		FOR BHF USE				

LL1

2022
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2022)

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	PROPRIETARY	GOVERNMENTAL
[ ] 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 ____	

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/22 to 12/31/22 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)	Paresh Vipani
	(Title)	CFO
Paid Preparer	(Signed)	(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

In the event there are further questions about this report, please contact:
Name: Aaron Mauer Telephone Number: 773-747-4506
Email Address:

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: 1/1/22 Ending: 12/31/22

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 ______

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	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	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI Medicaid Primary	MMAI Medicare Primary	Private Pay	Medicare Part A Only	Other	Total	
8	SNF	7,601	18,494	16,159	368	435	4,285	279	47,621	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	7,601	18,494	16,159	368	435	4,285	279	47,621	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 73.30%

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 [ ] Date 3/31/08 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [ ] If YES, enter certified beds.
number of certified beds 178

Medicare Intermediary ______

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/22 Fiscal Year: 12/31/22

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

Facility Name & ID Number: Lakeview Rehab Nrsg Center # 0051524 Report Period Beginning: 1/1/22 Ending: 12/31/22

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	398,558	33,203	46,434	478,195		478,195		478,195			1
2	Food Purchase		349,342		349,342		349,342	(5,941)	343,401			2
3	Housekeeping	308,394	53,172		361,566		361,566		361,566			3
4	Laundry	56,018	48,710		104,728		104,728		104,728			4
5	Heat and Other Utilities			344,875	344,875		344,875	1,507	346,382			5
6	Maintenance	106,106	31,124	63,029	200,259		200,259	4,814	205,073			6
7	Other (specify):*											7
8	TOTAL General Services	869,076	515,551	454,338	1,838,965		1,838,965	380	1,839,345			8
	B. Health Care and Programs											
9	Medical Director			19,220	19,220		19,220		19,220			9
10	Nursing and Medical Records	4,820,504	287,450	1,456,789	6,564,743		6,564,743	15,373	6,580,116			10
10a	Therapy			819,579	819,579		819,579		819,579			10a
11	Activities	166,191	11,151		177,342		177,342	(3,395)	173,947			11
12	Social Services	139,281		3,513	142,794		142,794		142,794			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			14,103	14,103		14,103		14,103			15
16	TOTAL Health Care and Programs	5,125,976	298,601	2,313,204	7,737,781		7,737,781	11,978	7,749,759			16
	C. General Administration											
17	Administrative	138,461			138,461		138,461	62,196	200,657			17
18	Directors Fees											18
19	Professional Services			857,132	857,132		857,132	(271,536)	585,596			19
20	Dues, Fees, Subscriptions & Promotions			3,603	3,603		3,603	(77)	3,526			20
21	Clerical & General Office Expenses	264,341	72,545	258,469	595,355		595,355	33,974	629,329			21
22	Employee Benefits & Payroll Taxes			1,408,009	1,408,009		1,408,009	38,203	1,446,212			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,397	14,397		14,397	11,884	26,281			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			387,740	387,740		387,740	63,134	450,874			26
27	Other (specify):*											27
28	TOTAL General Administration	402,802	72,545	2,929,350	3,404,697		3,404,697	(62,222)	3,342,475			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,397,854	886,697	5,696,892	12,981,443		12,981,443	(49,863)	12,931,580			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.

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			29,015	29,015		29,015	84,260	113,275			30
31	Amortization of Pre-Op. & Org.			3,248	3,248		3,248	422,316	425,564			31
32	Interest			942,284	942,284		942,284	237,192	1,179,476			32
33	Real Estate Taxes							418,360	418,360			33
34	Rent-Facility & Grounds			1,260,000	1,260,000		1,260,000	(1,155,000)	105,000			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,234,547	2,234,547		2,234,547	7,128	2,241,675			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			35,802	35,802		35,802		35,802			38
39	Ancillary Service Centers		231,870		231,870		231,870		231,870			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			373,084	373,084		373,084		373,084			42
43	Other (specify):*			270,108	270,108		270,108	(270,108)				43
44	**TOTAL Special Cost Centers**		231,870	678,994	910,864		910,864	(270,108)	640,756			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,397,854	1,118,567	8,610,433	16,126,854		16,126,854	(312,843)	15,814,011			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: 1/1/22 Ending: 12/31/22

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	(7,024)	30		9
10	Interest and Other Investment Income	(2,318)	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	(14,607)	21		18
19	Entertainment				19
20	Contributions	(1,780)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(270,108)	43		24
25	Fund Raising, Advertising and Promotional	(6,217)	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	(7,750)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (309,804)		$	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	(3,039)	Various	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (3,039)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (312,843)		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: 1/1/22

Ending: 12/31/22

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Political Action Committee Payments	$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Misc Income - HD Supply Rebate	(1,332)	5	3
4	Misc Income - Food Rebate	(5,941)	2	4
5	Misc Income - Medical Records	(477)	10	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
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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**	(7,750)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lakeview Rehab Nrsg Center # 0051524 Report Period Beginning: 1/1/22 Ending: 12/31/22

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,941)	0	0	0	0	0	0	0	0	0	0	(5,941)	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	(1,332)	0	2,839	0	0	0	0	0	0	0	0	1,507	5
6	Maintenance	0	0	4,814	0	0	0	0	0	0	0	0	4,814	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,273)	0	7,653	0	0	0	0	0	0	0	0	380	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	(477)	(40,607)	56,457	0	0	0	0	0	0	0	0	15,373	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	(3,395)	0	0	0	0	0	0	0	0	(3,395)	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	(477)	(40,607)	53,063	0	0	0	0	0	0	0	0	11,978	16
	C. General Administration													
17	Administrative	0	0	62,196	0	0	0	0	0	0	0	0	62,196	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(598,394)	326,859	0	0	0	0	0	0	0	0	(271,536)	19
20	Fees, Subscriptions & Promotions	0	(77)	0	0	0	0	0	0	0	0	0	(77)	20
21	Clerical & General Office Expenses	(22,604)	(125,748)	182,326	0	0	0	0	0	0	0	0	33,974	21
22	Employee Benefits & Payroll Taxes	0	(8,931)	47,134	0	0	0	0	0	0	0	0	38,203	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(5,329)	17,213	0	0	0	0	0	0	0	0	11,884	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	57,652	5,482	0	0	0	0	0	0	0	0	63,134	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(22,604)	(680,827)	641,210	0	0	0	0	0	0	0	0	(62,222)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(30,354)	(721,435)	701,926	0	0	0	0	0	0	0	0	(49,863)	29

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	(7,024)	91,284	0	0	0	0	0	0	0	0	0	84,260	30
31	Amortization of Pre-Op. & Org.	0	422,316	0	0	0	0	0	0	0	0	0	422,316	31
32	Interest	(2,318)	239,510	0	0	0	0	0	0	0	0	0	237,192	32
33	Real Estate Taxes	0	418,360	0	0	0	0	0	0	0	0	0	418,360	33
34	Rent-Facility & Grounds	0	(1,155,000)	0	0	0	0	0	0	0	0	0	(1,155,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(9,342)	16,470	0	0	0	0	0	0	0	0	0	7,128	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):*	(270,108)	0	0	0	0	0	0	0	0	0	0	(270,108)	43
44	**TOTAL Special Cost Centers**	(270,108)	0	0	0	0	0	0	0	0	0	0	(270,108)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(309,804)	(704,965)	701,926	0	0	0	0	0	0	0	0	(312,843)	45

Facility Name & ID Number Lakeview Rehab Nrsg Center # 0051524 Report Period Beginning: 1/1/22 Ending: 12/31/22

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%	Ambassador Nursing & Rehab Center	Chicago	Infinity Healthcare	Hillside	Consulting Co.
Michael Elkes	1%	Belhaven Nursing & Rehab Center	Chicago	Lincoln Park Holdings		Realty Co.
Daniel Borek	19%	City View Multicare Center	Cicero			
Dovid Gubin	10%	Continental Nursing & Rehab Center	Chicago			
Batsheva Nadoff	10%	Forest View Rehab & Nursing Center	Itasca			
Hadassah Gubin	10%	Midway Neurological & Rehab Center	Bridgeview			
Yosef Gubin	10%	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. [ ] 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	26	Insurance-Prop.Liab.Malpractice	$ 0	Lincoln Park Holdings		$ 57,652	$ 57,652	1
2	V	33	Real Estate Taxes (Other)	0	Lincoln Park Holdings		418,360	418,360	2
3	V	34	Rent-Facility & Grounds (Other)	1,155,000	Lincoln Park Holdings			(1,155,000)	3
4	V	19	Professional Fees		Lincoln Park Holdings		18,517	18,517	4
5	V	30	Depreciation		Lincoln Park Holdings		91,284	91,284	5
6	V	31	Amortization		Lincoln Park Holdings		422,316	422,316	6
7	V	32	Interest		Lincoln Park Holdings		239,510	239,510	7
8	V	10	Nursing and Medical Records	40,607	Infinity Healthcare			(40,607)	8
9	V	19	Professional Services	616,911	Infinity Healthcare			(616,911)	9
10	V	20	Dues, Fees, Subscriptions & Promotior	77	Infinity Healthcare			(77)	10
11	V	21	Clerical & General Office Expenses	125,748	Infinity Healthcare			(125,748)	11
12	V	22	Employee Benefits & Payroll Taxes	8,931	Infinity Healthcare			(8,931)	12
13	V	24	Travel and Seminar	5,329	Infinity Healthcare			(5,329)	13
14	Total			$ 1,952,604			$ 1,247,639	$ * (704,965)	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: 1/1/22 Ending: 12/31/22

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	11	Activities	$ 3,395	Infinity Healthcare		$	$ (3,395)	15
16	V	21	Clerical & General Office Expenses	2,784	Infinity Healthcare			(2,784)	16
17	V	5	Heat and Other Utilities		Infinity Healthcare		2,839	2,839	17
18	V	6	Maintenance		Infinity Healthcare		4,814	4,814	18
19	V	10	Nursing and Medical Records		Infinity Healthcare		56,457	56,457	19
20	V	17	Administrative		Infinity Healthcare		62,196	62,196	20
21	V	19	Professional Services		Infinity Healthcare		326,859	326,859	21
22	V	21	Clerical & General Office Expenses		Infinity Healthcare		185,111	185,111	22
23	V	22	Employee Benefits & Payroll Taxes		Infinity Healthcare		47,134	47,134	23
24	V	24	Travel and Seminar		Infinity Healthcare		17,213	17,213	24
25	V	26	Insurance-Prop.Liab.Malpractice		Infinity Healthcare		5,482	5,482	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 6,179			$ 708,105	$ * 701,926	39

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

STATE OF ILLINOIS | Ownership Listing-1

Lakeview Rehab Nrsg Center

ID# 0051524

Report Period Beginning: 1/1/22

Ending: 12/31/22

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Ownership Percentage	
1	Michael		Blisko	Surfside	FL	40.00000	1
2	Michael		Elkes	Chicago	IL	1.00000	2
3	Daniel		Borek	Chicago	IL	19.00000	3
4	Dovid		Gubin	Chicago	IL	10.00000	4
5	Batsheva		Nadoff	New York	NY	10.00000	5
6	Hadassah		Gubin	New York	NY	10.00000	6
7	Yosef		Gubin	Boca Raton	FL	10.00000	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							49
50							50

STATE OF ILLINOIS | Ownership Listing-2

Lakeview Rehab Nrsg Center

ID# 0051524

Report Period Beginning: 1/1/22

Ending: 12/31/22

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Owners of companies must be listed instead of company names.

-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	City (Place of Residence)	State (Place of Residence)	Ownership Percentage	
51							51
52							52
53							53
54							54
55							55
56							56
57							57
58							58
59							59
60							60
61							61
62							62
63							63
64							64
65							65
66							66
67							67
68							68
69							69
70							70
71							71
72							72
73							73
74							74
75							75
76							76
77							77
78							78
79							79
80							80
81							81
82							82
83							83
84							84
85							85
86							86
87							87
88							88
89							89
90							90
91							91
92							92
93							93
94							94
95							95
96							96
97							97
98							98
99							99
100							100

Facility Name & ID Number Lakeview Rehab Nrsg Center # 0051524 Report Period Beginning: 1/1/22 Ending: 12/31/22

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City	Facility 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: 1/1/22 Ending: 12/31/22

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
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: 1/1/22 Ending: 12/31/22

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

	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: 1/1/22 Ending: 12/31/22

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	HUD		X	Mortgage	$35,925.00	11/26/14	$ 8,953,100	$ 7,768,599	11/1/49	3.2300	$ 239,510	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Infinity Funding	X		Working Capital	None	Various	Various	6,842,596	None	Various	705,492	6
7	Credit Suisse		X	Working Capital	None	Various	Various	Zero	None	Various	236,792	7
8												8
9	TOTAL Facility Related				$35,925.00		$ 8,953,100	$ 14,611,195			$ 1,181,794	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	$ 14,611,195			$ 1,181,794	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 43,591 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: 1/1/22 Ending: 12/31/22

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2021 report.	$	0	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.)	$	459,270	2
3. Under or (over) accrual (line 2 minus line 1).	$	459,270	3
4. Real Estate Tax accrual used for 2022 report. (Detail and explain your calculation of this accrual on the lines below.)	$	(459,270)	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:			
	2017	354,434	8
	2018	351,610	9
	2019	357,624	10
	2020	396,529	11
	2021	459,270	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2021	$	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.

2021 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

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2021 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 2021.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-28-300-013-0000	Nursing Home	$ 459,270.35	$ 459,270.35
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 459,270.35	$ 459,270.35

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 2021 tax bills which were listed in Section A to this statement. Be sure to use the 2021 tax bill which is normally paid during 2022.

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 Numb Lakeview Rehab Nrsg Center # 0051524 Report Period Beginning: 1/1/22 Ending: 12/31/22

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. List the bed capacity for the building if it differs from the licensed total.
G. Have you properly capitalized all major repairs and equipment purchases?
H. Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement?
J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES ____ NO ____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

K. 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		7/31/1905	$ 500,000	1
2					2
3	TOTALS			$ 500,000	3

Facility Name & ID Number Lakeview Rehab Nrsg Center # 0051524 Report Period Beginning: 1/1/22 Ending: 12/31/22

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)	$ 739,781	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Suburban Elevatator			2011	28,500	731	39	731	731	8,466	9
10											10
11	Install Exaust Fans			2012	8,670	222	39	222	222	2,444	11
12	Suburban Elevatator			2012	16,050	412	39	412	412	4,529	12
13	Suburban Elevatator			2012	2,850	73	39	73	73	803	13
14	Suburban Elevatator - Pit Work & Drilling			2012	9,350	240	39	240	240	2,638	14
15	Provide & Install Railings			2012	2,630	67	39	67	67	740	15
16	New Awnings			2012	1,750	45	39		45	496	16
17											17
18	Replace podding in south floor elevator			2013	1,956	50	39	50	50	476	18
19	Heat Exchanger			2013	1,898	49	39	49	49	464	19
20	Fire Alarm System			2013	13,475	346	39	346	346	3,285	20
21	Electrical room walls & ceiling			2013	5,280	135	39	135	135	1,285	21
22	Patch parking lot			2013	3,450	88	39	88	88	838	22
23	Electrical wiring - 2nd floor			2013	18,101	464	39	464	464	4,409	23
24											24
25	Clean Network Closet			2014	1,992	51	39	51	51	459	25
26	Install Stair Rails			2014	2,325	60	39	60	60	538	26
27	New carpet, paint, cove base, & walls in therapy room			2014	63,081	1,617	39	1,617	1,617	14,556	27
28	Install Dome Light Modules			2014	2,280	58	39	58	58	524	28
29	New walls, floor tiles, & paint in shower rooms			2014	4,465	114	39	114	114	1,031	29
30											30
31	Reface doors, crown molding, partition walls, and cover lights										31
32	in patient room			2015	4,850	124	39	124		993	32
33	New carpet, paint, cove base, & walls in therapy room			2015	9,419	242	39	242		1,934	33
34	New walls, floor tiles, & paint in shower rooms			2015	5,469	140	39	140		1,121	34
35											35
36	New flooring in first floor resident rooms			2015	12,097	310	39	310		2,481	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: 1/1/22 Ending: 12/31/22

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	New cove base & wallcovering in therapy room	2015	$ 3,284	$ 84	39	$ 84	$	$ 673	37
38	Replaced Trane Chiller Compressor	2015	13,690	351	39	351		2,808	38
39	New flooring and cove bases in shower rooms	2015	3,296	85	39	85		678	39
40	Clean Cooling Tower	2015	4,925	126	39	126		1,009	40
41	Elevator hand rail/cubicle curtains in resident rooms	2015	7,489	192	39	192		1,536	41
42	New flooring and cove bases in shower rooms	2015	4,947	127	39	127		1,015	42
43	New sinks and drains in kitchen, janitor room, and elevator room	2015	11,500	295	39	295		2,359	43
44	Partition walls, cover lights, and fabricate desk in patient room	2015	23,290	597	39	597		4,777	44
45	Replace exhaust manifold heater	2015	2,900	74	39	74		593	45
46	Replace air handler coil	2015	15,480	397	39	397		3,176	46
47	Replace glycol feeder pumping station	2015	4,425	113	39	113		906	47
48	Rebuild generator and replace starter	2015	5,489	141	39	141		1,127	48
49	Rebuild B&G circulating pump	2015	2,987	77	39	77		614	49
50	Install new water circulating pump	2015	4,500	115	39	115		922	50
51									51
52	New Glycol Feeder	2016	4,425	113	39	113		793	52
53	Igeacom Nurse Calls	2016	2,525	65	39	65		454	53
54	Circulation Pump	2016	2,633	68	39	68		474	54
55	Roof Top Exhaust	2016	3,471	89	39	89		623	55
56	Butterfly Valve	2016	2,105	54	39	54		378	56
57	Cooling Tower Bearing Assembly	2016	3,253	83	39	83		583	57
58	New Doors - Restrooms	2016	2,740	70	39	70		491	58
59	Paint Rooms 320, 321, 322, 302, 214, 211	2016	5,100	131	39	131		916	59
60	Fire Alarm Panel	2016	14,652	376	39	376		2,631	60
61	Surface Panic Devices for 1st Floor Corridor	2016	6,849	176	39	176		1,230	61
62	1st Floor East Shower Rooms	2016	4,495	115	39	115		806	62
63	Propress Copper Pip Fitting & Piping	2016	3,087	79	39	79		553	63
64									64
65	105 Ton Carrier Chiller	2017	112,500	2,885	39	2,885		15,865	65
66	Remove Counter Top 1st Floor Nursing Station &Remove Floorin	2017	3,064	79	39	79		432	66
67	Install New Flooring on 2nd & 3rd Floor Nursing Stations	2017	6,240	160	39	160		880	67
68	Replace Alarm Sensor in Chilller Room	2017	3,397	87	39	87		479	68
69	New OEM Bearing for Cooling Tower	2017	6,260	161	39	161		883	69
70	TOTAL (lines 4 thru 69)		$ 4,074,936	$ 104,487		$ 104,441	$ 4,821	$ 844,956	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: 1/1/22 Ending: 12/31/22

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,074,936	$ 104,487		$ 104,441	$ (47)	$ 844,956	1
2	Tuff Storage Shed	2017	4,749	122	39	122		670	2
3	Rebuilt Bearing Assembly for Circulating Pump 1	2017	3,638	93	39	93		513	3
4	Replaced Water Cooler Compressor	2017	3,200	82	39	82		451	4
5									5
6	Remove wallpaper and paint walls in DON office and Library	2018	3,934	101	39	101		453	6
7	2 Elevator Door Edges	2018	4,200	108	39	108		485	7
8	New Circulating Pump for Hot Water Heat Exchanger	2018	2,116	54	39	54		244	8
9	New Retro Fit for Door for Walk-in Cooler	2018	3,362	86	39	86		388	9
10	New Phone System	2018	23,545	604	39	604		2,717	10
11	Replace filters in boiler room air handler & kitchen	2018	3,160	81	39	81		365	11
12									12
13	Replace Kitchen Air Handler Circulating Pump	2019	4,408	113	39	113		394	13
14	Fire Alarm Auxillary Control Panel & Installation	2019	3,423	88	39	88		295	14
15	New Basement Door; New Cylinder Locks on Stairwell Doors	2019	6,264	161	39	161		581	15
16	3rd Floor Wander System	2019	5,322	136	39	136		475	16
17	1st Floor Wander System	2019	6,948	178	39	178		668	17
18	Parts Replacement on Steam Tables 1 & 3	2019	2,649	68	39	68		243	18
19	Paint Resident Rooms & Bathrooms on 1st Floor (1st billing)	2019	3,500	90	39	90		322	19
20	Paint Resident Rooms & Bathrooms on 1st Floor (2nd billing)	2019	3,500	90	39	90		322	20
21	Paint Resident Rooms & Bathrooms on 1st Floor (3rd billing)	2019	700	18	39	18		64	21
22	Paint Rooms 108, 105, 110, 117, 109	2019	2,950	76	39	76		271	22
23	Installation of Wanderer System at Basement Exit Door Area	2019	2,974	76	39	76		267	23
24	Replace Pipe Insulation Above Ceiling in Therapy Room	2019	3,745	96	39	96		328	24
25	Paint Rooms 102, 107, 111, 112, 113, 118. Wall Repairs to Room 3(	2019	3,975	102	39	102		348	25
26	Installation of Stairway Keypads on Door Alarm Systems	2019	2,306	59	39	59		202	26
27	Remove Wall Paper in & Paint DON , ADON, Social Services & A	2019	2,625	67	39	67		219	27
28	Repairs to DON & ADON Offices, Paint MDS Office	2019	2,825	72	39	72		235	28
29	Replace Faulty Glycol Feed Station & Repair Leak on Main Air H	2019	2,717	70	39	70		226	29
30									30
31	Fire Damper Inspection Throughout Building	2019	6,038	155	39	155		464	31
32	New Basement Entry Convector	2019	4,500	115	39	115		346	32
33	Sand, Patch, Paint all Doors and Frames on 1st, 2nd, 3rd Floors ar	2020	2,200	56	39	56		169	33
34	TOTAL (lines 1 thru 33)		$ 4,200,408	$ 107,705		$ 107,658	$ (47)	$ 857,683	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: 1/1/22 Ending: 12/31/22

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		$ 4,200,408	$ 107,705		$ 107,658	$ (47)	$ 857,683	1
2	New Nurse Call System	2020	2,801	72	39	72		215	2
3	Finish Doors and Frames in Corridors Including Patching, Sandin	2020	1,750	45	39	45		135	3
4	New Nurse Call System (additional part)	2020	130	3	39	3		10	4
5	Repair and Paint Walls in Rooms 307, 309, 311, 312, 313	2020	2,495	64	39	64		192	5
6	Paint and Repair Walls on 3rd Florr Dememtia Unit 4	2020	2,400	62	39	62		185	6
7	New Kitchen Hot Water Pump	2020	3,161	81	39	81		243	7
8	New Hydro Relay Board for Elevator 1	2020	3,450	88	39	88		265	8
9	Install New Drywall, Sand and Paint Rooms 319, 316, 309, 304, 31	2020	2,475	63	39	63		190	9
10	Repair and Paint Walls in 3rd Floor Demenita Unit	2020	2,475	63	39	63		190	10
11	Repair and Paint Walls in 3rd Floor Demenita Unit	2020	2,295	59	39	59		177	11
12	Clean Cooling Tower and Install New Gaskets. Piped Water Suppl	2020	2,324	60	39	60		179	12
13	Furnish & Install Fire Service Software Upgrade	2020	14,800	379	39	379		1,138	13
14	Elevator Mechanical Rooms Violation Repairs	2020	2,390	61	39	61		184	14
15	Tower Chemical Cleaning	2020	2,628	67	39	67		202	15
16									16
17	Installation of System for Dial Tone for Call Lights on 2nd and 3r	2021	3,500	90	39	90		135	17
18	Fire Safety Evaluation System	2021	3,300	85	39	85		127	18
19	New Nurse Call System	2021	77,913	1,998	39	1,998		2,997	19
20	Sealcoat & Crackfill Parking Lot	2021	10,054	258	39	258		387	20
21	Winterize Chiller & Cooler Tower	2021	2,505	64	39	64		96	21
22									22
23	Installation of New Maglock on Basement Door & Time Relay for	2022	4,581	59	39	59		4,581	23
24	Installed Rebuilt Bearing Assembly for the Cooling Tower	2022	5,702	73	39	73		5,702	24
25	Install new car sill	2022	7,900	101	39	101		7,900	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,361,437	$ 111,601		$ 111,554	$ (47)	$ 883,112	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: 1/1/22 Ending: 12/31/22

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	$ 3,718	$ 744	$ 744	$ (0)	5	$ 1,116	71
72	Current Year Purchases	9,781	978	978	(0)	5	978	72
73	Fully Depreciated Assets	407,319				5	407,319	73
74								74
75	TOTALS	$ 420,818	$ 1,722	$ 1,722	$ (0)		$ 409,413	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)	$ 5,282,255	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 113,323	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 113,275	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (47)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,292,525	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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.	/2023	$
13.	/2024	$
14.	/2025	$

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.

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 [ ] NO

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$	4,759	$ 300,047	$	4,759	$ 300,047	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		3,558	146,297		3,558	146,297	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		5,989	373,235		5,989	373,235	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	209,874					209,874	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-2		12,430					12,430	12
13	Other (specify): Lab	39-2		9,490					9,490	13
14	TOTAL			$ 231,795	14,306	$ 819,579	$	14,306	$ 1,051,374	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: 1/1/22 Ending: 12/31/22

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/22 (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	$ (640,032)	$ (215,150)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,347,692	5,347,692	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	265,065	265,065	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)**	$ 4,972,725	$ 5,397,607	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	801,438	801,438	15
16	Equipment, at Historical Cost	444,368	444,368	16
17	Accumulated Depreciation (book methods)	(544,131)	(1,283,912)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	1,329,680	7,664,440	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,304,610)	(4,753,533)	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)**	$ 726,745	$ 6,932,801	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,699,470	$ 12,330,408	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,688,705	$ 2,688,705	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(9,182)	(9,182)	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	295,341	295,341	30
31	Accrued Taxes Payable (excluding real estate taxes)	34,964	325,842	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	**Due to Related Parties**	6,842,596	6,842,596	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 9,852,424	$ 10,143,302	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,768,599	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)**	$	$ 7,768,599	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 9,852,424	$ 17,911,901	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,152,954)	$ (5,581,493)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,699,470	$ 12,330,408	48

*(See instructions.)

Facility Name & ID Number Lakeview Rehab Nrsg Center # 0051524 Report Period Beginning: 1/1/22 Ending: 12/31/22

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,805,409)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,805,409)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,347,547)	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)**	$ (2,347,547)	17
	B. Transfers (Itemize):		
18	Round	2	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 2	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (4,152,954)	24 *

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

Facility Name & ID Number Lakeview Rehab Nrsg Center # 0051524 Report Period Beginning: 1/1/22 Ending: 12/31/22

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	$ 13,083,357	1
2	Discounts and Allowances for all Levels	(1,559,728)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,523,629	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,808,917	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,808,917	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	263,849	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	172,843	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 436,692	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,318	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,318	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a		7,749	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,749	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,779,305	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,838,966	31
32	Health Care	7,737,781	32
33	General Administration	3,404,694	33
	B. Capital Expense		
34	Ownership	2,234,547	34
	C. Ancillary Expense		
35	Special Cost Centers	910,864	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)***	$ 16,126,852	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,347,547)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,347,547)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$ 2,226,906.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	4,169,487.00	45
46	MMAI-Medicaid is the Primary Payer	3,643,059.00	46
47	MMAI-Medicare is the Primary Payer	214,973.00	47
48	Private Pay	103,125.00	48
49	Mediciare Part A	2,503,153.00	49
50	Other-(specify) Commercial Ins	222,654.00	50
51	Other-(specify) C/A	-1,559,728.00	51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,523,629	56

Facility Name & ID Number Lakeview Rehab Nrsg Center # 0051524 Report Period Beginning: 1/1/22 Ending: 12/31/22

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,728	1,941	$ 107,886	$ 55.58	1
2	Assistant Director of Nursing	3,370	3,627	145,192	40.03	2
3	Registered Nurses	18,008	19,048	950,772	49.91	3
4	Licensed Practical Nurses	23,810	25,706	1,122,058	43.65	4
5	CNAs & Orderlies	84,919	89,319	2,405,441	26.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,953	9,688	166,191	17.15	10
11	Social Service Workers	4,837	5,313	139,281	26.22	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,658	22,439	398,558	17.76	15
16	Dishwashers					16
17	Maintenance Workers	3,597	4,026	106,106	26.36	17
18	Housekeepers	17,271	18,893	285,131	15.09	18
19	Laundry	3,492	4,124	56,018	13.58	19
20	Administrator	1,720	1,777	138,461	77.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,308	12,403	337,531	27.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,853	1,997	39,228	19.64	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	204,524	220,301	$ 6,397,854 *	$ 29.04	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 46,434	1-3	35
36	Medical Director	Monthly	19,220	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	40,607	10-3	38
39	Pharmacist Consultant	Monthly	14,103	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	2,463	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 122,827		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	14,691	$ 264,361	10-3	50
51	Licensed Practical Nurses	526	332,793	10-3	51
52	Certified Nurse Assistants/Aides	14,164	819,028	10-3	52
53	TOTAL (lines 50 - 52)	29,381	$ 1,416,182		53

Facility Name & ID Number Lakeview Rehab Nrsg Center # 0051524 Report Period Beginning: 1/1/22 Ending: 12/31/22

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Graber, Joshua B	Administrator	0	$ 138,461
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 138,461

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
Infinity Healthcare Management	Consulting Fees	$ 679,356
GGM Associates	Accounting Fees	18,000
Credit Suisse Legal	Legal Fees	2,829
Dutton Casey & Mesoloras P.C.	Legal Fees	3,415
Gutnicki LLP	Legal Fees	789
Hinshaw & Culbertson	Legal Fees	497
Infinity Funding / Sedgwick	Legal Fees	62,527
Leonard J LeRose Jr LTD	Legal Fees	1,140
POLSINELLI PC	Legal Fees	803
Empire Risk Management Services, I	Professioanl Fees	12,000
Global Fiscal Midwest LLC	Professioanl Fees	6,070
See Additional Schedule		69,706
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 857,132

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 125,187
Unemployment Compensation Insurance	86,236
FICA Taxes	543,845
Employee Health Insurance	276,963
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Uniforms	591
Employee Other Benefits	409,560
Employee Background Checks	3,830
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,446,212

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	$ 2,724
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	102
Association Dues (total from pg 22, #4)	
CLIA Labs	180
City of Chicago	520
Less: Public Relations Expense	( )
PAC and Lobbying payments	( )
All non-allowable advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,526

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	21,491
Seminar Expense	4,789
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 26,281

**See instructions.

C. Professional Services

Vendor/Payee	Type	Amount
Infinity Healthcare Management	Professional Fees	6,505
MTS Consulting	Professional Fees	3,283
Nava Healthcare Recruitment	Professional Fees	21,000
People Powered LLC	Professional Fees	36,024
THE WATERS OF BATESVILLE	Professional Fees	2,894
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		69,706

Facility Name & ID Number **Lakeview Rehab Nrsg Center** **# 0051524** **Report Period Beginning: 1/1/22** **Ending: 12/31/22**

XX. GENERAL INFORMATION:

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

(2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.

Association Name	Amount
Total	

(3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

Total	

(4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

Total	

(5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. $ **32,907** Line **10**

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

(7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **373,084**
This amount is to be recorded on line 42 of Schedule V.

(8) 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.

(9) 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**

(10) 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.

(11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ ______ Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(12) 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. $ ______

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

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

(15) 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.