FOR BHF USE

LL1

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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0047779

Facility Name: LAKEFRONT NURSING & REHAB CTR.

Address: 7618 N. SHERIDAN ROAD (Number) CHICAGO (City) 60626 (Zip Code)

County: COOK

Telephone Number: (773) 743-7711 **Fax #** (773) 761-3387

HFS ID Number:

Date of Initial License for Current Owners: 04/01/06

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2011 to 12/31/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) MENACHEM SHABAT
(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, VICE PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR. # 0047779 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	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	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	582		1,859	2,441	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	30,678		1,227	31,905	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,260		3,086	34,346	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.05%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 4/1/06

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 4/1/06 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 99 and days of care provided 1,859

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR. # 0047779 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	193,792	15,682	15,674	225,148		225,148		225,148			1
2	Food Purchase		174,171		174,171	(21,462)	152,709	(777)	151,932			2
3	Housekeeping	141,676	21,390		163,066		163,066	574	163,640			3
4	Laundry	41,355	5,391		46,746		46,746		46,746			4
5	Heat and Other Utilities			80,529	80,529		80,529	1,186	81,715			5
6	Maintenance	35,769	14,850	27,011	77,630		77,630	2,760	80,390			6
7	Other (specify):* SECURITY	73,458		13,323	86,781		86,781		86,781			7
8	TOTAL General Services	486,050	231,484	136,537	854,071	(21,462)	832,609	3,743	836,352			8
	B. Health Care and Programs											
9	Medical Director			21,600	21,600		21,600		21,600			9
10	Nursing and Medical Records	1,468,321	53,144	56,088	1,577,553		1,577,553	(3,388)	1,574,165			10
10a	Therapy											10a
11	Activities	64,594	10,204	2,244	77,042		77,042		77,042			11
12	Social Services	104,537		5,567	110,104		110,104		110,104			12
13	CNA Training											13
14	Program Transportation			643	643		643		643			14
15	Other (specify):*							1,689	1,689			15
16	TOTAL Health Care and Programs	1,637,452	63,348	86,142	1,786,942		1,786,942	(1,699)	1,785,243			16
	C. General Administration											
17	Administrative	152,174		288,000	440,174		440,174	(248,000)	192,174			17
18	Directors Fees											18
19	Professional Services			137,710	137,710		137,710	(11,249)	126,461			19
20	Dues, Fees, Subscriptions & Promotions			99,043	99,043		99,043	(82,993)	16,050			20
21	Clerical & General Office Expenses	49,670	20,414	171,572	241,656		241,656	(95,058)	146,598			21
22	Employee Benefits & Payroll Taxes			423,539	423,539	21,462	445,001		445,001			22
23	Inservice Training & Education			670	670		670		670			23
24	Travel and Seminar							217	217			24
25	Other Admin. Staff Transportation			3,352	3,352		3,352	(3,352)				25
26	Insurance-Prop.Liab.Malpractice			56,562	56,562		56,562	216	56,778			26
27	Other (specify):*			156,352	156,352		156,352	(143,295)	13,057			27
28	TOTAL General Administration	201,844	20,414	1,336,800	1,559,058	21,462	1,580,520	(583,514)	997,006			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,325,346	315,246	1,559,479	4,200,071		4,200,071	(581,470)	3,618,601			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#: LAKEFRONT NURSING & REHAB CTR. #0047779 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	15,312	
	REPAIRS & MAINTENANCE		362	
			0	15,674
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		26,881	
	ELECTRICITY		37,818	
	WATER		9,775	
	CABLE TV - LOBBY		6,055	
			0	80,529
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		151	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		13,629	
	ELEVATOR MAINTENANCE & REPAIR		8,535	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,715	
	FIRE SERVICE		981	
			0	
			0	
			0	
			0	27,011
7	**OTHER**			
	SCAVENGER		5,886	
	SECURITY SERVICE		7,437	
			0	
			0	13,323
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	21,600	21,600

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		6,336	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	4,752	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	NURSING		12,000	
	NURSING PROGRAM CONSULTANT		33,000	56,088
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,244	
			0	2,244
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	5,567	
				5,567
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR. **#0047779** **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		643	643
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	288,000	288,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	28,367	
	ADMINISTRATIVE CONSULTANTS	XIX C	4,550	
	PROFESSIONAL FEES	XIX C	104,793	
			0	137,710
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	1,245	
	EMPLOYEE WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	78,649	
	DUES & SUBSCRIPTIONS	XIX F	7,730	
	LICENSES & PERMITS	XIX F	2,240	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	3,163	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,996	
	PATIENT BACKGROUND CHECKS	XIX F	4,020	
				99,043
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		680	
	EQUIPMENT REPAIR & MAINTENANCE		645	
	OUTSIDE CLERICAL SERVICES		150,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	160	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		20,087	
	MESSENGER SERVICE		0	
			0	171,572

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	175,089	
	UNEMPLOYMENT COMPENSATION	XIX D	54,840	
	WORKERS COMPENSATION INSURANC	XIX D	45,016	
	HOSPITALIZATION INSURANCE	XIX D	122,819	
	EMPLOYEE BENEFITS - OTHER	XIX D	1,871	
	EMPLOYEE PHYSICAL EXAMS	XIX D	1,200	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	19,236	
	CHICAGO HEAD TAX	XIX D	3,468	
			0	423,539
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		670	
				670
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		3,352	
				3,352
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		56,562	
				56,562
27	**OTHER**			
	BAD DEBTS	VI 24	156,352	
				156,352

GRAND TOTAL COLUMN 3 OTHER **1,559,479**

LAKEFRONT NURSING & REHAB CTR.
SCHEDULES
12/31/2011

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	174,171
LESS SALES TAX	(831)
NET FOOD	173,340
TOTAL PATIENT CENSUS	34,346
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	103,038
ADD # EMPLOYEE MEALS/DAY	40
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	14,600
PATIENT MEALS	103,038
ADD EMPLOYEE MEALS	14,600
TOTAL MEALS/YEAR	117,638
NET FOOD	173,340
DIVIDE TOTAL MEALS/YEAR	117,638
COST PER MEAL	1.47
TIME EMPLOYEE MEALS	14,600
EMPLOYEE MEAL RECLASSIFICATION	**21,462**
	========

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR. #0047779 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			29,115	29,115		29,115	3,764	32,879			30
31	Amortization of Pre-Op. & Org.			2,341	2,341		2,341		2,341			31
32	Interest			14,193	14,193		14,193	1,857	16,050			32
33	Real Estate Taxes					100,926	100,926	2,901	103,827			33
34	Rent-Facility & Grounds			621,954	621,954	(100,926)	521,028		521,028			34
35	Rent-Equipment & Vehicles			18,168	18,168		18,168		18,168			35
36	Other (specify):*											36
37	TOTAL Ownership			685,771	685,771		685,771	8,522	694,293			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		112,295	159,412	271,707		271,707		271,707			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		112,295	213,615	325,910		325,910		325,910			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,325,346	427,541	2,458,865	5,211,752		5,211,752	(572,948)	4,638,804			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 LAKEFRONT NURSING & REHAB CTR. # 0047779 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	206	30		9
10	Interest and Other Investment Income	(341)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(831)	2		13
14	Non-Care Related Interest	(936)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(160)	21		18
19	Entertainment		20		19
20	Contributions	(81,812)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(156,352)	27		24
25	Fund Raising, Advertising and Promotional	(1,245)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(41,532)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (283,003)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(289,945)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (289,945)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (572,948)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		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

STATE OF ILLINOIS

LAKEFRONT NURSING & REHAB CTR.

ID# 0047779

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$	6	1
2	BANK CHARGES	(680)	21	2
3	BARLOW KOBATA & DENIS-LEGAL FEES	(2,000)	19	3
4	LAKEFRONT HEALTHCARE-LEGAL FEES	(11,500)	19	4
5	NON ALLOWABLE TRANSPORTATION	(3,352)	25	5
6	MANAGEMENT FEES- MENACHEM SHABAT	(24,000)	17	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
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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**	(41,532)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR. # 0047779 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(831)	0	54	0	0	0	0	0	0	0	0	(777)	2
3	Housekeeping	0	0	574	0	0	0	0	0	0	0	0	574	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,186	0	0	0	0	0	0	0	0	1,186	5
6	Maintenance	0	0	2,760	0	0	0	0	0	0	0	0	2,760	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(831)	0	4,574	0	0	0	0	0	0	0	0	3,743	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	0	0	0	(3,388)	0	0	0	0	0	0	(3,388)	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	1,689	0	0	0	0	0	0	1,689	15
16	**TOTAL Health Care and Programs**	0	0	0	0	(1,699)	0	0	0	0	0	0	(1,699)	16
	C. General Administration													
17	Administrative	(24,000)	0	(224,000)	0	0	0	0	0	0	0	0	(248,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(13,500)	0	2,121	0	130	0	0	0	0	0	0	(11,249)	19
20	Fees, Subscriptions & Promotions	(83,057)	0	30	15	19	0	0	0	0	0	0	(82,993)	20
21	Clerical & General Office Expenses	(840)	0	(94,255)	0	37	0	0	0	0	0	0	(95,058)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	217	0	0	0	0	0	0	0	0	217	24
25	Other Admin. Staff Transportation	(3,352)	0	0	0	0	0	0	0	0	0	0	(3,352)	25
26	Insurance-Prop.Liab.Malpractice	0	0	216	0	0	0	0	0	0	0	0	216	26
27	Other (specify):*	(156,352)	0	13,057	0	0	0	0	0	0	0	0	(143,295)	27
28	**TOTAL General Administration**	(281,101)	0	(302,614)	15	186	0	0	0	0	0	0	(583,514)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(281,932)	0	(298,040)	15	(1,513)	0	0	0	0	0	0	(581,470)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR. # 0047779 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	206	0	354	3,204	0	0	0	0	0	0	0	3,764	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,277)	0	4	3,130	0	0	0	0	0	0	0	1,857	32
33	Real Estate Taxes	0	0	0	2,901	0	0	0	0	0	0	0	2,901	33
34	Rent-Facility & Grounds	0	0	8,440	(8,440)	0	0	0	0	0	0	0	0	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	(1,071)	0	8,798	795	0	0	0	0	0	0	0	8,522	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(283,003)	0	(289,242)	810	(1,513)	0	0	0	0	0	0	(572,948)	45

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR. # 0047779 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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
MENACHEM SHABAT	99					
AHUVA SHABAT	1	SEE ATTACHED SCHEDULE			SEE ATTACHED SCHEDULE	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR. # 0047779 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	$ 264,000	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		$	$ (264,000)	15
16	V	21	OUTSIDE CLERICAL	150,000	LEGACY HEALTHCARE FINANCIAL SERVICES LLC			(150,000)	16
17	V	2	FOOD		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		54	54	17
18	V	3	HOUSEKEEPING		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		574	574	18
19	V	5	UTILITIES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		1,186	1,186	19
20	V	6	GROUNDS & MAINTENANCE		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		2,760	2,760	20
21	V	17	MANAGEMENT FEES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		40,000	40,000	21
22	V	19	PROFESSIONAL FEES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		2,121	2,121	22
23	V	20	FEES,SUBSCRIPTIONS		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		30	30	23
24	V	21	CLERICAL & GENERAL		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		55,745	55,745	24
25	V	24	SEMINARS		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		217	217	25
26	V	26	INSURANCE		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		216	216	26
27	V	27	EMPL BENEFITS-GEN ADMIN		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		13,057	13,057	27
28	V	30	DEPRECIATION		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		354	354	28
29	V	32	INTEREST		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		4	4	29
30	V	34	RENT		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		8,440	8,440	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			$ 414,000			$ 124,758	$ * (289,242)	39

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

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR. # 0047779 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 8,440	LEGACY REAL PROPERTIES LLC		$	$ (8,440)	15
16	V	20	DUES & SUBSCRIPTIONS		LEGACY REAL PROPERTIES LLC		15	15	16
17	V	30	DEPRECIATION		LEGACY REAL PROPERTIES LLC		3,204	3,204	17
18	V	32	INTEREST EXPENSE		LEGACY REAL PROPERTIES LLC		3,130	3,130	18
19	V	33	REAL ESTATE TAXES		LEGACY REAL PROPERTIES LLC		2,901	2,901	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			$ 8,440			$ 9,250	$ * 810	39

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

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR. # 0047779 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSE CONSULTING	$ 24,000	PROGRESSIVE HEALTHCARE CONSULTING		$	$ (24,000)	15
16	V	10	RN SALARIES		PROGRESSIVE HEALTHCARE CONSULTING		20,612	20,612	16
17	V	15	EMPLOYEE BENEFITS		PROGRESSIVE HEALTHCARE CONSULTING		1,689	1,689	17
18	V	19	PROFESSIONAL FEES		PROGRESSIVE HEALTHCARE CONSULTING		130	130	18
19	V	20	FEES, SUBSCRIPTIONS		PROGRESSIVE HEALTHCARE CONSULTING		19	19	19
20	V	21	CLERICAL AND GENERAL		PROGRESSIVE HEALTHCARE CONSULTING		37	37	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			$ 24,000			$ 22,487	$ * (1,513)	39

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

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR. # 0047779 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR. # 0047779 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MENACHEM SHABAT	MEMBER	Administrative	99.00	See Attached	5	10.00	MGMT FEE	$ 20,000	17-3	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	$ 20,000		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 LAKEFRONT NURSING & REHAB CTR. # 0047779 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

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

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

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR. # 0047779 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 [X] NO [ ]

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

Name of Related Organization: LEGACY HEALTHCARE FINANCIALS
Street Address: 7040 RIDGEWAY
City / State / Zip Code: LINCOLNWOOD ILL 60712
Phone Number: (847) 679-9797
Fax Number: (847) 679-3676

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	FOOD	Bed Days Available	590,233	12	$ 890	$	36,135	$ 54	1
2	3	HOUSEKEEPING	Bed Days Available	590,233	12	9,370	9,260	36,135	574	2
3	5	UTILITIES	Bed Days Available	590,233	12	19,367		36,135	1,186	3
4	6	GROUNDS & MAINTENANCE	Bed Days Available	590,233	12	45,083	9,228	36,135	2,760	4
5	17	MANAGEMENT FEES	WEIGHTED AVERAGE	50	11	400,000		5	40,000	5
6	19	PROFESSIONAL FEES	Bed Days Available	590,233	12	34,648		36,135	2,121	6
7	20	FEES,SUBSCRIPTIONS	Bed Days Available	590,233	12	493		36,135	30	7
8	21	CLERICAL & GENERAL	Bed Days Available	590,233	12	910,553	832,276	36,135	55,745	8
9	24	SEMINARS	Bed Days Available	590,233	12	3,552		36,135	217	9
10	26	INSURANCE	Bed Days Available	590,233	12	3,535		36,135	216	10
11	27	EMPL BENEFITS-GEN ADMIN	Bed Days Available	590,233	12	213,280		36,135	13,057	11
12	30	DEPRECIATION	Bed Days Available	590,233	12	5,774		36,135	354	12
13	32	INTEREST	Bed Days Available	590,233	12	62		36,135	4	13
14	34	RENT	Bed Days Available	590,233	12	137,855		36,135	8,440	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,784,462	$ 850,764		$ 124,758	25

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR. # 0047779 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 [X] NO [ ]

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

Name of Related Organization: LEGACY REAL PROPERTIES LLC
Street Address: 7040 RIDGEWAY
City / State / Zip Code: LINCOLNWOOD ILL 60712
Phone Number: (847) 679-9797
Fax Number: (847) 679-3676

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	20	DUES & SUBSCRIPTIONS	Bed Days Available	590,233	12	$ 250	$	36,135	$ 15	1
2	30	DEPRECIATION	Bed Days Available	590,233	12	52,340		36,135	3,204	2
3	32	INTEREST EXPENSE	Bed Days Available	590,233	12	51,132		36,135	3,130	3
4	33	REAL ESTATE TAXES	Bed Days Available	590,233	12	47,377		36,135	2,901	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					$ 151,099	$		$ 9,250	25

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR. # 0047779 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 [X] NO [ ]

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

Name of Related Organization: Prosgressive Healthcare Consulting
Street Address: 7040 RIDGEWAY
City / State / Zip Code: LINCOLNWOOD ILL 60712
Phone Number: (847) 679-9797
Fax Number: (847) 679-3676

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	RN SALARIES	Bed Days Available	465,768	10	$ 265,681	$ 265,681	36,135	$ 20,612	1
2	15	EMPLOYEE BENEFITS	Bed Days Available	465,768	10	21,767		36,135	1,689	2
3	19	PROFESSIONAL FEES	Bed Days Available	465,768	10	1,681		36,135	130	3
4	20	FEES, SUBSCRIPTIONS	Bed Days Available	465,768	10	250		36,135	19	4
5	21	CLERICAL AND GENERAL	Bed Days Available	465,768	10	472		36,135	37	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					$ 289,851	$ 265,681		$ 22,487	25

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR. # 0047779 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5	MANAGEMENT ALLOC										3,134	5
	Working Capital											
6	BANK FINANCIAL		X	CONSTRUCTION LOAN	$1,830.75	12/14/07	100,000	15,998			1,669	6
7	BANK FINANCIAL		X	WORKING CAPITAL	INTEREST			757,867	REVOLV	prime +	10,661	7
8				INSURANCE							927	8
9	TOTAL Facility Related				$1,830.75		$ 100,000	$ 773,865			$ 16,391	9
	B. Non-Facility Related*											
10												10
11				MEDICARE FEDERAL HIB							936	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 936	14
15	TOTALS (line 9+line14)						$ 100,000	$ 773,865			$ 17,327	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** 36

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

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

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR. # 0047779 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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.)		$ 106,332	2
3. Under or (over) accrual (line 2 minus line 1).		$ 106,332	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$	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.		$ 106,332	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006	107,679	8
2007	107,410	9
2008	107,599	10
2009	96,716	11
2010	103,431	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LAKEFRONT NURSING & REHAB CTR. COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0047779

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-29-108-011-0000	NURSING HOME	$ 50,463.16	$ 50,463.16
2.	11-29-108-012-0000	NURSING HOME	$ 50,463.16	$ 50,463.16
3.			$	$
4.	10-35-104-076-0000	HOME OFFICE ALLOCATION	$ 40,915.78	$ 2,504.93
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 141,842.10	$ 103,431.25

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR. # 0047779 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,691 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

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).

N/A

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: 2,341 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2	REL PARTY-LEGACY		2009	5,009	2
3	TOTALS			$ 5,009	3

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR. # 0047779 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	NEW FLOOR IN COOLER			2006	1,528	56	27.5	56		218	9
10	EXHAUST FAN			2006	2,400	87	27.5	87		341	10
11	SECURITY SYSTEM			2006	27,540	1,001	27.5	1,001		3,923	11
12	ELEVATOR REHAB			2006	17,126	623	27.5	623		2,439	12
13	WATER PUMP			2006	4,500	164	27.5	164		642	13
14	ELECTRICAL WORK			2006	2,175	79	27.5	79		309	14
15	NURSE CALL SYSTEM			2007	9,378	341	27.5	341		1,378	15
16	DOOR			2007	5,365	195	27.5	195		609	16
17	WIRING FOR CABLE			2007	6,200	225	27.5	225		1,188	17
18	PAINTING & WALLPAPER			2007	25,660	2,956	5	8,211	5,255	27,199	18
19	LIGHT FIXTURES			2007	6,431	234	27.5	234		809	19
20	CUSTOM NURSE STATION			2007	11,517	419	27.5	419		1,449	20
21	COVE BASE, VCT, VINYL SHEET			2007	22,486	818	27.5	818		2,829	21
22	HAND RAILS & BUMPERS			2007	6,434	234	27.5	234		809	22
23	DRAPERIES			2007	3,063	111	27.5	111		384	23
24	WALLCOVERINGS			2007	4,121	150	27.5	150		519	24
25	SHOWER REHAB			2008	4,600	167	27.5	167		411	25
26	BOILER			2008	10,700	389	27.5	389		956	26
27	FIRE DOORS			2009	47,687	1,734	27.5	1,734		3,612	27
28	handrails, flooring, wallpaper,drywall,wallguards less 65,529 ins			2009	10,326	375	27.5	375		781	28
29	FIRE ALARM SYSTEM			2009	54,000	1,964	27.5	1,964		4,092	29
30	SIGN			2009	4,558	166	27.5	166		346	30
31	PUMP,CONDENSOR,COIL FOR CHILLER			2010	4,600	167	27.5	167		397	31
32	KITCHEN CABINETS,FLOORING,COUNTER TOPS AND PLUMBIN			2011	10,290	141	27.5	141		141	32
33	FIRE DAMPERS			2011	6,700	91	27.5	91		91	33
34	FIRE SPRINKLER			2011	4,250	58	27.5	58		58	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 LAKEFRONT NURSING & REHAB CTR. # 0047779 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41	RELATED PARTY INFORMATION								41
42	BUILDING:								42
43	ALLOCATED FROM LEGACY RP	2009	38,806	1,268	35	1,294	26		43
44									44
45									45
46									46
47	LEASEHOLD IMPROVEMENTS:								47
48	ALLOCATED FROM LEGACY RP	2009	22,038	508	20	1,102	594		48
49	ALLOCATED FROM LEGACY RP	2010	6,701	158	20	268	110		49
50	ALLOCATED FROM LEGACY RP	2011	9,525	210	20		(210)		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)		$ 390,705	$ 15,089		$ 20,864	$ 5,775	$ 55,930	70

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

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR. # 0047779 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 105,062	$ 9,210	$ 10,507	$ 1,297	10	$ 54,534	71
72	Current Year Purchases	6,960	6,960	348	(6,612)	10	348	72
73	Fully Depreciated Assets							73
74	MGMT ALLOC	11,599	1,413	1,159	(254)		2,162	74
75	TOTALS	$ 123,621	$ 17,583	$ 12,014	$ (5,569)		$ 57,044	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)	$ 519,335	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 32,672	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 32,878	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 206	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 112,974	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR. # 0047779 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: LAKEFRONT NURSING & REHAB PROPERTIES 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 [X] 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:		99		$ 621,954			3
4	Additions							4
5								5
6								6
7	TOTAL		99		$ 621,954 **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 18,168 Description: SEE SCHEDULE ATTACHED
    (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 LAKEFRONT NURSING & REHAB CTR. # 0047779 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR. # 0047779 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 58,628	$		$ 58,628	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			30,324			30,324	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			70,460			70,460	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				112,295		112,295	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$ 159,412	$ 112,295		$ 271,707	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.

STATE OF ILLINOIS

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR. # 0047779 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (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	$ 538	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (65,000))	1,396,613		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	53,737		6
7	Other Prepaid Expenses	16,370		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee Loan Assignmts	4,002		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,471,260	$	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	313,635		15
16	Equipment, at Historical Cost	144,317		16
17	Accumulated Depreciation (book methods)	(196,321)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	26,610		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(10,201)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 278,040	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,749,300	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 316,562	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,296		28
29	Short-Term Notes Payable	773,865		29
30	Accrued Salaries Payable	49,361		30
31	Accrued Taxes Payable (excluding real estate taxes)	36,520		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Legacy & North Main	76,059		36
37	Due to Lincoln Park	150,000		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,417,663	$	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)**	$ 1,417,663	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 331,637	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,749,300	$	48

***(See instructions.)**

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR. # 0047779 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 532,633	1
2	Restatements (describe):		2
3	**POST CLOSING BAD DEBTS ALLOWANCE**	(90,000)	3
4	**POST CLOSING**	(2,739)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 439,894	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	86,743	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	(195,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (108,257)	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)**	$ 331,637	24 *

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

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR. # 0047779 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,258,254	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,258,254	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	31,856	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 31,856	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***	341	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 341	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,290,451	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	854,071	31
32	Health Care	1,786,942	32
33	General Administration	1,559,058	33
	B. Capital Expense		
34	Ownership	685,771	34
	C. Ancillary Expense		
35	Special Cost Centers	271,707	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	(14,288)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,197,464	40
41	**Income before Income Taxes (line 30 minus line 40)****	92,987	41
42	**Income Taxes**	(6,244)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 86,743	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **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 LAKEFRONT NURSING & REHAB CTR. # 0047779 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,025	2,286	$ 101,913	$ 44.58	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,186	11,466	305,618	26.65	3
4	Licensed Practical Nurses	16,142	17,147	375,898	21.92	4
5	CNAs & Orderlies	50,551	55,294	585,252	10.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,009	2,118	33,554	15.84	9
10	Activity Assistants	2,977	3,235	31,040	9.60	10
11	Social Service Workers	5,155	5,433	104,537	19.24	11
12	Dietician	2,025	2,158	38,839	18.00	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,539	16,783	154,953	9.23	15
16	Dishwashers					16
17	Maintenance Workers	9,428	10,194	109,227	10.71	17
18	Housekeepers	13,215	14,750	141,676	9.61	18
19	Laundry	4,218	4,640	41,355	8.91	19
20	Administrator	2,041	2,286	115,403	50.48	20
21	Assistant Administrator	2,041	2,086	36,771	17.63	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,616	3,960	49,670	12.54	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)	3,592	3,929	43,527	11.08	30
31	Medical Records	1,913	2,081	56,113	26.96	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	146,673	159,846	$ 2,325,346 *	$ 14.55	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly Fee	$ 15,312	1-3	35
36	Medical Director	Monthly Fee	21,600	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	Monthly Fee	4,752	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	Monthly Fee	2,244	11-3	44
45	Social Service Consultant	94	5,567	12-3	45
46	Other(specify) NURSING	Monthly Fee	12,000	10-3	46
47	NURSING PROGRAM CONSULTAN	Monthly Fee	33,000	10-3	47
48					48
49	TOTAL (lines 35 - 48)	94	$ 94,475		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR. # 0047779 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ADLER,AHARON	ADMINISTRATOR	0	$ 115,403
DLATT,JAMIE	ASST ADMIN	0	36,771
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 152,174

B. Administrative - Other

Description	Amount
MANAGEMENT FEES-LEGACY HEALTHCARE FINANCIAI	$ 264,000
MANAGEMENT FEES-MENACHEM SHABAT	24,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 288,000

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		137,710
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 137,710

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 45,016
Unemployment Compensation Insurance	54,840
FICA Taxes	175,089
Employee Health Insurance	122,819
Employee Meals	21,462
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	1,871
EMPLOYEE PHYSICAL EXAMS	1,200
PENSION/PROFIT SHARING PLANS	19,236
CHICAGO HEAD TAX	3,468
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 445,001

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	0
Health Care Worker Background Check	1,996
(Indicate # of checks performed 199)	
Patient Background Checks 134	4,020
TRUST/FRANCHISE/CONTRIB/ETC	81,812
MARKETING/ADV/PROMO	1,245
LICENSES/DUES/SUBSCRIPTIONS	9,970
ALLOCATION	64
TRUST/FRANCHISE/CONTRIB/ETC	(81,812)
Less: Public Relations Expense	(0)
Non-allowable advertising	(1,245)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,050

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
MANAGEMENT COMPANY ALLOC	217
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 217

**See instructions.

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR. # 0047779 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

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

Facility Name & ID Number LAKEFRONT NURSING & REHAB CTR. # 0047779 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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. **ICLTC $6,035**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,628** 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.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **54,203**
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. $ **21,462** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(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. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
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. $ **N/A**

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

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.