

		FOR BHF USE					

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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 & Nrsg Center</u></p> <p>Address: <u>735 West 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>773-348-4055</u> Fax # ()</p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>06/01/2011</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</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>01/01/2014</u> to <u>12/31/2014</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:20%; 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:20%; 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 Center

0051524 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	64,970	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	178	TOTALS	178	64,970	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	40,748	3,147	8,678	52,573	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,748	3,147	8,678	52,573	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.92%

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 _____ 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 6,818

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: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number

Lakeview Rehab & Nrsg Center

0051524

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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	318,364		15,450	333,814		333,814	(3,092)	330,722		1
2	Food Purchase		286,303		286,303		286,303		286,303		2
3	Housekeeping	325,415	37,823		363,238		363,238		363,238		3
4	Laundry	54,955	27,801		82,756		82,756		82,756		4
5	Heat and Other Utilities			257,222	257,222		257,222	1,022	258,244		5
6	Maintenance	98,947	43,311	48,838	191,096		191,096	2,236	193,332		6
7	Other (specify):*										7
8	TOTAL General Services	797,681	395,238	321,510	1,514,429		1,514,429	166	1,514,595		8
	B. Health Care and Programs										
9	Medical Director			31,125	31,125		31,125		31,125		9
10	Nursing and Medical Records	3,228,803	394,892	36,468	3,660,163		3,660,163	28,836	3,688,999		10
10a	Therapy			894,224	894,224		894,224		894,224		10a
11	Activities	121,292	38,475		159,767		159,767		159,767		11
12	Social Services	81,271		10,207	91,478		91,478		91,478		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* rx consultant			13,294	13,294		13,294		13,294		15
16	TOTAL Health Care and Programs	3,431,366	433,367	985,318	4,850,051		4,850,051	28,836	4,878,887		16
	C. General Administration										
17	Administrative	132,589			132,589		132,589		132,589		17
18	Directors Fees										18
19	Professional Services			293,257	293,257		293,257	(285,990)	7,267		19
20	Dues, Fees, Subscriptions & Promotions			19,293	19,293		19,293		19,293		20
21	Clerical & General Office Expenses	296,998	140,494	17,329	454,821		454,821	94,713	549,534		21
22	Employee Benefits & Payroll Taxes			809,797	809,797		809,797	32,113	841,910		22
23	Inservice Training & Education										23
24	Travel and Seminar			28,599	28,599		28,599	(201)	28,398		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			376,895	376,895		376,895	1,019	377,914		26
27	Other (specify):*										27
28	TOTAL General Administration	429,587	140,494	1,545,170	2,115,251		2,115,251	(158,346)	1,956,905		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,658,634	969,099	2,851,998	8,479,731		8,479,731	(129,344)	8,350,387		29

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

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

Facility Name & ID Number Lakeview Rehab & Nrsg Center

#0051524

Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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			31,694	31,694		31,694	15,644	47,338			30
31	Amortization of Pre-Op. & Org.			43,991	43,991		43,991		43,991			31
32	Interest			363,097	363,097		363,097	(472)	362,625			32
33	Real Estate Taxes			232,266	232,266		232,266		232,266			33
34	Rent-Facility & Grounds			1,833,245	1,833,245		1,833,245	(1,243,975)	589,270			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* replacement tax			2,396	2,396		2,396		2,396			36
37	TOTAL Ownership			2,506,689	2,506,689		2,506,689	(1,228,803)	1,277,886			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		310,238		310,238		310,238		310,238			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			377,603	377,603		377,603		377,603			42
43	Other (specify):* bad debt expense			717,080	717,080		717,080	(717,080)				43
44	TOTAL Special Cost Centers		310,238	1,094,683	1,404,921		1,404,921	(717,080)	687,841			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,658,634	1,279,337	6,453,370	12,391,341		12,391,341	(2,075,227)	10,316,114			45

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

Facility Name & ID Number Lakeview Rehab & Nrsng Center

0051524

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

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	15,644	30		9
10	Interest and Other Investment Income	(472)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				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	(717,080)	43		24
25	Fund Raising, Advertising and Promotional	(33,315)	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 Various	(1,264,706)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,999,929)		\$	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)	(75,298)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (75,298)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (2,075,227)		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				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY					
48		49		50	51
					52

Lakeview Rehab & Nrsg Center

ID# 0051524

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	rent	\$ (1,260,000)	34	1
2	misc income	(4,706)	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	(1,264,706)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lakeview Rehab & Nrsg Center# 0051524

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	(3,092)	0	0	0	0	0	0	0	0	0	(3,092)	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	1,022	0	0	0	0	0	0	0	0	0	1,022	5
6	Maintenance	0	2,236	0	0	0	0	0	0	0	0	0	2,236	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	166	0	0	0	0	0	0	0	0	0	166	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	28,836	0	0	0	0	0	0	0	0	0	28,836	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	28,836	0	0	0	0	0	0	0	0	0	28,836	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	(285,990)	0	0	0	0	0	0	0	0	0	(285,990)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(38,021)	132,734	0	0	0	0	0	0	0	0	0	94,713	21
22	Employee Benefits & Payroll Taxes	0	32,113	0	0	0	0	0	0	0	0	0	32,113	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(201)	0	0	0	0	0	0	0	0	0	(201)	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	1,019	0	0	0	0	0	0	0	0	0	1,019	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(38,021)	(120,325)	0	0	0	0	0	0	0	0	0	(158,346)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(38,021)	(91,323)	0	0	0	0	0	0	0	0	0	(129,344)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lakeview Rehab & Nrsrg Center# 0051524

Report Period Beginning:

01/01/2014 Ending:

12/31/2014

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	15,644	0	0	0	0	0	0	0	0	0	0	15,644	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(472)	0	0	0	0	0	0	0	0	0	0	(472)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(1,260,000)	16,025	0	0	0	0	0	0	0	0	0	(1,243,975)	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	(1,244,828)	16,025	0	(1,228,803)	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):*	(717,080)	0	0	0	0	0	0	0	0	0	0	(717,080)	43
44	TOTAL Special Cost Centers	(717,080)	0	0	0	0	0	0	0	0	0	0	(717,080)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,999,929)	(75,298)	0	(2,075,227)	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	Hillside, IL	Management Co.
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	1 dietary	\$ 15,450	Infinity Healthcare Managemnt of Illinois		\$ 12,358	\$ (3,092)	1
2	V	6 maintenance		Infinity Healthcare Managemnt of Illinois		2,236	2,236	2
3	V	10 nursing	29,221	Infinity Healthcare Managemnt of Illinois		58,057	28,836	3
4	V	21 office	70,250	Infinity Healthcare Managemnt of Illinois		202,984	132,734	4
5	V	5 utilities		Infinity Healthcare Managemnt of Illinois		1,022	1,022	5
6	V	19 prof fees	292,456	Infinity Healthcare Managemnt of Illinois		6,466	(285,990)	6
7	V	22 employee expenses	1,946	Infinity Healthcare Managemnt of Illinois		34,059	32,113	7
8	V	24 travel	916	Infinity Healthcare Managemnt of Illinois		715	(201)	8
9	V	26 insurance		Infinity Healthcare Managemnt of Illinois		1,019	1,019	9
10	V	34 rent		Infinity Healthcare Managemnt of Illinois		16,025	16,025	10
11	V	2 food		Infinity Healthcare Managemnt of Illinois				11
12	V	32 interest		Infinity Healthcare Managemnt of Illinois				12
13	V							13
14	Total		\$ 410,239			\$ 334,941	\$ * (75,298)	14

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

Facility Name & ID Number

Lakeview Rehab & Nrsg Center

0051524

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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

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

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

Facility Name & ID Number Lakeview Rehab & Nrsg Center

0051524 Report Period Beginning: 01/01/2014

Ending: 2/31/2014

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				\$	\$		\$	

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	x		Financing	none	various	\$ 770,000	\$ 705,000	various	various	\$ 71,328	1					
2	HUD loan		x	mortgage	\$37,680.00	11/26/14	8,953,100	8,953,100	12/1/49	3.0250		2					
3												3					
4												4					
5												5					
Working Capital																	
6	capital one		x	working capital	none	08/31/2014	19,174,998	1,083,375	08/31/2018	various	83,978	6					
7	infinity funding	x		working capital	none	various	various	2,909,000	various	various	207,791	7					
8												8					
9	TOTAL Facility Related				\$37,680.00		\$ 28,898,098	\$ 13,650,475			\$ 363,097	9					
B. Non-Facility Related*																	
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 28,898,098	\$ 13,650,475			\$ 363,097	15					

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 2013 report.		\$	<u>322,951</u>		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.)		\$	<u>255,269</u>		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(67,682)</u>		3														
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>299,948</u>		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.		\$	<u>232,266</u>		7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2009	_____	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 2013 \$ _____</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 2013 \$ _____	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 2013 \$ _____	13																	
14	PLUS APPEAL COST FROM LINE 5 \$ _____	14																	
15	LESS REFUND FROM LINE 6 \$ _____	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$ _____	16																	
	2010	<u>228,518</u>	9																
	2011	<u>227,568</u>	10																
	2012	<u>251,860</u>	11																
	2013	<u>255,269</u>	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.

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 and 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	<u>land</u>		<u>6/1/2011</u>	<u>\$ 500,000</u>	1
2					2
3	TOTALS			\$ 500,000	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	2014		\$ 3,560,000	\$ 9,509	39	\$ 9,509	\$	\$ 9,509	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Suburban Elevator		2011	28,500	731	39	731		2,619	9
10										10
11	Install Exhaust Fans		2012	8,670	222	39	222		667	11
12	Suburban Elevator		2012	16,050	412	39	412		1,235	12
13	Suburban Elevator		2012	2,850	73	39	73		219	13
14	Suburban Elevator - Pit Work & Drilling		2012	9,350	240	39	240		719	14
15	Provide & Install Railings		2012	2,630	67	39	67		202	15
16	New Awnings		2012	1,750	45	39	45		135	16
17										17
18	Universal Elevator		2013	1,956	50	39	50		75	18
19	Charles Equipment		2013	1,898	49	39	49		73	19
20	Nova Fire Protection		2013	13,475	345	39	346	1	518	20
21	Superior Construction		2013	5,280	135	39	135		203	21
22	Pae Chicago Eco Seal		2013	3,450	88	39	88		132	22
23	TNS		2013	18,101	464	39	464		696	23
24										24
25	Clean Network Closet		2014	1,992	51	39	51		51	25
26	Install Stair Rails		2014	2,325	60	39	35	(25)	60	26
27	Remodel & Equip Therapy Room		2014	63,081	1,618	39	809	(809)	1,618	27
28	Install Dome Light Modules		2014	2,280	58	39	49	(9)	58	28
29	Shower Room Renovation		2014	4,465	115	39	38	(77)	115	29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lakeview Rehab & Nrsrg Center

0051524

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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				
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57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	3,748,103	\$	14,332	\$	13,413	\$	(919)	\$	18,904	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	\$ 161,352	\$ 10,825	\$ 32,270	\$ 21,445		\$ 129,708	71
72	Current Year Purchases	8,276	6,537	1,655	(4,882)		6,537	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 169,628	\$ 17,362	\$ 33,925	\$ 16,563		\$ 136,245	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,417,731	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 31,694	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 47,338	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 15,644	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 155,149	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	06/01/2011	\$ 1,260,000	20		3
4	Additions							4
5								5
6								6
7	TOTAL		178		\$ 1,260,000			7

10. Effective dates of current rental agreement:

Beginning 06/01/2011

Ending 12/31/2020

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

Fiscal Year Ending Annual Rent

12. 2015 \$ 1,260,000

13. 2016 \$ 1,260,000

14. 2017 \$ 1,260,000

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.

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		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	10a-3	hrs	\$		\$	169,634	\$		\$	169,634	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs				90,076				90,076	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	10a-3	hrs				634,514				634,514	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39-2	# of prescripts					290,318			290,318	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): <u>lab xray amb</u>	39-2						19,920			19,920	12
13	Other (specify):											13
14	TOTAL			\$		\$	894,224	\$	310,238	\$	1,204,462	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 & Nrsng Center# 0051524Report Period Beginning: 01/01/2014Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 205,593	\$ 208,212	1
2	Cash-Patient Deposits	5,757	5,757	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,031,033	3,031,033	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	403,062	403,062	6
7	Other Prepaid Expenses	1,320,108	1,320,108	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,965,553	\$ 4,968,172	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		500,000	13
14	Buildings, at Historical Cost		3,560,000	14
15	Leasehold Improvements, at Historical Cost	188,103	188,103	15
16	Equipment, at Historical Cost	169,628	169,628	16
17	Accumulated Depreciation (book methods)	(145,640)	(155,149)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		6,334,759	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(43,991)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spec reserves)		256,797	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 212,091	\$ 10,810,147	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,177,644	\$ 15,778,319	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,021,813	\$ 1,021,813	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	632,097	632,097	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>	3,992,375	3,992,375	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,646,285	\$ 5,646,285	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		705,000	39
40	Mortgage Payable		8,953,100	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)	\$	\$ 9,658,100	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,646,285	\$ 15,304,385	46
47	TOTAL EQUITY(page 18, line 24)	\$ (468,641)	\$ 473,934	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,177,644	\$ 15,778,319	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,550,678)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,550,678)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,319,760	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) <u>related party income</u>	(237,723)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,082,037	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)	\$ (468,641)	24 *

* This must agree with page 17, line 47.

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	\$ 12,162,923	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,162,923	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	283,000	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 283,000	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	472	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 472	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	misc income	4,706	28
28a	<u>Related Party Property Co Income</u>	1,260,000	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,264,706	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,711,101	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,514,429	31
32	Health Care	4,850,051	32
33	General Administration	2,115,251	33
B. Capital Expense			
34	Ownership	2,506,689	34
C. Ancillary Expense			
35	Special Cost Centers	310,238	35
36	Provider Participation Fee	377,603	36
D. Other Expenses (specify):			
37	<u>bad debt</u>	717,080	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,391,341	40
41	Income before Income Taxes (line 30 minus line 40)**	1,319,760	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,319,760	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 7,190,748	44
45	Private Pay - Net Inpatient Revenue	1,016,263	45
46	Medicare - Net Inpatient Revenue	3,268,766	46
47	Other-(specify)	687,146	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,162,923	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 & Nrsng Center

0051524

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

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	2,040	2,080	\$ 100,789	\$ 48.46	1
2	Assistant Director of Nursing	2,384	2,560	87,633	34.23	2
3	Registered Nurses	26,427	28,417	880,365	30.98	3
4	Licensed Practical Nurses	37,808	40,583	1,042,144	25.68	4
5	CNAs & Orderlies	92,165	99,712	1,081,602	10.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	6,245	6,684	121,292	18.15	9
10	Activity Assistants					10
11	Social Service Workers	5,133	5,458	81,271	14.89	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,081	23,970	318,364	13.28	15
16	Dishwashers					16
17	Maintenance Workers	4,061	4,453	98,947	22.22	17
18	Housekeepers	21,882	24,442	325,415	13.31	18
19	Laundry	3,695	4,128	54,955	13.31	19
20	Administrator	2,016	2,160	132,589	61.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,612	15,767	296,998	18.84	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	1,727	1,927	36,270	18.82	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	239,276	262,341	\$ 4,658,634 *	\$ 17.76	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	309	\$ 15,450	3-1	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	729	36,468	3-10	38
39	Pharmacist Consultant	266	13,294	3-15	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	204	10,207	3-12	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,508	\$ 75,419		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	
Dino Varnavos	Administrator		\$ 132,589	Workers' Compensation Insurance	\$ 117,192	IDPH License Fee	\$	
				Unemployment Compensation Insurance	149,977	Advertising: Employee Recruitment		
				FICA Taxes	347,407	Health Care Worker Background Check		
				Employee Health Insurance	155,140	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		illinois council	9,999	
				pension	30,980	mgmt and network svcs	750	
				employee expenses	41,214	various	4,763	
						clia	300	
						joint commission	3,481	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
\$ 132,589				\$ 841,910			\$ 19,293	
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	
							continuing education	832
							mileage	2,403
							auto allowance	25,163
							Seminar Expense	
							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)	
\$				\$			\$ 28,398	
C. Professional Services								
Vendor/Payee	Type	Amount						
Various	Consulting	\$ 207						
Infinity	Professional	289,800						
Johnson & Goldberg	Accounting	3,250						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)								
\$ 293,257								

* 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 & Nrsg Center

0051524

Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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? yes
If YES, give association name and amount. illinois council
- (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. \$ 65,157 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. \$ 377,603
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. n/a
- b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ n/a
- c. What percent of all travel expense relates to transportation of nurses and patients? 0%
- d. Have vehicle usage logs been maintained? n/a
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? n/a
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
- g. Does the facility transport residents to and from day training? no**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. yes
Attach invoices and a summary of services for all architect and appraisal fees.