	1,219,947	38	734,685		35,241	21,223	21
22										22
23										23
24										24
25	TOTALS					$ 6,684,506	$ 4,604,325		$ 193,097	25

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	1	Dietary Salary	Patient Days	603,308	20	$ 8,692	$ 8,692	35,241	$ 508	1
2	3	Housekeeping	Patient Days	603,308	20	2,303		35,241	135	2
3	5	Utilities	Patient Days	603,308	20	2,264		35,241	132	3
4	6	Maintenance	Patient Days	603,308	20	2,283		35,241	133	4
5	7	Emp. Ben. - Gen. Serv.	Patient Days	603,308	20	1,277		35,241	75	5
6	10	Nursing Salary	Patient Days	603,308	20	492,213	492,213	35,241	28,752	6
7	10	Nursing Expense	Patient Days	603,308	20	12,740		35,241	744	7
8	12	Social Service Salary	Patient Days	603,308	20	228,053	228,053	35,241	13,321	8
9	15	Emp. Ben, - Direct Alloc.	Direct Allocation		4	44,957				9
10	15	Emp. Ben. - Healthcare	Patient Days	603,308	20	105,855		35,241	6,183	10
11	17	Administration Salary	Patient Days	603,308	20	1,452,375	1,452,375	35,241	84,837	11
12	19	Professional Fees	Patient Days	603,308	20	20,171		35,241	1,178	12
13	19	Legal Fees - Direct Alloc.	Direct Allocation		6	15,220				13
14	20	Dues and Subscriptions	Patient Days	603,308	20	16,674		35,241	974	14
15	21	Office Salary	Patient Days	603,308	20	723,811	723,811	35,241	42,280	15
16	21	Office & Clerical Other	Patient Days	603,308	20	34,682		35,241	2,026	16
17	24	Travel and Seminar	Patient Days	603,308	20	5,708		35,241	333	17
18	26	Insurance	Patient Days	603,308	20	5,874		35,241	343	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	603,308	20	319,826		35,241	18,682	19
20	30	Depreciation	Patient Days	603,308	20	2,099		35,241	123	20
21	32	Interest	Patient Days	603,308	20	1,914		35,241	112	21
22	33	Real Estate Taxes	Patient Days	603,308	20	8,835		35,241	516	22
23										23
24										24
25	TOTALS					$ 3,507,824	$ 2,905,144		$ 201,387	25

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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						4,952	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					$	$		$ 4,952	25

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			$	$		$ 21,327	1
2	39	Ancillary	Direct Allocation						243,046	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					$	$		$ 264,372	25

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			$	$		$ 302,489	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					$	$		$ 302,489	25

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Heartland Bank		X	Mortgage			$	$ 6,277,854			$ 264,258	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 6,277,854			$ 264,258	9
	B. Non-Facility Related*											
10	Interest Income		X								(37,808)	10
11	Allocated from Extended Care Consulting										6,939	11
12	Allocated from Extended Care Clinical										112	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (30,757)	14
15	TOTALS (line 9+line14)						$	$ 6,277,854			$ 233,501	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

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

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 104,769	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.)		$ 102,145	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,624)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 102,655	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.)		$ 13	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.		$ 100,044	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	109,672	8
	2016	104,705	9
	2017	102,070	10
	2018	99,780	11
	2019	97,767	12

2020 Accrual = $97,767 x 1.05 = $102,655

Allocated from Extended Care Consulting $3862

Allocated from Extended Care Clinical $516

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lakewood Nrsg & Rehab Center COUNTY Will

FACILITY IDPH LICENSE NUMBER 0046169

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(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	$ 97,766.52	$ 97,766.52
2.	See Attached	Alloc from Extended Care Consulting	$ 197,162.69	$ 3,862.27
3.	See Attached	Alloc from Extended Care Clinical	$ 197,162.69	$ 516.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 492,091.90	$ 102,144.79

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 2019 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 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lakewood Nrsg & Rehab Center COUNTY Will

FACILITY IDPH LICENSE NUMBER 0046169

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

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

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

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			18,209	2
3	TOTALS	273,121		$ 255,588	3

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 301,672	39	$ 53,837	$ (247,835)	$ 912,288	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2003	11,804		20	83	83	11,578	9
10	Various			2004	41,672		20	1,819	1,819	35,043	10
11	Various			2005	14,592		20	430	430	12,664	11
12	Various			2006	66,264		20			66,264	12
13	Various			2007	40,549		20	1,132	1,132	33,394	13
14	Various			2008	65,346		20	1,169	1,169	56,536	14
15	Various			2009	41,805		20	738	738	35,337	15
16	Various			2010	10,259		20	513	513	5,331	16
17	Various			2011	76,043		20	3,401	3,401	26,960	17
18	Various			2012	54,672		20	2,733	2,733	22,797	18
19	Various			2013	76,999		20	3,680	3,680	30,091	19
20	Various			2014	193,800		20	7,940	7,940	129,819	20
21	Various			2015	6,209		20	310	310	1,679	21
22	Various			2016	102,237		20	5,112	5,112	21,745	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	4,772,299	67
68	Related Party Allocations (Pages 12H & 12I)		90,571	1,405		1,405		63,908	68
69	Financial Statement Depreciation			56,140			(56,140)		69
70	TOTAL (lines 4 thru 69)		$ 9,324,709	$ 359,217		$ 400,915	$ 41,698	$ 6,237,733	70

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 9,324,709	$ 359,217		$ 400,915	$ 41,698	$ 6,237,733	1
2	Flooring - Corridor	2017	12,500		20	625	625	2,448	2
3	Basement Door Replacement	2017	2,500		20	125	125	469	3
4	Water Heater - 100 Gal. 160,000 Btuh Manufacturer	2017	5,616		20	281	281	983	4
5	Frie Sprinkler System Repair	2017	3,297		20	165	165	618	5
6	Make-Up Air Unit - 273,000 Btu'S	2018	11,500		20	575	575	1,725	6
7	Water Heater - 120 Gal	2018	3,650		20	183	183	548	7
8	Nurses Station	2018	8,960		20	448	448	1,307	8
9	Rooftop Unit	2018	7,650		20	383	383	1,021	9
10	Generator Repair	2018	3,925		20	196	196	441	10
11	Installed Fire Protective Devices	2018	4,250		20	213	213	585	11
12	Repaired Air Compressor, Dry Valve, & Sprinkler System	2018	2,617		20	131	131	371	12
13	Repaired Fire Alarm	2018	3,812		20	191	191	493	13
14	Water Heater - 100 Gallon	2019	4,289		20	214	214	357	14
15	Water Heater 120 Gallon	2019	3,650		20	183	183	244	15
16	New Air Handler	2019	21,775		20	1,089	1,089	1,724	16
17	6000 Sq Ft Repair Leaking Roof	2019	24,500		20	1,225	1,225	1,429	17
18	Shingle Repairs (Phase 1)	2019	2,700		20	135	135	270	18
19	Shingle Repairs (Phase 2)	2019	3,320		20	166	166	332	19
20	Fire Sprinkler System Repair-Replace Piping-600 Wing	2019	3,347		20	167	167	334	20
21	Ats Controller	2019	2,529		20	126	126	126	21
22	Replace Water Pump On Generator	2020	6,595		20	330	330	330	22
23	Ptac'S	2020	3,379		20	169	169	169	23
24	Replaced Pipes On Fire Sprinkler	2020	3,900		20	195	195	195	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)		$ 9,474,971	$ 359,217		$ 408,430	$ 49,213	$ 6,254,252	34

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 9,474,971	$ 359,217		$ 408,430	$ 49,213	$ 6,254,252	1
2									2
3									3
4									4
5									5
6									6
7									7
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10									10
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12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,474,971	$ 359,217		$ 408,430	$ 49,213	$ 6,254,252	34

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 9,474,971	$ 359,217		$ 408,430	$ 49,213	$ 6,254,252	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,474,971	$ 359,217		$ 408,430	$ 49,213	$ 6,254,252	34

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 9,474,971	$ 359,217		$ 408,430	$ 49,213	$ 6,254,252	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		$ 9,474,971	$ 359,217		$ 408,430	$ 49,213	$ 6,254,252	34

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	1,086,184	9
10	Construction Project	2006	4,978,055		20	248,903	248,903	3,686,115	10
11									11
12									12
13									13
14									14
15									15
16									16
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22									22
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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	$ 316,613	$ 4,772,299	34

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 6,332,257	$		$ 316,613	$ 316,613	$ 4,772,299	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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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	$ 4,772,299	34

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	Related Party								2
3	Buildings:								3
4	Allocated from Extended Care Consulting-Care Center Bldg	2002	22,136	568	35	568		10,382	4
5	Allocated from Extended Care Consulting - Dyer Building	2007	6,933	154	35	154		2,073	5
6	Allocated from Extended Care Clinical - Care Center Bldg	2002	2,958	76	39	76		1,387	6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting-Care Center Bldg	2002	18,286		20			18,286	9
10	Allocated from Extended Care Consulting-Care Center Bldg	2003	21,549		20			21,549	10
11	Allocated from Extended Care Consulting-Care Center Bldg	2005	1,071		20			1,071	11
12	Allocated from Extended Care Consulting-Care Center Bldg	2009	193	10	20	10		116	12
13	Allocated from Extended Care Consulting-Care Center Bldg	2014	1,854	93	20	93		649	13
14	Allocated from Extended Care Consulting-Care Center Bldg	2015	305	15	20	15		197	14
15	Allocated from Extended Care Consulting-Care Center Bldg	2016	1,203	60	20	60		301	15
16	Allocated from Extended Care Consulting-Care Center Bldg	2017	2,087	104	20	104		417	16
17	Allocated from Extended Care Consulting-Care Center Bldg	2018	957	48	20	48		144	17
18	Allocated from Extended Care Consulting-Care Center Bldg	2019	360	18	20	18		36	18
19	Allocated from Extended Care Consulting-Care Center Bldg	2020	96	5	20	5		5	19
20	Allocated from Extended Care Clinical - Care Center Bldg	2002	2,443		20			2,443	20
21	Allocated from Extended Care Clinical - Care Center Bldg	2003	2,879		20			2,879	21
22	Allocated from Extended Care Clinical - Care Center Bldg	2005	143		20			143	22
23	Allocated from Extended Care Clinical - Care Center Bldg	2009	26	1	20	1		15	23
24	Allocated from Extended Care Clinical - Care Center Bldg	2014	240	12	20	12		84	24
25	Allocated from Extended Care Clinical - Care Center Bldg	2015	41	2	20	2		26	25
26	Allocated from Extended Care Clinical - Care Center Bldg	2016	161	8	20	8		40	26
27	Allocated from Extended Care Clinical - Care Center Bldg	2017	279	14	20	14		56	27
28	Allocated from Extended Care Clinical - Care Center Bldg	2018	128	6	20	6		19	28
29	Allocated from Extended Care Clinical - Care Center Bldg	2019	48	2	20	2		5	29
30	Allocated from Extended Care Clinical - Care Center Bldg	2020	13	1	20	1		1	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 86,389	$ 1,196		$ 1,196	$	$ 62,324	34

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 86,389	$ 1,196		$ 1,196	$	$ 62,324	1
2	Allocated from Extended Care Consulting	2007	133	7	20	7		93	2
3	Allocated from Extended Care Consulting	2009	79	4	20	4		48	3
4	Allocated from Extended Care Consulting	2010	779	39	20	39		429	4
5	Allocated from Extended Care Consulting	2011	280	14	20	14		140	5
6	Allocated from Extended Care Consulting	2012	92	5	20	5		42	6
7	Allocated from Extended Care Consulting	2014	1,281	64	20	64		449	7
8	Allocated from Extended Care Consulting	2016	1,536	77	20	77		384	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 90,571	$ 1,405		$ 1,405	$	$ 63,908	34

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 22,508	$ 658	$ 2,251	$ 1,593	10	$ 11,756	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	850,317				10	850,317	73
74								74
75	TOTALS	$ 872,825	$ 658	$ 2,251	$ 1,593		$ 862,073	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		Alloc. Extended Care Clinical	2012	$ 3,001	$	$	$	5	$ 3,001	76
77		Alloc. Extended Care Consulting	2014	736				5	736	77
78										78
79										79
80	TOTALS			$ 3,737	$	$	$		$ 3,737	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)	$ 10,607,120	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 359,875	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 410,681	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 50,806	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,120,062	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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				832			5
6								6
7	TOTAL				$ 832 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 12,951 Description: See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 398,995	$		$ 398,995	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			149,745			149,745	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			410,017			410,017	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				277,730		277,730	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					13,236	57,868		71,104	13
14	TOTAL			$		$ 971,993	$ 335,598		$ 1,307,591	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 Nrsg & Rehab Center **#** 0046169 **Report Period Beginning:** 01/01/20 **Ending:** 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/20 **(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	$ 189,721	$ 530,282	1
2	Cash-Patient Deposits	36,881	36,881	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,960,805	1,960,805	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	74,429	74,429	6
7	Other Prepaid Expenses	3,926	3,926	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	7,006,899	7,006,899	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 9,272,661	$ 9,613,222	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	754,629	5,779,734	15
16	Equipment, at Historical Cost	700,969	700,969	16
17	Accumulated Depreciation (book methods)	(1,183,620)	(6,612,793)	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		3,590,259	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 271,978	$ 7,779,930	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,544,639	$ 17,393,152	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 487,108	$ 487,109	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,173	33,173	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	149,842	149,842	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,629	3,629	31
32	Accrued Real Estate Taxes(Sch.IX-B)	102,655	102,655	32
33	Accrued Interest Payable		793,651	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	960,650	960,650	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,737,057	$ 2,530,709	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,277,854	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	612,636	1,265,437	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 612,636	$ 7,543,291	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,349,693	$ 10,074,000	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 7,194,946	$ 7,319,152	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,544,639	$ 17,393,152	48

***(See instructions.)**

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,968,692	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,968,691	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,264,656	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	3,599	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(42,000)	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)**	$ 2,226,255	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)**	$ 7,194,946	24 *

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 10,970,876	1
2	Discounts and Allowances for all Levels	(3,781,508)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,189,368	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,646,849	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,646,849	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	136	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	268,375	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	108,267	19
20	Radiology and X-Ray	28,161	20
21	Other Medical Services	16,014	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 420,953	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	37,808	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 37,808	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	1,214,657	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,214,657	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,509,635	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,372,677	31
32	Health Care	3,924,404	32
33	General Administration	2,261,322	33
	B. Capital Expense		
34	Ownership	1,125,366	34
	C. Ancillary Expense		
35	Special Cost Centers	1,307,591	35
36	Provider Participation Fee	253,619	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,244,979	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,264,656	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,264,656	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,202,331	44
45	Private Pay - Net Inpatient Revenue	760,255	45
46	Medicare - Net Inpatient Revenue	1,599,328	46
47	Other-(specify) Hospice	491,537	47
48	Other-(specify) Insurance	135,917	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,189,368	49

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

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

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

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

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,044	2,257	$ 112,614	$ 49.90	1
2	Assistant Director of Nursing	1,955	2,182	98,691	45.23	2
3	Registered Nurses	22,922	25,331	833,141	32.89	3
4	Licensed Practical Nurses	22,478	24,553	780,377	31.78	4
5	CNAs & Orderlies	47,543	51,183	799,891	15.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,032	5,931	159,154	26.83	8
9	Activity Director	2,028	2,179	41,450	19.02	9
10	Activity Assistants	3,314	3,574	36,757	10.28	10
11	Social Service Workers	6,408	6,896	173,034	25.09	11
12	Dietician					12
13	Food Service Supervisor	1,689	1,908	53,569	28.08	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,931	6,325	120,857	19.11	15
16	Dishwashers	11,819	12,964	149,786	11.55	16
17	Maintenance Workers	3,378	3,669	91,722	25.00	17
18	Housekeepers	8,074	8,936	109,696	12.28	18
19	Laundry	3,813	4,104	55,643	13.56	19
20	Administrator	354	502	12,887	25.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,337	6,854	111,107	16.21	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	1,750	2,138	54,463	25.47	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	2,407	2,706	50,174	18.54	33
34	TOTAL (lines 1 - 33)	159,276	174,192	$ 3,845,013 *	$ 22.07	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	409	$ 21,608	01-03	35
36	Medical Director	Monthly	19,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,437	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	591	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	409	$ 49,136		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	275	$ 26,318	10-03	50
51	Licensed Practical Nurses	801	64,448	10-03	51
52	Certified Nurse Assistants/Aides	8,876	277,210	10-03	52
53	TOTAL (lines 50 - 52)	9,952	$ 367,976		53

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Melissa Nackovic-Kline	Administrator	0	$ 9,973
Melissa Wierzgac	Administrator	0	2,914
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 12,887

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
Marcum LLP	Accounting	$ 25,700
Personnel Planners	Unemployment Consultant	1,365
Extended Care Consulting	Home Office Expense	392,160
Extended Care Clinical	Home Office Expense	116,268
Propay HR	Payroll Services	24,627
Red Moose Technologies	IT Support	1,336
Pinnacle Quality Insight	Customer Satisfaction	280
MPAC Healthcare	Healthcare Consultant	18,998
RHP Risk Management	Health & Safety Solutions	20,099
MidCap	Line of Credit Audit	7,425
See Attached	Legal	7,391
See Supplemental Schedule		23,319
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 638,968

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 102,604
Unemployment Compensation Insurance	22,054
FICA Taxes	281,684
Employee Health Insurance	167,964
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	770
Other Employee Welfare	15,264
Holiday Expense	1,621
TOTAL (agree to Schedule V, line 22, col.8)	$ 591,961

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	$ 3,151
Advertising: Employee Recruitment	167,213
Health Care Worker Background Check	
(Indicate # of checks performed 121)	1,214
Patient Background Checks	
Dues & Subscriptions	24,264
Licenses & Fees	2,260
See Supplemental Schedule	2,852
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 200,954

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,766
See Supplemental Schedule	639
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,405

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lakewood Nrsg & Rehab Center # 0046169 Report Period Beginning: 01/01/20 Ending: 12/31/20

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. **HCCI - $14,705**

(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. $ **55,579** 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. $ **253,619**
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. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(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? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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