FOR BHF USE

LL1

2021
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2021)

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: 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: Aaron Mauer **Telephone Number:** 773-747-4506
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 1/1/21 to 12/31/21 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) 4/25/2022 (Date)
(Type or Print Name) Paresh Vipani
(Title) CFO

Paid Preparer

(Signed) 4/25/2022 (Date)
(Print Name and Title) Aaron Mauer, President
(Firm Name & Address) GGM Associates, Inc., 6101 Nimtz Parkway South Bend IN 46628
(Telephone) 773-747-4506 Fax # 773-747-4725

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: 1/1/21 Ending: 12/31/21

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 NA

	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	4,565	2	39,323	43,890	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,565	2	39,323	43,890	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.55%

D. How many bed reserve days during this year were paid by the Department?
0 (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 3/31/08

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/31/08 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 2,796

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/21 Fiscal Year: 12/31/21

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

Facility Name & ID Number Lakeview Rehab Nrsg Center # 0051524 Report Period Beginning: 1/1/21 Ending: 12/31/21

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	398,493	27,461	14,500	440,454		440,454		440,454			1
2	Food Purchase		263,271		263,271		263,271	(9,063)	254,208			2
3	Housekeeping	393,523	59,326		452,849		452,849		452,849			3
4	Laundry	77,017	27,644		104,660		104,660		104,660			4
5	Heat and Other Utilities			334,590	334,590		334,590	2,653	337,243			5
6	Maintenance	94,612	35,781	52,023	182,416		182,416	3,759	186,175			6
7	Other (specify):*											7
8	**TOTAL General Services**	963,644	413,484	401,113	1,778,241		1,778,241	(2,652)	1,775,589			8
	B. Health Care and Programs											
9	Medical Director			18,420	18,420		18,420		18,420			9
10	Nursing and Medical Records	3,553,694	275,116	1,952,450	5,781,260		5,781,260	(1,843)	5,779,417			10
10a	Therapy			703,818	703,818		703,818		703,818			10a
11	Activities	170,394	9,268		179,663		179,663	(25)	179,638			11
12	Social Services	78,794		14,019	92,813		92,813		92,813			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*			11,844	11,844		11,844		11,844			15
16	**TOTAL Health Care and Programs**	3,802,883	284,385	2,700,551	6,787,818		6,787,818	(1,868)	6,785,949			16
	C. General Administration											
17	Administrative	139,342		990	140,332		140,332	(772)	139,560			17
18	Directors Fees											18
19	Professional Services			751,344	751,344		751,344	(260,229)	491,115			19
20	Dues, Fees, Subscriptions & Promotions			4,387	4,387		4,387	2,764	7,151			20
21	Clerical & General Office Expenses	246,002	79,989	335,767	661,758		661,758	65,053	726,811			21
22	Employee Benefits & Payroll Taxes			1,230,517	1,230,517		1,230,517	42,033	1,272,550			22
23	Inservice Training & Education											23
24	Travel and Seminar			23,155	23,155		23,155	6,306	29,461			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			360,642	360,642		360,642	61,365	422,007			26
27	Other (specify):*											27
28	**TOTAL General Administration**	385,344	79,989	2,706,800	3,172,133		3,172,133	(83,479)	3,088,654			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,151,871	777,857	5,808,464	11,738,192		11,738,192	(88,000)	11,650,192			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: 1/1/21 Ending: 12/31/21

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			21,564	21,564		21,564	89,342	110,906			30
31	Amortization of Pre-Op. & Org.			1,276,359	1,276,359		1,276,359	448,720	1,725,079			31
32	Interest			611,298	611,298		611,298	251,753	863,051			32
33	Real Estate Taxes							319,194	319,194			33
34	Rent-Facility & Grounds			1,260,000	1,260,000		1,260,000	(1,259,215)	785			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*							1,731	1,731			36
37	**TOTAL Ownership**			3,169,221	3,169,221		3,169,221	(148,474)	3,020,747			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			11,262	11,262		11,262		11,262			38
39	Ancillary Service Centers		164,814		164,814		164,814		164,814			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			345,019	345,019		345,019		345,019			42
43	Other (specify):*			228,926	228,926		228,926	(228,926)	(0)			43
44	**TOTAL Special Cost Centers**		164,814	585,207	750,021		750,021	(228,926)	521,095			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,151,871	942,671	9,562,891	15,657,434		15,657,434	(465,400)	15,192,034			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: 1/1/21 Ending: 12/31/21

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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,942)	30		9
10	Interest and Other Investment Income	(4,455)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(38,220)	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	(228,926)	43		24
25	Fund Raising, Advertising and Promotional	(25,420)	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	(10,765)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (309,728)		$	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)			34
35	Other- Attach Schedule	(155,672)	Various	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (155,672)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (465,400)		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

Lakeview Rehab Nrsg Center
ID# 0051524
Report Period Beginning: 1/1/21
Ending: 12/31/21

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc Income - Med Records	$ (637)	10	1
2	Misc Income - Food Rebate	(9,063)	2	2
3	Misc Income - Maint Supp Rebate	(1,065)	6	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**	(10,765)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lakeview Rehab Nrsg Center # 0051524 Report Period Beginning: 1/1/21 Ending: 12/31/21

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,063)	0	0	0	0	0	0	0	0	0	0	(9,063)	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	2,653	0	0	0	0	0	0	0	0	0	2,653	5
6	Maintenance	(1,065)	4,824	0	0	0	0	0	0	0	0	0	3,759	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(10,128)	7,476	0	0	0	0	0	0	0	0	0	(2,652)	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	(637)	(1,206)	0	0	0	0	0	0	0	0	0	(1,843)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	(25)	0	0	0	0	0	0	0	0	0	(25)	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**	(637)	(1,231)	0	0	0	0	0	0	0	0	0	(1,868)	16
	C. General Administration													
17	Administrative	0	0	(772)	0	0	0	0	0	0	0	0	(772)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(288,004)	27,775	0	0	0	0	0	0	0	0	(260,229)	19
20	Fees, Subscriptions & Promotions	0	2,764	0	0	0	0	0	0	0	0	0	2,764	20
21	Clerical & General Office Expenses	(63,640)	128,693	0	0	0	0	0	0	0	0	0	65,053	21
22	Employee Benefits & Payroll Taxes	0	42,033	0	0	0	0	0	0	0	0	0	42,033	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6,306	0	0	0	0	0	0	0	0	0	6,306	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	12	61,353	0	0	0	0	0	0	0	0	61,365	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(63,640)	(108,196)	88,356	0	0	0	0	0	0	0	0	(83,479)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(74,405)	(101,951)	88,356	0	0	0	0	0	0	0	0	(88,000)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lakeview Rehab Nrsg Center # 0051524 Report Period Beginning: 1/1/21 Ending: 12/31/21

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	(1,942)	0	91,284	0	0	0	0	0	0	0	0	89,342	30
31	Amortization of Pre-Op. & Org.	0	0	448,720	0	0	0	0	0	0	0	0	448,720	31
32	Interest	(4,455)	59	256,149	0	0	0	0	0	0	0	0	251,753	32
33	Real Estate Taxes	0	0	319,194	0	0	0	0	0	0	0	0	319,194	33
34	Rent-Facility & Grounds	0	(1,259,215)	0	0	0	0	0	0	0	0	0	(1,259,215)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	1,731	0	0	0	0	0	0	0	0	1,731	36
37	TOTAL Ownership	(6,397)	(1,259,156)	1,117,078	0	0	0	0	0	0	0	0	(148,474)	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):*	(228,926)	0	0	0	0	0	0	0	0	0	0	(228,926)	43
44	TOTAL Special Cost Centers	(228,926)	0	0	0	0	0	0	0	0	0	0	(228,926)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(309,728)	(1,361,107)	1,205,435	0	0	0	0	0	0	0	0	(465,400)	45

Facility Name & ID Number Lakeview Rehab Nrsg Center # 0051524 Report Period Beginning: 1/1/21 Ending: 12/31/21

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 Healthcare	Hillside	Consulting Co.
Gubin Enterprises LP	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			
		Hope Creek Nursing and Rehabilitation, LLC	Moline			

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	5	Heat and Other Utilities	$	Infinity Healthcare mgmt		$ 2,653	$ 2,653	1
2	V	6	Maintenance		Infinity Healthcare mgmt		4,824	4,824	2
3	V	10	Nursing and Medical Records	40,607	Infinity Healthcare mgmt		39,401	(1,206)	3
4	V	19	Professional Services	639,977	Infinity Healthcare mgmt		351,974	(288,004)	4
5	V	20	Dues, Fees, Subscriptions & Promotions		Infinity Healthcare mgmt		2,764	2,764	5
6	V	21	Clerical & General Office Expenses	120,688	Infinity Healthcare mgmt		249,381	128,693	6
7	V	22	Employee Benefits & Payroll Taxes	2,176	Infinity Healthcare mgmt		44,209	42,033	7
8	V	24	Travel and Seminar	5,880	Infinity Healthcare mgmt		12,186	6,306	8
9	V	26	Insurance-Prop.Liab.Malpractice		Infinity Healthcare mgmt		12	12	9
10	V	32	Interest		Infinity Healthcare mgmt		37	37	10
11	V	32	Interest		Infinity Healthcare mgmt		22	22	11
12	V	34	Rent-Facility & Grounds	1,260,000	Lincoln Park Holdings		785	(1,259,215)	12
13	V	11	Activites	25	Infinity Healthcare mgmt			(25)	13
14	Total			$ 2,069,353			$ 708,247	$ * (1,361,107)	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: 1/1/21 Ending: 12/31/21

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	17	Administrative	$ 772	Infinity Healthcare mgmt		$	$ (772)	15
16	V	19	Professional Services		Lincoln Park Holdings		27,775	27,775	16
17	V	26	Insurance-Prop.Liab.Malpractice		Lincoln Park Holdings		61,353	61,353	17
18	V	30	Depreciation		Lincoln Park Holdings		91,284	91,284	18
19	V	31	Amoritization		Lincoln Park Holdings		448,720	448,720	19
20	V	32	Interest		Lincoln Park Holdings		256,149	256,149	20
21	V	33	Real Estate Taxes		Lincoln Park Holdings		319,194	319,194	21
22	V	36	Replacement Tax		Lincoln Park Holdings		1,731	1,731	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			$ 772			$ 1,206,207	$ * 1,205,435	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: 1/1/21 Ending: 12/31/21

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 Nrusing & 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	Streater				4
5			Parkshore Estates Nursing & Rehab Ctr	Chicago				5
6			Southpoint Nursing & Rehab Center	Chicago				6
7			West Suburban Nursing & Rehab Center	Bloomington				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: 1/1/21 Ending: 12/31/21

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: 1/1/21 Ending: 12/31/21

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 Lakeview Rehab Nrsg Center # 0051524 Report Period Beginning: 1/1/21 Ending: 12/31/21

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		X	Mortgage	$35,925.00	11/26/14	$ 8,953,100	$ 7,951,247	11/1/49	3.2300	$ 256,149	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Credit Suisse		X	Working Capital	None	Various	Various	4,949,844	none	various	81,882	6
7	Infinity funding	X		Working Capital	None	Various	Various	Various	none	various	529,417	7
8												8
9	TOTAL Facility Related				$35,925.00		$ 8,953,100	$ 12,901,091			$ 867,447	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 8,953,100	$ 12,901,091			$ 867,447	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 44,820 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: 1/1/21 Ending: 12/31/21

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2020 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 373,743	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.)		$ 396,529	2
3. Under or (over) accrual (line 2 minus line 1).		$ 22,786	3
4. Real Estate Tax accrual used for 2021 report. (Detail and explain your calculation of this accrual on the lines below.)		$ (22,786)	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.		$ 0	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2016	274,156	8
2017	354,434	9
2018	351,610	10
2019	357,624	11
2020	396,529	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2020	$	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.

2020 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 Aaron Mauer

TELEPHONE 773-747-4506 FAX #: 773-747-4725

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

Enter the tax index number and real estate tax assessed for 2020 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 2020.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-28-300-013-0000	Nursing Home	$ 396,529.34	$ 396,529.34
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 396,529.34	$ 396,529.34

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 copies of the original 2020 tax bills which were listed in Section A to this statement. Be sure to use the 2020 tax bill which is normally paid during 2021.

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: 1/1/21 Ending: 12/31/21

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,604 B. General Construction Type: Exterior Brick Frame Brick & Steel 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? [X] (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).

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		7/3/1905	$ 500,000	1
2					2
3	TOTALS			$ 500,000	3

Facility Name & ID Number Lakeview Rehab Nrsg Center # 0051524 Report Period Beginning: 1/1/21 Ending: 12/31/21

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)	$ 648,491	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Suburban Elevatator			2011	28,500	731	39	731		7,735	9
10											10
11	Install Exaust Fans			2012	8,670	222	39	222		2,222	11
12	Suburban Elevatator			2012	16,050	412	39	412		4,118	12
13	Suburban Elevatator			2012	2,850	73	39	73		730	13
14	Suburban Elevatator - Pit Work & Drilling			2012	9,350	240	39	240		2,398	14
15	Provide & Install Railings			2012	2,630	67	39	67		672	15
16	New Awnings			2012	1,750	45	39	45		452	16
17											17
18	Replace podding in south floor elevator			2013	1,956	50	39	50		425	18
19	Heat Exchanger			2013	1,898	49	39	49		415	19
20	Fire Alarm System			2013	13,475	346	39	346		2,940	20
21	Electrical room walls & ceiling			2013	5,280	135	39	135		1,149	21
22	Patch parking lot			2013	3,450	88	39	88		749	22
23	Electrical wiring - 2nd floor			2013	18,101	464	39	464		3,944	23
24											24
25	Clean Network Closet			2014	1,992	51	39	51		408	25
26	Install Stair Rails			2014	2,325	60	39	60		479	26
27	New carpet, paint, cove base, & walls in therapy room			2014	63,081	1,617	39	1,617		12,938	27
28	Install Dome Light Modules			2014	2,280	58	39	58		465	28
29	New walls, floor tiles, & paint in shower rooms			2014	4,465	114	39	114		916	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: 1/1/21 Ending: 12/31/21

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		869	38
39	New carpet, paint, cove base, & walls in therapy room	2015	9,419	242	39	242		1,693	39
40	New walls, floor tiles, & paint in shower rooms	2015	5,469	140	39	140		981	40
41									41
42	New flooring in first floor resident rooms	2015	12,097	310	39	310		2,171	42
43	New cove base & wallcovering in therapy room	2015	3,284	84	39	84		589	43
44	Replaced Trane Chiller Compressor	2015	13,690	351	39	351		2,457	44
45	New flooring and cove bases in shower rooms	2015	3,296	85	39	85		594	45
46	Clean Cooling Tower	2015	4,925	126	39	126		883	46
47	Elevator hand rail/cubicle curtains in resident rooms	2015	7,489	192	39	192		1,344	47
48	New flooring and cove bases in shower rooms	2015	4,947	127	39	127		889	48
49	New sinks and drains in kitchen, janitor room, and elevator room	2015	11,500	295	39	295		2,065	49
50	Partition walls, cover lights, and fabricate desk in patient room	2015	23,290	597	39	597		4,180	50
51	Replace exhaust manifold heater	2015	2,900	74	39	74		519	51
52	Replace air handler coil	2015	15,480	397	39	397		2,779	52
53	Replace glycol feeder pumping station	2015	4,425	113	39	113		792	53
54	Rebuild generator and replace starter	2015	5,489	141	39	141		986	54
55	Rebuild B&G circulating pump	2015	2,987	77	39	77		538	55
56	Install new water circulating pump	2015	4,500	115	39	115		806	56
57									57
58	New Glycol Feeder	2016	4,425	113	39	113		679	58
59	Igeacom Nurse Calls	2016	2,525	65	39	65		389	59
60	Circulation Pump	2016	2,633	68	39	68		407	60
61	Roof Top Exhaust	2016	3,471	89	39	89		534	61
62	Butterfly Valve	2016	2,105	54	39	54		324	62
63	Cooling Tower Bearing Assembly	2016	3,253	83	39	83		499	63
64	New Doors - Restrooms	2016	2,740	70	39	70		421	64
65	Paint Rooms 320, 321, 322, 302, 214, 211	2016	5,100	131	39	131		785	65
66	Fire Alarm Panel	2016	14,652	376	39	376		2,255	66
67	Surface Panic Devices for 1st Floor Corridor	2016	6,849	176	39	176		1,055	67
68	1st Floor East Shower Rooms	2016	4,495	115	39	115		691	68
69	Propress Copper Pip Fitting & Piping	2016	3,087	79	39	79		473	69
70	TOTAL (lines 4 thru 69)		$ 3,943,475	$ 101,117		$ 101,115	$ (2)	$ 725,293	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: 1/1/21 Ending: 12/31/21

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		$ 3,943,475	$ 101,117		$ 101,115	$ (2)	$ 725,293	1
2	105 Ton Carrier Chiller	2017	112,500	2,885	39	2,885		12,981	2
3	Remove Counter Top 1st Floor Nursing Station &Remove Floorin	2017	3,064	79	39	79		354	3
4	Install New Flooring on 2nd & 3rd Floor Nursing Stations	2017	6,240	160	39	160		720	4
5	Replace Alarm Sensor in Chillller Room	2017	3,397	87	39	87		392	5
6	New OEM Bearing for Cooling Tower	2017	6,260	161	39	161		723	6
7	Tuff Storage Shed	2017	4,749	122	39	122		548	7
8	Rebuilt Bearing Assembly for Circulating Pump 1	2017	3,638	93	39	93		420	8
9	Replaced Water Cooler Compressor	2017	3,200	82	39	82		369	9
10									10
11	Remove wallpaper and paint walls in DON office and Library	2018	3,934	101	39	101		353	11
12	2 Elevator Door Edges	2018	4,200	108	39	108		377	12
13	New Circulating Pump for Hot Water Heat Exchanger	2018	2,116	54	39	54		190	13
14	New Retro Fit for Door for Walk-in Cooler	2018	3,362	86	39	86		302	14
15	New Phone System	2018	23,545	604	39	604		2,113	15
16	Replace filters in boiler room air handler & kitchen	2018	3,160	81	39	81		284	16
17									17
18	Replace Kitchen Air Handler Circulating Pump	2019	4,408	65	39	65	0	281	18
19	Fire Alarm Auxillary Control Panel & Installation	2019	3,423	39	39	39		207	19
20	New Basement Door; New Cylinder Locks on Stairwell Doors	2019	6,264	112	39	112		420	20
21	3rd Floor Wander System	2019	5,322	88	39	88		338	21
22	1st Floor Wander System	2019	6,948	178	39	178		490	22
23	Parts Replacement on Steam Tables 1 & 3	2019	2,649	68	39	68		175	23
24	Paint Resident Rooms & Bathrooms on 1st Floor (1st billing)	2019	3,500	90	39	90		232	24
25	Paint Resident Rooms & Bathrooms on 1st Floor (2nd billing)	2019	3,500	90	39	90		232	25
26	Paint Resident Rooms & Bathrooms on 1st Floor (3rd billing)	2019	700	18	39	18		46	26
27	Paint Rooms 108, 105, 110, 117, 109	2019	2,950	76	39	76		195	27
28	Installation of Wanderer System at Basement Exit Door Area	2019	2,974	76	39	76		191	28
29	Replace Pipe Insulation Above Ceiling in Therapy Room	2019	3,745	96	39	96		232	29
30	Paint Rooms 102, 107, 111, 112, 113, 118. Wall Repairs to Room 3(	2019	3,975	102	39	102		246	30
31	Installation of Stairway Keypads on Door Alarm Systems	2019	2,306	59	39	59		143	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,179,504	$ 106,975		$ 106,973	$ (2)	$ 748,848	34

**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: 1/1/21 Ending: 12/31/21

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		$ 4,179,504	$ 106,975		$ 106,973	$ (2)	$ 748,848	1
2	Remove Wall Paper in & Paint DON , ADON, Social Services & A	2019	2,625	67	39	67		151	2
3	Repairs to DON & ADON Offices, Paint MDS Office	2019	2,825	72	39	72		163	3
4	Replace Faulty Glycol Feed Station & Repair Leak on Main Air H	2019	2,717	70	39	70		157	4
5									5
6									6
7	Fire Damper Inspection Throughout Building	2020	6,038	155	39	155		310	7
8	New Basement Entry Convector	2020	4,500	115	39	115		231	8
9	Sand, Patch, Paint all Doors and Frames on 1st, 2nd, 3rd Floors ar	2020	2,200	56	39	56		113	9
10	New Nurse Call System	2020	2,801	72	39	72		144	10
11	Finish Doors and Frames in Corridors Including Patching, Sandin	2020	1,750	45	39	45		90	11
12	New Nurse Call System (additional part)	2020	130	3	39	3		7	12
13	Repair and Paint Walls in Rooms 307, 309, 311, 312, 313	2020	2,495	64	39	64		128	13
14	Paint and Repair Walls on 3rd Florr Dememtia Unit 4	2020	2,400	62	39	62		123	14
15	New Kitchen Hot Water Pump	2020	3,161	81	39	81		162	15
16	New Hydro Relay Board for Elevator 1	2020	3,450	88	39	88		177	16
17	Install New Drywall, Sand and Paint Rooms 319, 316, 309, 304, 31	2020	2,475	63	39	63		127	17
18	Repair and Paint Walls in 3rd Floor Demenita Unit	2020	2,475	63	39	63		127	18
19	Repair and Paint Walls in 3rd Floor Demenita Unit	2020	2,295	59	39	59		118	19
20	Clean Cooling Tower and Install New Gaskets. Piped Water Suppl	2020	2,324	60	39	60		119	20
21	Furnish & Install Fire Service Software Upgrade	2020	14,800	379	39	379		759	21
22	Elevator Mechanical Rooms Violation Repairs	2020	2,390	61	39	61		123	22
23	Tower Chemical Cleaning	2020	2,628	67	39	67		135	23
24									24
25	Installation of System for Dial Tone for Call Lights on 2nd and 3r	2021	3,500	45	39	75	30	45	25
26	Fire Safety Evaluation System	2021	3,300	42	39	63	21	42	26
27	New Nurse Call System	2021	77,913	999	39	1,498	499	999	27
28	Sealcoat & Crackfill Parking Lot	2021	10,054	129	39	86	(43)	129	28
29	Winterize Chiller & Cooler Tower	2021	2,505	32	39	11	(21)	32	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,343,254	$ 109,927		$ 110,411	$ 484	$ 753,556	34

**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: 1/1/21 Ending: 12/31/21

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	$	$	$	$		$	71
72	Current Year Purchases	3,718	3,098	496	(2,602)		372	72
73	Fully Depreciated Assets	407,319					407,319	73
74								74
75	TOTALS	$ 411,037	$ 3,098	$ 496	$ (2,602)		$ 407,691	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)	$ 5,254,291	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 113,025	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 110,906	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (2,118)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,161,247	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: 1/1/21 Ending: 12/31/21

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.	/2022	$
13.	/2023	$
14.	/2024	$

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: 1/1/21 Ending: 12/31/21

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: 1/1/21 Ending: 12/31/21

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	$	4,267	$ 272,899	$	4,267	$ 272,899	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		2,190	84,233		2,190	84,233	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		5,733	346,685		5,733	346,685	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				141,216		141,216	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-2					8,125		8,125	12
13	Other (specify): Lab	39-2					15,473		15,473	13
14	TOTAL			$	12,190	$ 703,818	$ 164,814	12,190	$ 868,632	14

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

Facility Name & ID Number Lakeview Rehab Nrsg Center # 0051524 Report Period Beginning: 1/1/21 Ending: 12/31/21

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/21 (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	$ (430,631)	$ 13,891	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,154,324	4,154,324	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	245,229	245,229	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,968,923	$ 4,413,444	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	783,255	783,255	15
16	Equipment, at Historical Cost	434,587	434,587	16
17	Accumulated Depreciation (book methods)	(515,116)	(1,163,613)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	1,303,634	7,638,394	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,301,362)	(4,327,969)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 704,999	$ 7,424,654	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,673,921	$ 11,838,098	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,313,488	$ 1,353,488	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(3,915)	(3,915)	28
29	Short-Term Notes Payable	4,949,845	4,949,844	29
30	Accrued Salaries Payable	199,874	199,874	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,038	280,327	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		20,209	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,479,330	$ 6,799,827	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,951,247	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 7,951,247	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,479,330	$ 14,751,074	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,805,409)	$ (2,912,976)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,673,921	$ 11,838,098	48

*(See instructions.)

Facility Name & ID Number Lakeview Rehab Nrsg Center # 0051524 Report Period Beginning: 1/1/21 Ending: 12/31/21

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,179,194	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,179,194	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(3,984,603)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (3,984,603)	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)**	$ (1,805,409)	24 *

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

Facility Name & ID Number Lakeview Rehab Nrsg Center # 0051524 Report Period Beginning: 1/1/21 Ending: 12/31/21

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,046,899	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,046,899	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	378,917	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 378,917	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	211,337	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	817	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	19,642	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 231,796	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,455	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,455	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a	Misc. Income	10,764	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 10,764	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,672,831	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,778,241	31
32	Health Care	6,787,818	32
33	General Administration	3,172,133	33
	B. Capital Expense		
34	Ownership	3,169,221	34
	C. Ancillary Expense		
35	Special Cost Centers	750,021	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,657,434	40
41	**Income before Income Taxes (line 30 minus line 40)****	(3,984,603)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (3,984,603)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,369,854	44
45	Private Pay - Net Inpatient Revenue	34,845	45
46	Medicare - Net Inpatient Revenue	1,892,900	46
47	Other-(specify) Insurance & Hospice	749,300	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,046,899	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.**

Facility Name & ID Number Lakeview Rehab Nrsg Center # 0051524 Report Period Beginning: 1/1/21 Ending: 12/31/21

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	2,056	2,080	$ 113,618	$ 54.62	1
2	Assistant Director of Nursing	4,537	4,818	203,629	42.26	2
3	Registered Nurses	11,211	11,832	443,759	37.50	3
4	Licensed Practical Nurses	32,154	34,229	1,280,673	37.41	4
5	CNAs & Orderlies	69,745	74,403	1,432,282	19.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,120	10,891	170,394	15.65	10
11	Social Service Workers	2,773	3,374	78,794	23.35	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,602	23,425	398,493	17.01	15
16	Dishwashers					16
17	Maintenance Workers	3,735	4,021	94,612	23.53	17
18	Housekeepers	19,774	21,400	393,522	18.39	18
19	Laundry	5,011	5,333	77,017	14.44	19
20	Administrator	2,088	2,326	139,342	59.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,555	11,634	241,490	20.76	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	536	560	12,306	21.98	31
32	Other Health Care(specify)					32
33	Other(specify) Admissions	1,996	2,380	71,938	30.23	33
34	TOTAL (lines 1 - 33)	197,891	212,706	$ 5,151,869 *	$ 24.22	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	Monthly	$ 14,500	1-3	35
36	Medical Director	Monthly	18,420	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	40,607	10-3	38
39	Pharmacist Consultant	Monthly	11,844	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	Monthly	12,449	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 97,820		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	37,568	1,911,843	10-3	52
53	TOTAL (lines 50 - 52)	37,568	$ 1,911,843		53

Facility Name & ID Number Lakeview Rehab Nrsg Center # 0051524 Report Period Beginning: 1/1/21 Ending: 12/31/21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Graber, Joshua B	Administrator	0	$ 3,693
Ingraffia, Jeffrey	Administrator	0	135,649
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 139,342

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
Johnson, Goldburg	Accounting Fees	$ 3,000
GGM Associates Inc.	Accounting Fees	15,000
Infinity H Funding	COVID-19 Professional Fees	1,950
Offshore Solutions, LLC	COVID-19 Professional Fees	2,364
People Powered, LLC	COVID-19 Professional Fees	30,224
Dutton Casey & Mesoloras P.C.	Legal Service	5,163
Infinity Funding / Sedgwick	Legal Service	87,548
McGuire Woods, LLP	Legal Service	2,982
Infinity Healthcare Management of Il	Management Fees	572,314
Empire Risk Management Services, I	Professional Fees	12,000
Global Fiscal Midwest, LLC	Professional Fees	18,502
See attached schedule		298
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 751,345

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 117,919
Unemployment Compensation Insurance	25,445
FICA Taxes	435,538
Employee Health Insurance	278,182
Employee Meals	337
Illinois Municipal Retirement Fund (IMRF)*	
Pension	25,379
Other	389,750
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,272,550

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Other	5,161
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,151

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage	15,481
Travel	4,067
Automobile Expense	2,241
Seminar Expense	
Employee Education	6,273
Employee Education CNA	1,400
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 29,461

* Attach copy of IMRF notifications

**See instructions.

C. Professional Services

Vendor/Payee	Type	Amount
Infinity Healthcare Management of Il	Professional Fees	$ 50
RCG Management Group, LLC	Professional Fees	248
SUBTOTAL		298

Facility Name & ID Number Lakeview Rehab Nrsg Center # 0051524 Report Period Beginning: 1/1/21 Ending: 12/31/21

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. **N/A**

(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?

(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 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **58,917** Line **10-3**

(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?
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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **345,019**
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. $

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

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

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