

		FOR BHF USE					

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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.

<p>I. IDPH License ID Number: <u>0051524</u></p> <p>Facility Name: <u>LAKEVIEW REHAB & NRSR CTR</u></p> <p>Address: <u>735 W DIVERSEY</u> <u>CHICAGO</u> <u>60614</u> <small>Number City Zip Code</small></p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>708-449-1900</u> Fax # ()</p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>6/1/11</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Alan Sorscher</u> Telephone Number: <u>708-449-1900 ext 305</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2012</u> to <u>12/31/2012</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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>Alan Sorscher</u> (Title) <u>CFO</u> </td> </tr> <tr> <td style="width:15%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) _____ Fax # () </td> </tr> </table> <p align="right"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Alan Sorscher</u> (Title) <u>CFO</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) _____ Fax # ()
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Alan Sorscher</u> (Title) <u>CFO</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) _____ Fax # ()							

Facility Name & ID Number LAKEVIEW REHAB & NRSG CTR

0051524 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	178	Skilled (SNF)	178	65,148	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	178	TOTALS	178	65,148	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	40,904	3,251	6,241	50,396	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,904	3,251	6,241	50,396	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.36%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
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 06/01/2011

J. Was the facility purchased or leased after January 1, 1978?
YES Date 06/01/2011 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 178 and days of care provided 5,835

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.

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	281,236	21,347	15,000	317,583		317,583	(5,082)	312,501		1
2	Food Purchase		212,983		212,983		212,983		212,983		2
3	Housekeeping	268,340	30,201		298,541		298,541		298,541		3
4	Laundry	92,959	16,116		109,075		109,075		109,075		4
5	Heat and Other Utilities			222,117	222,117		222,117	683	222,800		5
6	Maintenance	95,067	36,531	44,356	175,954		175,954	(1,959)	173,995		6
7	Other (specify):*										7
8	TOTAL General Services	737,602	317,178	281,473	1,336,253		1,336,253	(6,358)	1,329,895		8
	B. Health Care and Programs										
9	Medical Director			30,000	30,000		30,000		30,000		9
10	Nursing and Medical Records	3,136,207	406,266	32,500	3,574,973		3,574,973	16,988	3,591,961		10
10a	Therapy			637,864	637,864		637,864		637,864		10a
11	Activities	118,367	22,831		141,198		141,198		141,198		11
12	Social Services	76,944		9,194	86,138		86,138		86,138		12
13	CNA Training										13
14	Program Transportation			2,843	2,843		2,843		2,843		14
15	Other (specify):* Pharmacy Consultant			14,100	14,100		14,100		14,100		15
16	TOTAL Health Care and Programs	3,331,518	429,097	726,501	4,487,116		4,487,116	16,988	4,504,104		16
	C. General Administration										
17	Administrative	97,833			97,833		97,833		97,833		17
18	Directors Fees										18
19	Professional Services			746,572	746,572		746,572	(274,863)	471,709		19
20	Dues, Fees, Subscriptions & Promotions			17,943	17,943		17,943		17,943		20
21	Clerical & General Office Expenses	224,500	116,291	18,480	359,271		359,271	32,591	391,862		21
22	Employee Benefits & Payroll Taxes			980,954	980,954		980,954	61,087	1,042,041		22
23	Inservice Training & Education										23
24	Travel and Seminar			18,752	18,752		18,752	7	18,759		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			133,903	133,903		133,903	65,207	199,110		26
27	Other (specify):*										27
28	TOTAL General Administration	322,333	116,291	1,916,604	2,355,228		2,355,228	(115,971)	2,239,257		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,391,453	862,566	2,924,578	8,178,597		8,178,597	(105,341)	8,073,256		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number LAKEVIEW REHAB & NRSR CTR

#0051524

Report Period Beginning: 01/01/2012 Ending: 12/31/2012

12/31/2012

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			11,486	11,486	11,486	2,685	14,171				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			249,596	249,596	249,596	80,750	330,346				32
33	Real Estate Taxes						223,438	223,438				33
34	Rent-Facility & Grounds			1,260,000	1,260,000	1,260,000	(621,714)	638,286				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Replacement Tax			10,530	10,530	10,530		10,530				36
37	TOTAL Ownership			1,531,612	1,531,612	1,531,612	(314,841)	1,216,771				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			320,438	320,438	320,438		320,438				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			520,346	520,346	520,346		520,346				42
43	Other (specify):* Bad Debt			90,000	90,000	90,000	(90,000)					43
44	TOTAL Special Cost Centers			930,784	930,784	930,784	(90,000)	840,784				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,391,453	862,566	5,386,974	10,640,993	10,640,993	(510,182)	10,130,811				45

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

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	2,510	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(68)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(90,000)	43		24
25	Fund Raising, Advertising and Promotional	(15,785)	21		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(29,482)	various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (132,825)		\$	30

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	2	
		Amount	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)	(377,357)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (377,357)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (510,182)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

LAKEVIEW REHAB & NRSG CTR

ID# 0051524

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	work comp refund	\$ (16,534)	22	1
2	misc inc	(12,948)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(29,482)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LAKEVIEW REHAB & NRSR CTR

0051524

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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	(68)	(5,014)	0	0	0	0	0	0	0	0	0	(5,082)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	683	0	0	0	0	0	0	0	0	0	683	5
6	Maintenance	0	(1,959)	0	0	0	0	0	0	0	0	0	(1,959)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(68)	(6,290)	0	0	0	0	0	0	0	0	0	(6,358)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	16,988	0	0	0	0	0	0	0	0	0	16,988	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	16,988	0	0	0	0	0	0	0	0	0	16,988	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(274,863)	0	0	0	0	0	0	0	0	0	(274,863)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(28,733)	61,324	0	0	0	0	0	0	0	0	0	32,591	21
22	Employee Benefits & Payroll Taxes	(16,534)	77,621	0	0	0	0	0	0	0	0	0	61,087	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	7	0	0	0	0	0	0	0	0	0	7	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	64,743	464	0	0	0	0	0	0	0	0	65,207	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(45,267)	(71,168)	464	0	(115,971)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(45,335)	(60,470)	464	0	(105,341)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKEVIEW REHAB & NRSR CTR

0051524

Report Period Beginning:

01/01/2012 Ending:

12/31/2012

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	2,510	0	175	0	0	0	0	0	0	0	0	2,685	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	80,750	0	0	0	0	0	0	0	0	0	80,750	32
33	Real Estate Taxes	0	223,438	0	0	0	0	0	0	0	0	0	223,438	33
34	Rent-Facility & Grounds	0	(628,879)	7,165	0	0	0	0	0	0	0	0	(621,714)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	2,510	(324,691)	7,340	0	(314,841)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(90,000)	0	0	0	0	0	0	0	0	0	0	(90,000)	43
44	TOTAL Special Cost Centers	(90,000)	0	0	0	0	0	0	0	0	0	0	(90,000)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(132,825)	(385,161)	7,804	0	0	0	0	0	0	0	0	(510,182)	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
Michael Blisko	40%			Infinity Healthcare M	Hillside, IL	Management
Moishe Gubin	40%					
Majestic Healthcare Consultants	20%					

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	21 office	\$	Lincoln Park Holding, LLC		\$ 3,270	\$ 3,270	1
2	V	26 insurance		Lincoln Park Holding, LLC		64,743	64,743	2
3	V	32 interest		Lincoln Park Holding, LLC		80,750	80,750	3
4	V	34 rent	1,260,000	Lincoln Park Holding, LLC		631,121	(628,879)	4
5	V	33 real estate taxes		Lincoln Park Holding, LLC		223,438	223,438	5
6	V	1 dietary	15,710	Infinity Healthcare		10,696	(5,014)	6
7	V	6 maint	6,275	Infinity Healthcare		4,316	(1,959)	7
8	V	10 nursing	25,200	Infinity Healthcare		42,188	16,988	8
9	V	21 office	38,001	Infinity Healthcare		96,055	58,054	9
10	V	5 utilities		Infinity Healthcare		683	683	10
11	V	19 prof fees	276,000	Infinity Healthcare		1,137	(274,863)	11
12	V	22 employee exp	2,593	Infinity Healthcare		80,214	77,621	12
13	V	24 auto/travel	273	Infinity Healthcare		280	7	13
14	Total		\$ 1,624,052			\$ 1,238,891	\$ * (385,161)	14

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

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	26 insurance	\$	Infinity Healthcare		\$ 464	\$	464	15
16	V	34 rent		Infinity Healthcare		7,165		7,165	16
17	V	30 depreciation		Infinity Healthcare		175		175	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		\$			\$ 7,804	\$ *	7,804	39

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

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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number LAKEVIEW REHAB & NRSR CTR

0051524

Report Period Beginning:

01/01/2012

Ending: 2/31/2012

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

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

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

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

LAKEVIEW REHAB & NRSR CTR

0051524

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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	Name of Lender	2		3	4	5	6		8	9	10						
		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	Strawberry Patch Alef	x		Financing	none	various	\$ 770,000	\$ 770,000	various	various	\$ 80,750						
2																	
3																	
4																	
5																	
Working Capital																	
6	bank financial		x	working capital	none	6/1/11	2,500,000	1,606,169	9/15/13	various	100,744						
7	Inifinity Funding	x		working capital	none	various	various	2,100,000	various	various	148,852						
8																	
9	TOTAL Facility Related						\$ 3,270,000	\$ 4,476,169			\$ 330,346						
B. Non-Facility Related*																	
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 3,270,000	\$ 4,476,169			\$ 330,346						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ n/a Line # _____

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 2011 report.		\$	113,087		1														
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	227,568		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	114,481		3														
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	108,957		4														
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5														
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	223,438		7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2007	_____	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2011 \$ _____</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$ _____</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ _____</td> <td style="text-align: center;">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	_____	9																
	2009	_____	10																
	2010	228,518	11																
	2011	227,568	12																

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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LAKEVIEW REHAB & NRSNG CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0051524

CONTACT PERSON REGARDING THIS REPORT Alan Sorscher

TELEPHONE 708-449-1900 FAX #: _____

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.	<u>14-28-300-13-0000</u>	<u>nursing facility</u>	\$ <u>227,567.82</u>	\$ <u>227,567.82</u>
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u><u>227,567.82</u></u>	\$ <u><u>227,567.82</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 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.**

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (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).

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				\$	1
2					2
3	TOTALS			\$	3

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	178			\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Suburban Elevator	2011		28,500	731	39	731	(0)	1,157
10									
11	Install Exhaust Fans	2012		8,670	222	39	185	(37)	222
12	Suburban Elevator	2012		16,050	412	39	274	(138)	412
13	Suburban Elevator	2012		2,850	73	39	49	(24)	73
14	Suburban Elevator - Pit Work & Drilling	2012		9,350	240	39	100	(140)	240
15	Provide & Install Railings	2012		2,630	67	39	11	(56)	67
16	New Awnings	2012		1,750	45	39	7	(38)	45
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

See Page 12A, Line 70 for total

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	
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									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 69,800	\$ 1,790		\$ 1,357	\$ (433)	\$ 2,216	70

**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	\$ 57,632	\$	\$ 11,526	\$ 11,526	5	\$ 57,632	71
72	Current Year Purchases	9,696	9,696	1,288	(8,408)	5	9,696	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 67,328	\$ 9,696	\$ 12,814	\$ 3,118		\$ 67,328	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 137,128	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 11,486	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 14,171	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,685	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 69,544	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: Lincoln Park Holdings, LLC

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:		178	06/1/11	\$ 642,887	20		3
4	Additions							4
5								5
6								6
7	TOTAL		178		\$ 642,887			7

10. Effective dates of current rental agreement:

Beginning 6/1/11

Ending 12/31/2020

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

Fiscal Year Ending Annual Rent

12. /2013 \$ #####

13. /2014 \$ #####

14. /2015 \$ #####

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: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number LAKEVIEW REHAB & NRSR CTR # 0051524 Report Period Beginning: 01/01/2012 Ending: 12/31/2012
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$		\$ 243,980	\$		\$ 243,980	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			107,426			107,426	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			286,458			286,458	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescripts				310,735		310,735	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): radiology & lab	39-3					9,703		9,703	12
13	Other (specify):									13
14	TOTAL			\$		\$ 637,864	\$ 320,438		\$ 958,302	14

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

Facility Name & ID Number LAKEVIEW REHAB & NRSG CTR# 0051524Report Period Beginning: 01/01/2012

Ending:

12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 95,214	\$ 125,026	1
2	Cash-Patient Deposits	(8,794)	(8,794)	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	5,722,832	5,813,921	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	136,135	136,135	6
7	Other Prepaid Expenses		225,073	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,945,387	\$ 6,291,361	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	69,800	69,800	15
16	Equipment, at Historical Cost	67,328	67,329	16
17	Accumulated Depreciation (book methods)	(69,544)	(69,544)	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):		954,966	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 67,584	\$ 1,022,551	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,012,971	\$ 7,313,912	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 957,074	\$ 957,074	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	478,978	478,978	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>working capital</u>	3,706,169	4,476,169	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,142,221	\$ 5,912,221	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,142,221	\$ 5,912,221	46
47	TOTAL EQUITY(page 18, line 24)	\$ 870,750	\$ 1,401,691	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,012,971	\$ 7,313,912	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 703,004	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 703,004	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	396,872	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	(229,126)	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)	\$ 167,746	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)	\$ 870,750	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number LAKEVIEW REHAB & NRSG CTR

0051524

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

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.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,977,011	1
2	Discounts and Allowances for all Levels	(542,061)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,434,950	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	267,583	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 267,583	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	263,857	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	37,368	19
20	Radiology and X-Ray	4,625	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 305,850	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc	29,482	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 29,482	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,037,865	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,336,253	31
32	Health Care	4,487,116	32
33	General Administration	2,355,228	33
B. Capital Expense			
34	Ownership	1,531,612	34
C. Ancillary Expense			
35	Special Cost Centers	320,438	35
36	Provider Participation Fee	520,346	36
D. Other Expenses (specify):			
37	bad debt	90,000	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,640,993	40
41	Income before Income Taxes (line 30 minus line 40)**	396,872	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 396,872	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 6,513,069	44
45	Private Pay - Net Inpatient Revenue	730,296	45
46	Medicare - Net Inpatient Revenue	3,027,431	46
47	Other-(specify) comm ins	164,154	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,434,950	49

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

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

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

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

Facility Name & ID Number **LAKEVIEW REHAB & NRSRG CTR**

0051524

Report Period Beginning: **01/01/2012**

Ending:

12/31/2012

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	1,912	2,168	\$ 106,314	\$ 49.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	39,033	41,945	1,321,197	31.50	3
4	Licensed Practical Nurses	20,563	22,187	532,809	24.01	4
5	CNAs & Orderlies	96,650	107,111	1,136,034	10.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	9,786	10,583	118,367	11.18	9
10	Activity Assistants					10
11	Social Service Workers	3,984	4,316	76,944	17.83	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,536	22,592	281,236	12.45	15
16	Dishwashers					16
17	Maintenance Workers	3,860	4,360	95,067	21.80	17
18	Housekeepers	18,671	20,952	268,340	12.81	18
19	Laundry	7,469	8,096	92,959	11.48	19
20	Administrator	2,008	2,140	97,833	45.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,459	11,795	224,499	19.03	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,928	2,176	39,854	18.32	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	236,859	260,421	\$ 4,391,453 *	\$ 16.86	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	429	\$ 15,000	10-1	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	650	32,500	10-3	38
39	Pharmacist Consultant	282	14,100	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	263	9,194	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,623	\$ 70,794		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Chaim Dubovick	Admin		\$ 97,833	Workers' Compensation Insurance	\$ 146,510	IDPH License Fee	\$	
				Unemployment Compensation Insurance	158,015	Advertising: Employee Recruitment		
				FICA Taxes	431,922	Health Care Worker Background Check		
				Employee Health Insurance	261,023	(Indicate # of checks performed _____)		
				Employee Meals		clia	150	
				Illinois Municipal Retirement Fund (IMRF)*		illinois council	8,910	
				pension exp	29,199	sec of state	250	
				employee exp	15,331	chicago dept of rev	3,390	
				uniforms	41	other	4,279	
						joint commission	964	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 97,833	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 1,042,041		\$ 17,943		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description	Amount			Description	Line #	Amount	Description	Amount
	\$					\$	Out-of-State Travel	\$
							In-State Travel	
							mileage	10,012
							auto	7,123
							Seminar Expense	
							education	385
							seminar	1,089
							travel	150
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 18,759	
C. Professional Services								
Vendor/Payee	Type	Amount						
infinity healthcare	healthcare consulting	\$ 276,000						
ambassador	admin	8,854						
sandra thiel	legal	1,240						
michael feldman	admin	1,250						
majestic healthcare	consulting	450,000						
achieve	prof fees	976						
bradley & associates	acctg	8,252						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 746,572					

* Attach copy of IMRF notifications

**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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number LAKEVIEW REHAB & NRSR CTR

0051524

Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? yes
- (2) Are there any dues to nursing home associations included on the cost report? no
If YES, give association name and amount. n/a
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? n/a
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? n/a
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 33,040 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. n/a
- (9) Are you presently operating under a sublease agreement? x YES NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. n/a
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 520,346
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? n/a Indicate the amount. \$ n/a
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ n/a
- c. What percent of all travel expense relates to transportation of nurses and patients? 0%
- d. Have vehicle usage logs been maintained? n/a
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? n/a
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
- 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. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? no
Firm Name: n/a
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? n/a
- (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? n/a
Attach invoices and a summary of services for all architect and appraisal fees.