

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: <u>0046169</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Lakewood Nursing & Rehab Center, Llc</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/12</u> to <u>12/31/12</u> 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.																							
Address: <u>14718 South Eastern Ave</u> <u>Plainfield</u> <u>60544</u>																									
Number City Zip Code																									
County: <u>Will</u>																									
Telephone Number: <u>(815) 436-3400</u> Fax # <u>(815) 436-1357</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Lisa M. Hanlon, C.P.A.</u></td></tr><tr><td>(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Print Name and Title) <u>Lisa M. Hanlon, C.P.A.</u>	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	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												
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	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																								
Date of Initial License for Current Owners: <u>02/01/03</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☒ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236-1111</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc

0046169 Report Period Beginning: 01/01/12 Ending: 12/31/12

III. STATISTICAL DATA

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

	1	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	<u>131</u>	Skilled (SNF)	<u>131</u>	<u>47,946</u>	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	<u>131</u>	TOTALS	<u>131</u>	<u>47,946</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>26,621</u>	<u>5,616</u>	<u>10,932</u>	<u>43,169</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>26,621</u>	<u>5,616</u>	<u>10,932</u>	<u>43,169</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.04%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 02/01/2003

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 02/01/2003 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 131 and days of care provided 10,200

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	299,850	46,498	13,738	360,086		360,086	8,720	368,806			1
2	Food Purchase		274,548		274,548		274,548	(426)	274,122			2
3	Housekeeping	184,275	44,864		229,139		229,139	539	229,678			3
4	Laundry	51,597	19,022		70,619		70,619		70,619			4
5	Heat and Other Utilities			159,998	159,998		159,998	779	160,777			5
6	Maintenance	123,643		194,182	317,825		317,825	5,460	323,285			6
7	Other (specify):*							4,117	4,117			7
8	TOTAL General Services	659,365	384,932	367,918	1,412,215		1,412,215	19,189	1,431,404			8
	B. Health Care and Programs											
9	Medical Director			27,600	27,600		27,600		27,600			9
10	Nursing and Medical Records	2,988,282	238,562	104,145	3,330,989		3,330,989	50,370	3,381,359			10
10a	Therapy	229,560		156	229,716		229,716		229,716			10a
11	Activities	149,302	33,838		183,140		183,140		183,140			11
12	Social Services	194,956			194,956		194,956	20,255	215,211			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							11,728	11,728			15
16	TOTAL Health Care and Programs	3,562,100	272,400	131,901	3,966,401		3,966,401	82,353	4,048,754			16
	C. General Administration											
17	Administrative	158,246			158,246		158,246	78,011	236,257			17
18	Directors Fees											18
19	Professional Services			599,185	599,185		599,185	(473,097)	126,088			19
20	Dues, Fees, Subscriptions & Promotions			29,158	29,158		29,158	(14,231)	14,927			20
21	Clerical & General Office Expenses	168,840	30,418	240,375	439,633		439,633	(76,061)	363,572			21
22	Employee Benefits & Payroll Taxes			743,103	743,103		743,103	(3,471)	739,632			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,151	3,151		3,151	959	4,110			24
25	Other Admin. Staff Transportation			6,913	6,913		6,913	744	7,657			25
26	Insurance-Prop.Liab.Malpractice			160,660	160,660		160,660	1,387	162,047			26
27	Other (specify):*							29,486	29,486			27
28	TOTAL General Administration	327,086	30,418	1,782,545	2,140,049		2,140,049	(456,273)	1,683,776			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,548,551	687,750	2,282,364	7,518,665		7,518,665	(354,731)	7,163,934			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			58,146	58,146		58,146	381,475	439,621			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,451	7,451		7,451	551,805	559,256			32
33	Real Estate Taxes			120,871	120,871		120,871	2,473	123,344			33
34	Rent-Facility & Grounds			657,605	657,605		657,605	(656,339)	1,266			34
35	Rent-Equipment & Vehicles			1,107	1,107		1,107	700	1,807			35
36	Other (specify):*											36
37	TOTAL Ownership			845,180	845,180		845,180	280,114	1,125,294			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		935,352	1,150,849	2,086,201		2,086,201	(14,946)	2,071,255			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			271,883	271,883		271,883		271,883			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		935,352	1,422,732	2,358,084		2,358,084	(14,946)	2,343,138			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,548,551	1,623,102	4,550,276	10,721,929		10,721,929	(89,564)	10,632,365			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	150,475	30		9
10	Interest and Other Investment Income	(4,317)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(353)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,860)	21		18
19	Entertainment				19
20	Contributions	(275)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(172,071)	21		24
25	Fund Raising, Advertising and Promotional	(17,303)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(99,421)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (146,125)		\$	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)	56,561		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 56,561		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (89,564)		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

Report Period Beginning:

Ending:

ID#

0046169

01/01/12

12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Other Income	\$ (189)	21	1
2	Jury Duty Income	(98)	10	2
3	Patient Clothing	(72)	10	3
4	Theft Loss	(730)	21	4
5	Collection Expense	(4,544)	21	5
6	Bldg Co. - Legal Expense	(2,024)	19	6
7	Bldg Co. - Bank Service Charges	(89)	21	7
8	Bldg Co. - Filing Fees	(250)	21	8
9	Bldg Co. - Amortization	(24,887)	31	9
10	Related Party Interest Expense	(59,136)	32	10
11	Capitalized R&M	(2,800)	06	11
12	Non Allowable Legal	(3,500)	19	12
13	Vending Income	(503)	02	13
14	Non Allowable Seminar	(600)	24	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
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42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(99,421)		49

ID#

0046169

Report Period Beginning:

01/01/12

Ending:

12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
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98			49

STATE OF ILLINOIS

Summary A

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

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			225		8,818	(323)						8,720	1
2	Food Purchase	(856)		430									(426)	2
3	Housekeeping			430		109							539	3
4	Laundry													4
5	Heat and Other Utilities			621		158							779	5
6	Maintenance	(2,800)		2,461	5,750	49							5,460	6
7	Other (specify):*				2,656	1,461							4,117	7
8	TOTAL General Services	(3,656)		4,167	8,406	10,595	(323)						19,189	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(170)				50,549	(9)						50,370	10
10a	Therapy													10a
11	Activities													11
12	Social Services					20,255							20,255	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					11,728							11,728	15
16	TOTAL Health Care and Programs	(170)				82,532	(9)						82,353	16
	C. General Administration													
17	Administrative			2,658	12,448	62,905							78,011	17
18	Directors Fees													18
19	Professional Services	(5,523)	2,024	(314,962)		(154,636)							(473,097)	19
20	Fees, Subscriptions & Promotions	(17,578)		3,259		88							(14,231)	20
21	Clerical & General Office Expenses	(180,733)	339	11,124	87,374	5,835							(76,061)	21
22	Employee Benefits & Payroll Taxes				(3,471)								(3,471)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(600)		200		1,359							959	24
25	Other Admin. Staff Transportation			744									744	25
26	Insurance-Prop.Liab.Malpractice			878		509							1,387	26
27	Other (specify):*				18,423	11,063							29,486	27
28	TOTAL General Administration	(204,434)	2,363	(296,099)	114,774	(72,877)							(456,273)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(208,260)	2,363	(291,932)	123,180	20,250	(332)						(354,731)	29

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	150,475	223,384	6,247		1,369							381,475	30
31	Amortization of Pre-Op. & Org.	(24,887)	24,887											31
32	Interest	(63,453)	585,689	3,885		25,684							551,805	32
33	Real Estate Taxes			1,971		502							2,473	33
34	Rent-Facility & Grounds		(656,339)										(656,339)	34
35	Rent-Equipment & Vehicles			961				(261)					700	35
36	Other (specify):*													36
37	TOTAL Ownership	62,135	177,621	13,064		27,555		(261)					280,114	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(2,609)	(9,983)	(1,878)		(476)		(14,946)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers						(2,609)	(9,983)	(1,878)		(476)		(14,946)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(146,125)	179,984	(278,868)	123,180	47,805	(2,942)	(10,245)	(1,878)		(476)		(89,564)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ 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)	
1	V	34	Rent	\$ 656,339	Lakewood Plainfield Property LLC	100.00%	\$	\$ (656,339)	1
2	V	33	Rent - R/E Taxes	120,566	Lakewood Plainfield Property LLC	100.00%		(120,566)	2
3	V	19	Legal Expense		Lakewood Plainfield Property LLC	100.00%	2,024	2,024	3
4	V	21	Bank Service Charges		Lakewood Plainfield Property LLC	100.00%	89	89	4
5	V	21	Filing Fees		Lakewood Plainfield Property LLC	100.00%	250	250	5
6	V	30	Depreciation		Lakewood Plainfield Property LLC	100.00%	223,384	223,384	6
7	V	31	Amortization		Lakewood Plainfield Property LLC	100.00%	24,887	24,887	7
8	V	33	Real Estate Tax Expense		Lakewood Plainfield Property LLC	100.00%	120,566	120,566	8
9	V	32	Interest - Hunter Mgmt		Lakewood Plainfield Property LLC	100.00%	37,595	37,595	9
10	V	32	Interest - Rothner Health Ventures GII		Lakewood Plainfield Property LLC	100.00%	21,541	21,541	10
11	V	32	Interest - Citizens FNB		Lakewood Plainfield Property LLC	100.00%	526,553	526,553	11
12	V								12
13	V								13
14	Total			\$ 776,905			\$ 956,889	\$ * 179,984	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	01	Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 225	\$ 225	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	430	430	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	430	430	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	621	621	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	2,461	2,461	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	2,658	2,658	20
21	V	19	Professional Fees	318,720	Extended Care Consulting, LLC	100.00%	3,758	(314,962)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	3,259	3,259	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	11,124	11,124	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	200	200	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	744	744	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	878	878	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	6,247	6,247	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	3,885	3,885	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,971	1,971	29
30	V	34	Rent - Building		Extended Care Consulting, LLC	100.00%			30
31	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	961	961	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 318,720			\$ 39,852	\$ * (278,868)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	5,750	\$ 5,750	15
16	V	06	Maintenance (Direct)	11,002	Extended Care Consulting, LLC	100.00%	11,002		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,056	1,056	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	1,600	1,600	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	12,448	12,448	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	87,374	87,374	22
23	V	21	Office and Clerical (Direct)	569	Extended Care Consulting, LLC	100.00%	569		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	18,340	18,340	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	83	83	25
26	V	22	Employee Benefits	3,471	Extended Care Consulting, LLC	100.00%		(3,471)	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			\$ 15,042			\$ 138,222	\$ * 123,180	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	03	Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 109	\$ 109	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	158	158	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	49	49	17
18	V	19	Professional Fees	156,984	Extended Care Clinical, LLC	100.00%	2,348	(154,636)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	88	88	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	1,952	1,952	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,359	1,359	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	509	509	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	1,369	1,369	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	25,684	25,684	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	502	502	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	8,818	8,818	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,461	1,461	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	50,549	50,549	28
29	V								29
30	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	20,255	20,255	30
31	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	11,728	11,728	31
32	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	62,905	62,905	32
33	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	3,883	3,883	33
34	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	11,063	11,063	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 156,984			\$ 204,789	\$ * 47,805	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	1	Dietary Supplies, Supplements	\$ 1,155	Care Centers Health Systems, Inc.	100.00%	\$ 832	\$ (323)	15
16	V	10	Nursing Supplies	32	Care Centers Health Systems, Inc.	100.00%	23	(9)	16
17	V	39	Ancillary Expense	9,320	Care Centers Health Systems, Inc.	100.00%	6,711	(2,609)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 10,507			\$ 7,565	\$ * (2,942)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	39	Ventilator Equipment	17,530	Vent Lease LLC	100.00%	7,547	\$ (9,983)	15
16	V	39	Other Ancillary		Vent Lease LLC	100.00%			16
17	V	35	Matrix Leasing	261	Vent Lease LLC	100.00%		(261)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 17,791			\$ 7,547	\$ * (10,245)	39

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	39	Therapy	\$ 1,076,745	Tri Care Rehab	100.00%	\$ 1,074,867	\$ (1,878)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,076,745			\$ 1,074,867	\$ * (1,878)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 149,940	\$ 149,940	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	149,940	CCS Employee Benefits Group	100.00%		(149,940)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 149,940			\$ 149,940	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

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

1		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	39	Ancillary Expense	53,458	Reliable Medical of the Midwest, LLC	100.00%	52,982	\$ (476)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 53,458			\$ 52,982	\$ * (476)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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	ERIC ROTHNER	1.000%	AVENUE CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	LAKEWOOD PLAINFIELD PRO		BUILDING CO.	1
2	ROTHNER HEALTH VENTURES G II, LLC	99.000%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC BEECHER		EXTENDED CARE CONSULTING	EVANSTON	MANAGEMENT/BOOKK	2
3			BOULEVARD CARE NURSING AND REHABILITATION CENTER,LLC CHICAGO		EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4			BRIAR PLACE LTD	INDIAN HEAD PARK	CARE CENTER HEALTH SYSTE	DES PLAINES	DIETARY & FOOD SUPP	4
5			CHATEAU NURSING AND REHABILITATION CENTER, LLC	WILLOWBROOK	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	5
6			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	ROTHNER VENTS LLC	EVANSTON	VENTALATOR RENTAL	6
7			DEVON GABLES REHABILITATION CENTER	ARIZONA	TRICARE REHAB	HILLSIDE	THERAPY	7
8			DYER NURSING & REHAB	DYER, IN	RELIABLE MEDICAL SUPPLY C	DES PLAINES	MEDICAL SUPPLY	8
9			FOOTHILLS REHABILITATION CENTER LLC	ARIZONA	2201 MAIN, LLC	EVANSTON	BLDG COMPANY	9
10			GOLDEN PLAINES REHABILITATION CENTER	HUTCHINSON, KS				10
11			GRASMERE PLACE, LLC	CHICAGO				11
12			HILLCREST NURSING AND REHABILITATION CENTER,LLC	JOLIET				12
13			HOMESTEAD NURSING & REAHB	LINCOLN, NE				13
14			LAKE COUNTY NURSING & REHAB	EAST CHICAGO, IN				14
15			LANCASTER MANOR	LINCOLN, NE				15
16			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				16
17			MCKINLEY HEALTH CARE CENTER	CANTON, OH				17
18			OAK PARK HEALTHCARE CENTER, L.L.C.	OAK PARK				18
19			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				19
20			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				20
21			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				21
22			RAINBOW BEACH QOC, L.L.C.	CHICAGO				22
23			SEBOS NURSING & REHAB	HOBART, IN				23
24			SHEFFIELD MANOR	DYER, IN				24
25			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				25
26			SNOW VALLEY NURSING AND REHABILITATION CENTER, L.L.C.	LISLE				26
27			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				27
28			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				28
29			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				29
30			WHEATON CARE CENTER	WHEATON				30

VII. RELATED PARTIES

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

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

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Adam Vales	Relative	Clerical	0.00%	See Attached	1.29	3.23%	Alloc. Salary	\$ 2,352	22-7	1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	2.85	5.18%	Al Sal/Al Fee	9,911	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 12,263		13

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

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

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

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

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

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 Extended Care Consulting, LLC
Street Address 2201 West Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905-3000
Fax Number (847) 905-3030

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	01	Dietary	Patient Days	1,364,178	31	\$ 7,101	\$	43,169	\$ 225	1
2	02	Food	Patient Days	1,364,178	31	13,586		43,169	430	2
3	03	Housekeeping	Patient Days	1,364,178	31	13,573		43,169	430	3
4	05	Utilities	Patient Days	1,364,178	31	19,636		43,169	621	4
5	06	Maintenance	Patient Days	1,364,178	31	77,756		43,169	2,461	5
6	17	Administrative	Patient Days	1,364,178	31	84,000		43,169	2,658	6
7	19	Professional Fees	Patient Days	1,364,178	31	118,750		43,169	3,758	7
8	20	Dues and Subscriptions	Patient Days	1,364,178	31	102,984		43,169	3,259	8
9	21	Office and Clerical	Patient Days	1,364,178	31	351,528		43,169	11,124	9
10	24	Seminar and Travel	Patient Days	1,364,178	31	6,315		43,169	200	10
11	25	Other Staff Admin. Trans.	Patient Days	1,364,178	31	23,506		43,169	744	11
12	26	Insurance	Patient Days	1,364,178	31	27,741		43,169	878	12
13	30	Depreciation	Patient Days	1,364,178	31	197,424		43,169	6,247	13
14	32	Interest	Patient Days	1,364,178	31	122,765		43,169	3,885	14
15	33	Real Estate Taxes	Patient Days	1,364,178	31	62,275		43,169	1,971	15
16	34	Rent - Building	Patient Days	1,364,178	31			43,169		16
17	35	Rent - Equipment & Auto	Patient Days	1,364,178	31	30,363		43,169	961	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,259,303	\$		\$ 39,852	25

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

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 Extended Care Consulting, LLC
Street Address 2201 West Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905-3000
Fax Number (847) 905-3030

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	06	Maintenance (Pooled)	Patient Days	1,364,178	31	181,713	181,713	43,169	5,750	1
2	06	Maintenance (Direct)	Direct		31	256,754	256,754		11,002	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,364,178	31	33,386		43,169	1,056	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	40,137			1,600	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,364,178	31	393,362	393,362	43,169	12,448	7
8	21	Office and Clerical (Pooled)	Patient Days	1,364,178	31	2,761,089	2,761,089	43,169	87,374	8
9	21	Office and Clerical (Direct)	Direct		31	368,461	368,461		569	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,364,178	31	579,570		43,169	18,340	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	65,039			83	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 4,679,511	\$ 3,961,379		\$ 138,222	25

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

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 Extended Care Clinical, LLC
Street Address 2201 West Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905-3000
Fax Number (847) 905-3030

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	03	Housekeeping	Patient Days	611,520	14	\$ 1,549	\$	43,169	\$ 109	1
2	05	Utilities	Patient Days	611,520	14	2,241		43,169	158	2
3	06	Maintenance	Patient Days	611,520	14	691		43,169	49	3
4	19	Professional Fees	Patient Days	611,520	14	33,266		43,169	2,348	4
5	20	Dues and Subscriptions	Patient Days	611,520	14	1,249		43,169	88	5
6	21	Office & Clerical	Patient Days	611,520	14	27,644		43,169	1,952	6
7	24	Travel and Seminar	Patient Days	611,520	14	19,257		43,169	1,359	7
8	26	Insurance	Patient Days	611,520	14	7,216		43,169	509	8
9	30	Depreciation	Patient Days	611,520	14	19,393		43,169	1,369	9
10	32	Interest	Patient Days	611,520	14	363,826		43,169	25,684	10
11	33	Real Estate Taxes	Patient Days	611,520	14	7,106		43,169	502	11
12	01	Dietary Salary	Patient Days	611,520	14	124,907	124,907	43,169	8,818	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	611,520	14	20,691		43,169	1,461	13
14	10	Nursing Salary	Patient Days	611,520	14	716,058	716,058	43,169	50,549	14
15										15
16	12	Social Service Salary	Patient Days	611,520		286,925	286,925	43,169	20,255	16
17	15	Emp. Ben. - Healthcare	Patient Days	611,520		166,142		43,169	11,728	17
18	17	Administration Salary	Patient Days	611,520		891,091	891,091	43,169	62,905	18
19	21	Office Salary	Patient Days	611,520		55,009	55,009	43,169	3,883	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	611,520		156,720		43,169	11,063	20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,900,982	\$ 2,073,990		\$ 204,789	25

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

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 Care Centers Health Systems, Inc.
Street Address 200 Howard
City / State / Zip Code Des Plaines, Illinois 60018
Phone Number (224) 612-5662
Fax Number (224) 612-5862

	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	Dietary Supplies, Supplements	Direct Allocation			\$	\$		832	1
	2	Nursing Supplies	Direct Allocation						23	2
	3	Ancillary Expense	Direct Allocation						6,711	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				\$	\$		7,565	25

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

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 Vent Lease, LLC
Street Address 2201 W. Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 674-1180
Fax Number (847) 673-7741

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	39	Ventilator Equipment	Direct Allocation						7,547	1
2	39	Other Ancillary	Direct Allocation							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					\$	\$		\$ 7,547	25

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

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 TriCare Rehab
Street Address 150 Fencil Lane
City / State / Zip Code Hillside, IL 60162
Phone Number (773) 449-9400
Fax Number (773) 449-9700

	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	39	Therapy	Direct Allocation		\$	\$		\$ 1,074,867	1
	2									2
	3									3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	\$		\$ 1,074,867	25

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

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 CCS Employee Benefits Group, Inc.
Street Address 2201 Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847)905-4000
Fax Number (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation			\$	\$		\$ 149,940	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					\$	\$		\$ 149,940	25

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

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 Reliable Medical of the Midwest, LLC
Street Address 200 Howard Avenue
City / State / Zip Code Des Plaines, Illinois 60018-5909
Phone Number (847) 566-0800
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	39	Ancillary Expense	Direct Allocation					52,982	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				\$	\$		\$ 52,982	25

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

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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

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	HFG		X	Note Payable			\$	187,238			\$	7,451	1
2	Rothner Health G II	X										21,541	2
3	Hunter Management	X										37,595	3
4	Hunter Management	X										(37,595)	4
5	See Supplemental Schedule							7,865,305				505,012	5
	Working Capital												
6													6
7													7
8	See Supplemental Schedule												8
9	TOTAL Facility Related						\$	8,052,543			\$	534,004	9
	B. Non-Facility Related*												
10	Interest Income		X									(4,317)	10
11	Allocated from EC Consulting	X										3,885	11
12	Allocated from EC Clinical	X										25,684	12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$				\$	25,252	14
15	TOTALS (line 9+line14)						\$	8,052,543			\$	559,256	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Citizens FNB		X				\$	7,865,305			\$	526,553	1
2	Rothner Health GII	X										(21,541)	2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term							7,865,305				505,012	7
	Working Capital												
8							\$				\$		8
9													9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital												14
	B. Non-Facility Related*												
15							\$				\$		15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related												20

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

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

		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 2011 report.				\$	110,2111																				
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.)				\$	115,1962																				
3. Under or (over) accrual (line 2 minus line 1).				\$	4,9853																				
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	118,3594																				
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 \$ 305 For 2008 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.				\$	123,3447																				
Real Estate Tax History:																									
Real Estate Tax Bill for Calendar Year:		2007	71,033	8	<table><tr><td></td><td colspan="2">FOR BHF USE ONLY</td><td></td></tr><tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2011</td><td>\$</td><td>13</td></tr><tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr><tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr><tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr></table>		FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2011	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
	FOR BHF USE ONLY																								
13	FROM R. E. TAX STATEMENT FOR 2011	\$	13																						
14	PLUS APPEAL COST FROM LINE 5	\$	14																						
15	LESS REFUND FROM LINE 6	\$	15																						
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																						
		2008	76,852	9																					
		2009	99,504	10																					
		2010	104,963	11																					
		2011	112,723	12																					
2012 Accrual = \$112,723 x 1.05 = \$118,359																									
Allocated from Extended Care Consulting = \$1,971																									
Allocated from Extended Care Clinical = \$502																									

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.

FACILITY NAME	<u>Lakewood Nursing & Rehab Center, Llc</u>	COUNTY	<u>Will</u>
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CONTACT PERSON REGARDING THIS REPORT

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. 06-03-10-312-003-0000	Long Term Care Property	\$ 112,722.64	\$ 112,722.64
2. See Attached	Allocation from 2201 Main	\$ 127,119.67	\$ 1,964.27
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 239,842.31	\$ 114,686.91

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lakewood Nursing & Rehab Center, Llc COUNTY Will

FACILITY IDPH LICENSE NUMBER 0046169

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

15,925

B. General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	273,121	2003	\$ 237,379	1
2	Allocated from ECC 2201 Main LLC/EC Clinical 2201 Main			12,671	2
3	TOTALS	273,121		\$ 250,050	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	131			1971	\$ 2,099,630	\$	39	\$ 49,105	\$ 49,105	\$ 491,056
5										
6										
7										
8										
	Improvement Type**									
9	Various		2003	11,804		20	695	695		9,349
10	Various		2004	41,672		20	2,162	2,162		19,385
11	Various		2005	14,592		20	1,072	1,072		9,227
12	Various		2006	66,264		20	5,470	5,470		49,974
13	Various		2007	40,549		20	1,806	1,806		23,198
14	Various		2008	65,346		20	1,169	1,169		47,183
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
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

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	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		6,332,257	223,384		316,613	93,229	2,239,395	67
68	Related Party Allocations (Pages 12H & 12I)		51,374	3,491		3,491		31,309	68
69	Financial Statement Depreciation			58,146			(58,146)		69
70	TOTAL (lines 4 thru 69)		\$ 8,723,487	\$ 285,021		\$ 381,583	\$ 96,562	\$ 2,920,076	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc

0046169

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

1	2	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		\$ 8,723,487	\$ 285,021		\$ 381,583	\$ 96,562	\$ 2,920,076	1
2	Roof Repair	2009	2,650		20	133	133	486	2
3	Painting	2009	7,624		20			7,624	3
4	Painting	2009	6,744		20			6,744	4
5	Painting	2009	4,216		20			4,216	5
6	Painting	2009	4,995		20			4,995	6
7	Ceiling	2009	5,250		20	263	263	831	7
8	Ceiling	2009	6,833		20	342	342	1,053	8
9	Painting	2009	1,651		20			1,651	9
10	Painting	2009	843		20			843	10
11	Painting	2009	999		20			999	11
12	Furnace	2010	4,036		20	202	202	437	12
13	Repair Roof From Storm Damage	2010	3,100		20	155	155	400	13
14	Repairs To Carrier Varialbe Volume & Temp. Controls System	2010	3,123		20	156	156	390	14
15	Roofing Project	2011	65,295		20	1,674	1,674	2,581	15
16	Commercial Heat Equipment - Water Heater	2011	5,448		20	1,090	1,090	2,088	16
17	Commercial Heat Equipment - Water Heater	2011	2,590		20	518	518	863	17
18	Roof Repairs	2011	2,710		20	136	136	271	18
19	Abc Supply Co. - Supplies For Roof Replacement	2012	17,702		20	295	295	295	19
20	Hugo'S Construction - Roof Replacement	2012	30,781		20	513	513	513	20
21	Schwartz Brothers - Plaster, Prime, Paint Rooms In 400 Wing	2012	3,389		20	28	28	28	21
22	Hot Water Heater Burner & Pipes	2012	2,800		20	140	140	140	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,906,265	\$ 285,021		\$ 387,226	\$ 102,205	\$ 2,957,526	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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		\$ 8,906,265	\$ 285,021		\$ 387,226	\$ 102,205	\$ 2,957,526	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,906,265	\$ 285,021		\$ 387,226	\$ 102,205	\$ 2,957,526	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 8,906,265	\$ 285,021		\$ 387,226	\$ 102,205	\$ 2,957,526	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,906,265	\$ 285,021		\$ 387,226	\$ 102,205	\$ 2,957,526	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 12D, Carried Forward		\$ 8,906,265	\$ 285,021		\$ 387,226	\$ 102,205	\$ 2,957,526	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,906,265	\$ 285,021		\$ 387,226	\$ 102,205	\$ 2,957,526	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9			223,384			(223,384)		9
10								10
11	2005	1,354,202		20	67,710	67,710	544,504	11
12	2006	4,978,055		20	248,903	248,903	1,694,891	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		\$	\$		\$	\$	\$	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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		\$ 6,332,257	\$ 223,384		\$ 316,613	\$ 93,229	\$ 2,239,395	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting 2201 Main LLC	2002	13,918	357	39	357		3,673	3
4	Allocated from Extended Care Clinical 2201 Main LLC	2002	3,543	91	39	91		935	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting 2201 Main LLC	2002	11,497	1,051	20	1,051		9,467	9
10	Allocated from Extended Care Consulting 2201 Main LLC	2003	13,549	1,238	20	1,238		11,156	10
11	Allocated from Extended Care Consulting 2201 Main LLC	2005	673	72	20	72		457	11
12	Allocated from Extended Care Consulting 2201 Main LLC	2009	121	6	20	6		24	12
13									13
14	Allocated from Extended Care Consulting	2007	146	7	20	7		44	14
15	Allocated from Extended Care Consulting	2009	87	4	20	4		17	15
16	Allocated from Extended Care Consulting	2010	854	43	20	43		128	16
17	Allocated from Extended Care Consulting	2011	307	15	20	15		31	17
18	Allocated from Extended Care Consulting	2012	101	5	20	5		5	18
19									19
20	Allocated from Extended Care Clinical 2201 Main LLC	2002	2,927	267	20	267		2,410	20
21	Allocated from Extended Care Clinical 2201 Main LLC	2003	3,449	315	20	315		2,840	21
22	Allocated from Extended Care Clinical 2201 Main LLC	2005	171	18	20	18		116	22
23	Allocated from Extended Care Clinical 2201 Main LLC	2009	31	2	20	2		6	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		\$ 51,374	\$ 3,491		\$ 3,491	\$	\$ 31,309	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$417,073	\$2,566	\$50,123	\$47,557	10	\$382,841	71
72	Current Year Purchases	3,566		713	713	10	713	72
73	Fully Depreciated Assets	281,381				10	281,381	73
74								74
75	TOTALS	\$702,020	\$2,566	\$50,836	\$48,270		\$664,935	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from EC Consulting	1900	\$4,904	\$981	\$981		5	\$4,904	76
77		Allocated from EC Clinical	1900	3,627	578	578		5	347	77
78										78
79										79
80	TOTALS			\$8,531	\$1,559	\$1,559			\$5,251	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$9,866,866	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$289,146	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$439,621	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$150,475	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,627,712	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: 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	Storage Unit Rental				1,266			5
6								6
7	TOTAL				\$ 1,266			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:
- *

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: \$ 1,807
- Description:
- See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.

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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		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)	\$			

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 410,829	\$		\$ 410,829	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			187,448			187,448	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			490,851			490,851	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				669,254		669,254	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)									
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					61,721	266,098		327,819	13
14	TOTAL			\$		\$ 1,150,849	\$ 935,352		\$ 2,086,201	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 1,492	\$ 11,321	1
2	Cash-Patient Deposits	20,315	20,315	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,716,118	1,716,118	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	311,171	311,171	6
7	Other Prepaid Expenses	4,521	4,521	7
8	Accounts Receivable (owners or related parties)	413,104	114,543	8
9	Other(specify): See Attached Schedule	928,533	928,533	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,395,254	\$ 3,106,522	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		237,379	13
14	Buildings, at Historical Cost		4,084,382	14
15	Leasehold Improvements, at Historical Cost	323,034	5,348,139	15
16	Equipment, at Historical Cost	520,339	520,339	16
17	Accumulated Depreciation (book methods)	(631,456)	(2,939,804)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		104,364	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 211,917	\$ 7,354,799	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,607,171	\$ 10,461,321	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,719,037	\$ 1,719,038	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,863	23,863	28
29	Short-Term Notes Payable	187,238	187,238	29
30	Accrued Salaries Payable	198,137	198,137	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,110	10,110	31
32	Accrued Real Estate Taxes(Sch.IX-B)	118,359	118,359	32
33	Accrued Interest Payable		627,662	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,256,744	\$ 2,884,407	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,865,305	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 7,865,305	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,256,744	\$ 10,749,712	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,350,427	\$ (288,391)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,607,171	\$ 10,461,321	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,714,434	1
2	Restatements (describe):		2
3	Rounding	(7)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,714,427	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(289,000)	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	(75,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (364,000)	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)	\$ 1,350,427	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 10,130,277	1
2	Discounts and Allowances for all Levels	(5,298,770)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,831,507	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,422,484	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,422,484	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,211	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	687,949	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	222,662	19
20	Radiology and X-Ray	30,810	20
21	Other Medical Services	230,894	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,173,526	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,317	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,317	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,095	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,095	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,432,929	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,412,215	31
32	Health Care	3,966,401	32
33	General Administration	2,140,049	33
	B. Capital Expense		
34	Ownership	845,180	34
	C. Ancillary Expense		
35	Special Cost Centers	2,086,201	35
36	Provider Participation Fee	271,883	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,721,929	40
41	Income before Income Taxes (line 30 minus line 40)**	(289,000)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (289,000)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,118,293	44
45	Private Pay - Net Inpatient Revenue	1,029,130	45
46	Medicare - Net Inpatient Revenue	162,666	46
47	Other-(specify) Hospice	495,999	47
48	Other-(specify) Insurance	25,419	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,831,507	49

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.
*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

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	1,964	2,213	\$ 91,684	\$ 41.43	1
2	Assistant Director of Nursing	1,436	1,503	55,586	36.98	2
3	Registered Nurses	20,825	23,403	698,120	29.83	3
4	Licensed Practical Nurses	31,832	35,237	928,708	26.36	4
5	CNAs & Orderlies	84,669	92,702	1,143,697	12.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,240	12,506	229,560	18.36	8
9	Activity Director	1,925	2,109	40,569	19.24	9
10	Activity Assistants	8,329	8,882	108,733	12.24	10
11	Social Service Workers	7,961	8,682	194,956	22.46	11
12	Dietician					12
13	Food Service Supervisor	2,580	2,645	51,238	19.37	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,634	5,974	84,327	14.12	15
16	Dishwashers	16,043	17,676	164,285	9.29	16
17	Maintenance Workers	6,021	6,655	123,643	18.58	17
18	Housekeepers	16,841	18,304	184,275	10.07	18
19	Laundry	5,214	5,749	51,597	8.97	19
20	Administrator	2,008	2,465	109,186	44.29	20
21	Assistant Administrator	2,035	2,157	49,060	22.74	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,790	9,596	168,840	17.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,539	2,886	55,855	19.35	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	885	1,050	14,632	13.94	33
34	TOTAL (lines 1 - 33)	238,771	262,394	\$ 4,548,551 *	\$ 17.33	34

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	275	\$ 13,738	01-03	35
36	Medical Director	Monthly	27,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	15,000	10-03	38
39	Pharmacist Consultant	Monthly	8,624	10-03	39
40	Physical Therapy Consultant	3	156	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	278	\$ 65,118		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	127	\$ 7,191	10-03	50
51	Licensed Practical Nurses	1,361	56,523	10-03	51
52	Certified Nurse Assistants/Aides	560	16,807	10-03	52
53	TOTAL (lines 50 - 52)	2,048	\$ 80,521		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberLakewood Nursing & Rehab Center, Llc# 0046169Report Period Beginning:01/01/12Ending:12/31/12Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Shannon Deckinga (1/1 - 10/19/12)	Administrator	0	\$ 79,706
Sherri Mitchell (10/20 - 11/2/12)	Administrator	0	16,378
Margie Thompson (11/3 - 12/31/12)	Administrator	0	13,102
Anna Mohr	Asst Admin	0	49,060
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 158,246

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
Frost, Ruttenberg & Rothblatt	Accounting	\$ 29,117
Paycor	Payroll Services	16,486
eHealth Data Solutions	MDS Software Fee	3,710
Achieve	Data Processing	13,196
Pro Payroll Solutions	Payroll Services	5,821
IIT/Sourcetechn	Operator Monthly Support	660
Ability Network	Data Processing	1,624
AIS Assessment & Intelligence	Data Processing	1,343
National Datacare Corporation	Resident Fund Processing	1,034
Bylmas	Tax Credit Services	2,545
COMS Interactive	Clinical Assessment	4,000
See Supplemental Schedule		519,649
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 599,185

D. Employee Benefits and Payroll Taxes

Description	Amount	
Workers' Compensation Insurance	\$ 179,154	
Unemployment Compensation Insurance	110,739	
FICA Taxes	343,695	
Employee Health Insurance	85,668	
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
Employee Physicals	12,644	
Other Employee Welfare	4,472	
Holiday Expense	3,260	
TOTAL (agree to Schedule V, line 22, col.8)		\$ 739,632

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	\$	
Advertising: Employee Recruitment	25	
Health Care Worker Background Check (Indicate # of checks performed 506)	1,655	
Patient Background Checks	4,020	
Dues & Subscriptions	2,835	
License & Fees	3,045	
Allocated from EC Consulting	3,259	
Allocated from EC Clinical	88	
Less: Public Relations Expense	()	
Non-allowable advertising	()	
Yellow page advertising	()	
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 14,927

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	2,551
Allocated from EC Consulting	200
Allocated from EC Clinical	1,359
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 4,110

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

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

No

(2) Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount. IL Council on LTC: \$2,237

(3) Did the nursing home make political contributions or payments to a political action organization?

Yes

If YES, have these costs been properly adjusted out of the cost report?

Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A

(5) Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

10 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$89,677 Line10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A

(9) Are you presently operating under a sublease agreement?

YES

X

NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YESNOX

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$271,883

This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$Has any meal income been offset against related costs?

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?

N/A

If YES, please indicate the amount of income earned from such a program during this reporting period. \$N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

N/A

d. Have vehicle usage logs been maintained?

N/A

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period. \$N/A

(17) Has an audit been performed by an independent certified public accounting firm?

No

Firm Name: N/A

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

Yes

(19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

Yes

Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT