FOR BHF USE

LL1

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

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0051524

Facility Name: Lakeview Rehab & Nrsg Center

Address: 735 West Diversey (Number) | Chicago (City) | 60614 (Zip Code)

County: Cook

Telephone Number: (708) 449-1900 **Fax #** (708) 449-1500

HFS ID Number:

Date of Initial License for Current Owners: 06/01/11

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: Daniel S. Gaafar **Telephone Number:** (317) 237-5500
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 01/01/15 to 12/31/15 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) Flora Reznik
(Title) CFO

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Daniel S. Gaafar, Partner
(Firm Name & Address) Bradley Associates, 201 S. Capitol Ave, Suite 700, Indianapolis, IN 46225
(Telephone) (317) 237-5500 Fax # (317) 235-5503

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 Lakeview Rehab & Nrsg Center # 0051524 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	178	Skilled (SNF)	178	64,970	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	178	TOTALS	178	64,970	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	40,387	3,008	6,805	50,200	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,387	3,008	6,805	50,200	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.27%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

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 03/31/08

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/31/08 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 178 and days of care provided 6,576

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: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number Lakeview Rehab & Nrsg Center # 0051524 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	310,154		39,580	349,734		349,734	(5,474)	344,260			1
2	Food Purchase		277,075		277,075		277,075		277,075			2
3	Housekeeping	280,234	33,843		314,077		314,077		314,077			3
4	Laundry	95,269	23,147		118,416		118,416		118,416			4
5	Heat and Other Utilities			267,362	267,362		267,362	2,402	269,764			5
6	Maintenance	105,407	98,241	64,923	268,571		268,571	1,653	270,224			6
7	Other (specify):*											7
8	TOTAL General Services	791,064	432,306	371,865	1,595,235		1,595,235	(1,419)	1,593,816			8
	B. Health Care and Programs											
9	Medical Director			21,500	21,500		21,500		21,500			9
10	Nursing and Medical Records	3,075,730	339,484	31,321	3,446,535		3,446,535	4,843	3,451,378			10
10a	Therapy			957,243	957,243		957,243		957,243			10a
11	Activities	108,471	29,490		137,961		137,961		137,961			11
12	Social Services	75,697		13,128	88,825		88,825		88,825			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharmacy Consult			14,634	14,634		14,634		14,634			15
16	TOTAL Health Care and Programs	3,259,898	368,974	1,037,826	4,666,698		4,666,698	4,843	4,671,541			16
	C. General Administration											
17	Administrative	130,928			130,928		130,928		130,928			17
18	Directors Fees											18
19	Professional Services			367,421	367,421		367,421	(368,631)	(1,210)			19
20	Dues, Fees, Subscriptions & Promotions			4,330	4,330		4,330		4,330			20
21	Clerical & General Office Expenses	285,351	114,408	6,686	406,445		406,445	107,030	513,475			21
22	Employee Benefits & Payroll Taxes			877,172	877,172		877,172	32,483	909,655			22
23	Inservice Training & Education											23
24	Travel and Seminar			28,986	28,986		28,986	1,710	30,696			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			517,436	517,436		517,436	62,839	580,275			26
27	Other (specify):*											27
28	TOTAL General Administration	416,279	114,408	1,802,031	2,332,718		2,332,718	(164,569)	2,168,149			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,467,241	915,688	3,211,722	8,594,651		8,594,651	(161,145)	8,433,506			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 Lakeview Rehab & Nrsg Center #0051524 Report Period Beginning: 01/01/15 Ending: 12/31/15

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			73,482	73,482		73,482	71,334	144,816			30
31	Amortization of Pre-Op. & Org.							422,316	422,316			31
32	Interest			349,986	349,986		349,986	330,662	680,648			32
33	Real Estate Taxes							264,559	264,559			33
34	Rent-Facility & Grounds			1,260,000	1,260,000		1,260,000	(1,133,979)	126,021			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Replacement Tax							2,145	2,145			36
37	TOTAL Ownership			1,683,468	1,683,468		1,683,468	(42,963)	1,640,505			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			15,541	15,541		15,541		15,541			38
39	Ancillary Service Centers		246,635		246,635		246,635		246,635			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			362,343	362,343		362,343		362,343			42
43	Other (specify):* Bad Debt Exp.			428,000	428,000		428,000	(428,000)				43
44	TOTAL Special Cost Centers		246,635	805,884	1,052,519		1,052,519	(428,000)	624,519			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,467,241	1,162,323	5,701,074	11,330,638		11,330,638	(632,108)	10,698,530			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 Lakeview Rehab & Nrsg Center # 0051524 Report Period Beginning: 01/01/15 Ending: 12/31/15

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(19,950)	30		9
10	Interest and Other Investment Income	(3,950)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(85)	1		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	(1,228)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(428,000)	43		24
25	Fund Raising, Advertising and Promotional	(39,706)	21		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	(6,524)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (499,443)		$	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)	(132,665)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (132,665)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (632,108)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Lakeview Rehab & Nrsg Center

ID# 0051524

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc. Income	$ (6,524)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				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**	(6,524)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Lakeview Rehab & Nrsg Center **#** 0051524 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(85)	(5,389)	0	0	0	0	0	0	0	0	0	(5,474)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	2,402	0	0	0	0	0	0	0	0	0	2,402	5
6	Maintenance	0	1,653	0	0	0	0	0	0	0	0	0	1,653	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(85)	(1,334)	0	0	0	0	0	0	0	0	0	(1,419)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	4,843	0	0	0	0	0	0	0	0	0	4,843	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	4,843	0	0	0	0	0	0	0	0	0	4,843	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(355,701)	(12,930)	0	0	0	0	0	0	0	0	(368,631)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(47,458)	154,223	265	0	0	0	0	0	0	0	0	107,030	21
22	Employee Benefits & Payroll Taxes	0	32,483	0	0	0	0	0	0	0	0	0	32,483	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,710	0	0	0	0	0	0	0	0	0	1,710	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	2,834	60,005	0	0	0	0	0	0	0	0	62,839	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(47,458)	(164,451)	47,340	0	0	0	0	0	0	0	0	(164,569)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(47,543)	(160,942)	47,340	0	0	0	0	0	0	0	0	(161,145)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lakeview Rehab & Nrsg Center # 0051524 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(19,950)	0	91,284	0	0	0	0	0	0	0	0	71,334	30
31	Amortization of Pre-Op. & Org.	0	0	422,316	0	0	0	0	0	0	0	0	422,316	31
32	Interest	(3,950)	0	334,612	0	0	0	0	0	0	0	0	330,662	32
33	Real Estate Taxes	0	4,166	260,393	0	0	0	0	0	0	0	0	264,559	33
34	Rent-Facility & Grounds	0	6,021	(1,140,000)	0	0	0	0	0	0	0	0	(1,133,979)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	2,145	0	0	0	0	0	0	0	0	2,145	36
37	**TOTAL Ownership**	(23,900)	10,187	(29,250)	0	0	0	0	0	0	0	0	(42,963)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(428,000)	0	0	0	0	0	0	0	0	0	0	(428,000)	43
44	**TOTAL Special Cost Centers**	(428,000)	0	0	0	0	0	0	0	0	0	0	(428,000)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(499,443)	(150,755)	18,090	0	0	0	0	0	0	0	0	(632,108)	45

Facility Name & ID Number Lakeview Rehab & Nrsg Center # 0051524 Report Period Beginning: 01/01/15 Ending: 12/31/15

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
Michael Blisko	40.00%	Ambassador Nursing & Rehab Center	Chicago	Infinity	Hillside	Mgmt Co
Moishe Gubin	40.00%	Belhaven Nursing & Rehab Center	Chicago	Lincoln Park Holdings		Realty Co
D. Borak	19.00%	City View Multicare Center	Cicero			
M. Elkes	1.00%	Continental Nursing & Rehab Center	Chicago			
		Forest View Rehab & Nursing Center	Itasca			
		Midway Neurological & Rehab Center	Bridgeview			

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	1	Dietary	$ 15,450	Infinity Healthcare Management of Illinois		$ 10,061	$ (5,389)	1
2	V	5	Utilities		Infinity Healthcare Management of Illinois		2,402	2,402	2
3	V	6	Maintenance		Infinity Healthcare Management of Illinois		1,653	1,653	3
4	V	10	Nursing	42,760	Infinity Healthcare Management of Illinois		47,603	4,843	4
5	V	19	Professional Fees	356,735	Infinity Healthcare Management of Illinois		1,034	(355,701)	5
6	V	21	Office Expense	59,119	Infinity Healthcare Management of Illinois		213,342	154,223	6
7	V	22	Employee Expenses	3,730	Infinity Healthcare Management of Illinois		36,213	32,483	7
8	V	24	Travel	936	Infinity Healthcare Management of Illinois		2,646	1,710	8
9	V	26	Insurance		Infinity Healthcare Management of Illinois		2,834	2,834	9
10	V	33	Property Tax		Infinity Healthcare Management of Illinois		4,166	4,166	10
11	V	34	Rent Expense		Infinity Healthcare Management of Illinois		6,021	6,021	11
12	V							0	12
13	V								13
14	Total			$ 478,730			$ 327,975	$ * (150,755)	14

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

Facility Name & ID Number Lakeview Rehab & Nrsg Center # 0051524 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	19	Professional Fees	$	Lincoln Park Holdings, LLC		$ (12,930)	$ (12,930)	15
16	V	21	Office Expense		Lincoln Park Holdings, LLC		265	265	16
17	V	26	Insurance		Lincoln Park Holdings, LLC		60,005	60,005	17
18	V	30	Depreciation		Lincoln Park Holdings, LLC		91,284	91,284	18
19	V	31	Amortization		Lincoln Park Holdings, LLC		422,316	422,316	19
20	V	32	Interest		Lincoln Park Holdings, LLC		334,612	334,612	20
21	V	33	RE Taxes		Lincoln Park Holdings, LLC		260,393	260,393	21
22	V	34	Rent	1,260,000	Lincoln Park Holdings, LLC		120,000	(1,140,000)	22
23	V	36	Replacement Tax		Lincoln Park Holdings, LLC		2,145	2,145	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							0	37
38	V								38
39	Total			$ 1,260,000			$ 1,278,090	$ * 18,090	39

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

Facility Name & ID Number Lakeview Rehab & Nrsg Center # 0051524 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			Momence Meadows Nursing & Rehab Ctr	Momence				1
2			Niles Nursing & Rehab Center	Niles				2
3			Oak Lawn Respiratory & Rehab Center	Oak Lawn				3
4			Parker Nursing & Rehab Center	Streator				4
5			Parkshore Estates Nursing & Rehab Ctr	Chicago				5
6			Southpoint Nursing & Rehab Center	Chicago				6
7			West Suburban Nursing & Rehab Center	Bloomingdale				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 Lakeview Rehab & Nrsg Center # 0051524 Report Period Beginning: 01/01/15 Ending: 12/31/15

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									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		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 Lakeview Rehab & Nrsg Center # 0051524 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Lakeview Rehab & Nrsg Center # 0051524 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	HUD Loan		X	Mortgage	$37,680.00	11/26/14	$ 8,953,100	$ 8,823,802	11/1/49	3.6300	$ 334,612	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Capital One		X	Working Capital	None	8/31/14	19,174,998	1,520,905	8/31/18	Various	152,452	6
7	Infintiy Funding	X		Working Capital	None	Various	Various	1,970,648	Various	Various	197,534	7
8												8
9	TOTAL Facility Related				$37,680.00		$ 28,128,098	$ 12,315,355			$ 684,598	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 28,128,098	$ 12,315,355			$ 684,598	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 40,242 Line # 26

*** 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 Lakeview Rehab & Nrsg Center # 0051524 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 299,269	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.)		$ 260,411	2
3. Under or (over) accrual (line 2 minus line 1).		$ (38,858)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 303,457	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 264,599	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	228,518	8
	2011	227,568	9
	2012	251,860	10
	2013	255,269	11
	2014	260,411	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lakeview Rehab & Nrsg Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051524

CONTACT PERSON REGARDING THIS REPORT Daniel S. Gaafar

TELEPHONE (317) 237-5500 FAX #: (317) 235-5503

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-28-300-013-000	Nursing Facility	$ 260,411.00	$ 260,411.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 260,411.00	$ 260,411.00

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 X _____ 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Lakeview Rehab & Nrsg Center # 0051524 Report Period Beginning: 01/01/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,604 B. General Construction Type: Exterior Brick Frame Brick & Stell Number of Stories 3

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? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (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	Nursing Home		2011	$ 500,000	1
2					2
3	TOTALS			$ 500,000	3

Facility Name & ID Number Lakeview Rehab & Nrsg Center # 0051524 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	178		2014		$ 3,560,000	$ 91,284	39	$ 91,282	$ (2)	$ 100,793	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Suburban Elevatator			2011	28,500	731	39	731		3,350	9
10											10
11	Install Exaust Fans			2012	8,670	222	39	222		889	11
12	Suburban Elevatator			2012	16,050	412	39	412		1,647	12
13	Suburban Elevatator			2012	2,850	73	39	73		292	13
14	Suburban Elevatator - Pit Work & Drilling			2012	9,350	240	39	240		959	14
15	Provide & Install Railings			2012	2,630	67	39	67		269	15
16	New Awnings			2012	1,750	45	39	45		181	16
17											17
18	Replace podding in south floor elevator			2013	1,956	50	39	50		125	18
19	Heat Exchanger			2013	1,898	49	39	49		122	19
20	Fire Alarm System			2013	13,475	345	39	345		865	20
21	Electrical room walls & ceiling			2013	5,280	135	39	135		338	21
22	Patch parking lot			2013	3,450	88	39	88		220	22
23	Electrical wiring - 2nd floor			2013	18,101	464	39	464		1,160	23
24											24
25	Clean Network Closet			2014	1,992	51	39	51		102	25
26	Install Stair Rails			2014	2,325	60	39	60		120	26
27	New carpet, paint, cove base, & walls in therapy room			2014	63,081	1,618	39	1,618		3,235	27
28	Install Dome Light Modules			2014	2,280	58	39	58		116	28
29	New walls, floor tiles, & paint in shower rooms			2014	4,465	115	39	115		229	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 Lakeview Rehab & Nrsg Center # 0051524 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Reface doors, crown molding, partition walls, and cover lights		$	$		$	$	$	37
38	in patient room	2015	4,850	124	39	124		124	38
39	New carpet, paint, cove base, & walls in therapy room	2015	9,419	242	39	242		242	39
40	New walls, floor tiles, & paint in shower rooms	2015	5,469	140	39	140		148	40
41									41
42	New flooring in first floor resident rooms	2015	12,097	310	39	310		310	42
43	New cove base & wallcovering in therapy room	2015	3,284	84	39	84		84	43
44	Replaced Trane Chiller Compressor	2015	13,690	351	39	351		351	44
45	New flooring and cove bases in shower rooms	2015	3,296	85	39	85		85	45
46	Clean Cooling Tower	2015	4,925	126	39	126		126	46
47	Elevator hand rail/cubicle curtains in resident rooms	2015	7,489	192	39	192		192	47
48	New flooring and cove bases in shower rooms	2015	4,947	127	39	127		127	48
49	New sinks and drains in kitchen, janitor room, and elevator room	2015	11,500	295	39	295		295	49
50	Partition walls, cover lights, and fabricate desk in patient room	2015	23,290	598	39	597	(1)	598	50
51	Replace exhaust manifold heater	2015	2,900	74	39	74		74	51
52	Replace air handler coil	2015	15,480	398	39	397	(1)	398	52
53	Replace glycol feeder pumping station	2015	4,425	113	39	113		113	53
54	Rebuild generator and replace starter	2015	5,489	141	39	141		141	54
55	Rebuild B&G circulating pump	2015	2,987	77	39	77		77	55
56	Install new water circulating pump	2015	4,500	114	39	114		114	56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,888,140	$ 99,698		$ 99,694	$ (4)	$ 118,611	70

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

Facility Name & ID Number Lakeview Rehab & Nrsg Center # 0051524 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 169,628	$ 9,086	$ 33,926	$ 24,840	5	$ 145,331	71
72	Current Year Purchases	55,982	55,982	11,196	(44,786)	5	55,982	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 225,610	$ 65,068	$ 45,122	$ (19,946)		$ 201,313	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 4,613,750	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 164,766	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 144,816	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (19,950)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 319,924	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 Lakeview Rehab & Nrsg Center # 0051524 Report Period Beginning: 01/01/15 Ending: 12/31/15

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								5
6								6
7	TOTAL				$ **			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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ Description:
    (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 Lakeview Rehab & Nrsg Center # 0051524 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Lakeview Rehab & Nrsg Center # 0051524 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	10a-3	hrs	$	6,220	$ 388,371	$	6,220	$ 388,371	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		3,393	151,261		3,393	151,261	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		6,623	417,611		6,623	417,611	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				239,762		239,762	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray & Lab	39-2					6,874		6,874	12
13	Other (specify):									13
14	TOTAL			$	16,236	$ 957,243	$ 246,636	16,236	$ 1,203,879	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 Lakeview Rehab & Nrsg Center # 0051524 Report Period Beginning: 01/01/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/15 (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	$ (137,643)	$ 64,450	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,093,114	5,093,114	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	188,041	188,041	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Escrow Accounts		187,344	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,143,512	$ 5,532,949	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		500,000	13
14	Buildings, at Historical Cost		3,560,000	14
15	Leasehold Improvements, at Historical Cost	328,139	328,139	15
16	Equipment, at Historical Cost	225,611	225,611	16
17	Accumulated Depreciation (book methods)	(219,122)	(319,915)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		6,334,759	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(466,307)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Security Deposit		225,458	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 334,628	$ 10,387,745	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,478,140	$ 15,920,694	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,540,568	$ 1,649,637	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(17,550)	(17,550)	28
29	Short-Term Notes Payable		134,072	29
30	Accrued Salaries Payable	232,151	232,151	30
31	Accrued Taxes Payable (excluding real estate taxes)	59,754	59,754	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		26,692	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Working Capital	1,520,905	1,520,905	36
37	Working Capital	1,970,648	1,970,648	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,306,476	$ 5,576,309	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,689,730	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 8,689,730	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,306,476	$ 14,266,039	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 171,664	$ 1,654,655	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,478,140	$ 15,920,694	48

*(See instructions.)

Facility Name & ID Number Lakeview Rehab & Nrsg Center # 0051524 Report Period Beginning: 01/01/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (468,641)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (468,641)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,073,120	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(432,815)	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)**	$ 640,305	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)**	$ 171,664	24	*

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

Facility Name & ID Number Lakeview Rehab & Nrsg Center # 0051524 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 10,883,105	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,883,105	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,367,894	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,367,894	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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	140,895	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,500	19
20	Radiology and X-Ray	666	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 145,061	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,174	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,174	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income	6,524	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,524	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,403,758	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,595,235	31
32	Health Care	4,666,698	32
33	General Administration	2,332,718	33
	B. Capital Expense		
34	Ownership	1,683,468	34
	C. Ancillary Expense		
35	Special Cost Centers	262,176	35
36	Provider Participation Fee	362,343	36
	D. Other Expenses (specify):		
37	Bad Debt Expense	428,000	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,330,638	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,073,120	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,073,120	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,028,677	44
45	Private Pay - Net Inpatient Revenue	708,850	45
46	Medicare - Net Inpatient Revenue	2,073,915	46
47	Other-(specify)	1,071,663	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,883,105	49

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

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

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

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

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,202	2,276	$ 96,265	$ 42.30	1
2	Assistant Director of Nursing	4,862	5,532	181,573	32.82	2
3	Registered Nurses	22,379	25,065	723,116	28.85	3
4	Licensed Practical Nurses	29,925	32,873	854,299	25.99	4
5	CNAs & Orderlies	90,877	103,053	1,167,701	11.33	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	9,200	9,988	108,471	10.86	9
10	Activity Assistants					10
11	Social Service Workers	3,931	4,442	75,697	17.04	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,283	22,977	310,154	13.50	15
16	Dishwashers					16
17	Maintenance Workers	4,233	5,299	105,407	19.89	17
18	Housekeepers	17,912	20,676	280,234	13.55	18
19	Laundry	6,794	8,112	95,269	11.74	19
20	Administrator	1,992	2,177	130,928	60.14	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,957	19,652	304,824	15.51	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,064	2,264	33,304	14.71	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	233,611	264,386	$ 4,467,242 *	$ 16.90	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	441	$ 15,450	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	895	31,321	10-3	38
39	Pharmacist Consultant	293	14,634	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	375	13,128	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,004	$ 74,533		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jonathan Dixon	Administrator		$ 130,928
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 130,928

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
Bradley Associates	Accounting	$ 7,616
Johnson, Goldburg & Brown	Accounting	2,500
Secretary of State	Professional	25
Infinity Healthcare	Professional/Mgmt	357,280
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 367,421

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 115,018
Unemployment Compensation Insurance	90,493
FICA Taxes	330,142
Employee Health Insurance	282,553
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	88,719
Uniforms	1,141
Employee Expense	1,589
TOTAL (agree to Schedule V, line 22, col.8)	$ 909,655

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
City of Chicago	840
The Joint Commission	3,415
Illinois Healthcare Association	75
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,330

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage	26,738
Seminar Expense	
Education & Seminars	3,790
Business Seminar Expense	168
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 30,696

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(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? **5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **36,727** Line **10-2**

(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? **X** YES ____ 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **362,343**
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. $ **0** 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? **0%**
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:

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

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