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.

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

I. IDPH License ID Number: 0047779

Facility Name: LAKEFRONT NSG & REHAB CTR

Address: 7618 N SHERIDAN RD (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: SANFORD BOKOR **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 01/01/2012 to 12/31/2012 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) SANFORD BOKOR, 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 NSG & REHAB CTR # 0047779 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

III. STATISTICAL DATA

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

	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	36,234	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	36,234	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	2,322	6	2,363	4,691	8
9	SNF/PED					9
10	ICF	28,694		910	29,604	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,016	6	3,273	34,295	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.65%

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 04/01/06

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/06 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 2,290

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

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

Facility Name & ID Number LAKEFRONT NSG & REHAB CTR # 0047779 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	196,708	14,359	21,165	232,232		232,232		232,232			1
2	Food Purchase		180,460		180,460	(22,399)	158,061	(692)	157,369			2
3	Housekeeping	140,249	23,794	9,972	174,015		174,015	612	174,627			3
4	Laundry	44,551	6,940		51,491		51,491		51,491			4
5	Heat and Other Utilities			79,572	79,572		79,572	887	80,459			5
6	Maintenance	40,323	16,857	43,772	100,952		100,952	1,447	102,399			6
7	Other (specify):* SECURITY	78,783		14,644	93,427		93,427		93,427			7
8	TOTAL General Services	500,614	242,410	169,125	912,149	(22,399)	889,750	2,254	892,004			8
	B. Health Care and Programs											
9	Medical Director			19,800	19,800		19,800		19,800			9
10	Nursing and Medical Records	1,442,076	53,876	56,394	1,552,346		1,552,346	(17,589)	1,534,757			10
10a	Therapy											10a
11	Activities	95,857	9,598	2,448	107,903		107,903		107,903			11
12	Social Services	98,078		2,625	100,703		100,703	1,327	102,030			12
13	CNA Training											13
14	Program Transportation			650	650		650		650			14
15	Other (specify):*							868	868			15
16	TOTAL Health Care and Programs	1,636,011	63,474	81,917	1,781,402		1,781,402	(15,394)	1,766,008			16
	C. General Administration											
17	Administrative	136,407		370,208	506,615		506,615	(288,475)	218,140			17
18	Directors Fees											18
19	Professional Services			78,944	78,944		78,944	3,480	82,424			19
20	Dues, Fees, Subscriptions & Promotions			109,690	109,690		109,690	(95,268)	14,422			20
21	Clerical & General Office Expenses	48,835	21,435	188,358	258,628		258,628	(75,081)	183,547			21
22	Employee Benefits & Payroll Taxes			484,928	484,928	22,399	507,327		507,327			22
23	Inservice Training & Education			1,701	1,701		1,701		1,701			23
24	Travel and Seminar							111	111			24
25	Other Admin. Staff Transportation			1,834	1,834		1,834		1,834			25
26	Insurance-Prop.Liab.Malpractice			74,345	74,345		74,345	389	74,734			26
27	Other (specify):* SEE ATTACHED			90,349	90,349		90,349	(67,465)	22,884			27
28	TOTAL General Administration	185,242	21,435	1,400,357	1,607,034	22,399	1,629,433	(522,309)	1,107,124			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,321,867	327,319	1,651,399	4,300,585		4,300,585	(535,449)	3,765,136			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 NSG & REHAB CTR #0047779 **Report Period Beginning: 01/01/2012** **Ending: 12/31/2012**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	15,142	
	REPAIRS & MAINTENANCE		6,023	
			0	21,165
3	**HOUSEKEEPING**			
	PROPERTY SPECIALIST - LEGACY		9,972	
			0	9,972
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		23,870	
	ELECTRICITY		32,789	
	WATER		17,836	
	CABLE TV - LOBBY		5,077	
			0	79,572
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		0	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		24,608	
	ELEVATOR MAINTENANCE & REPAIR		9,451	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		5,725	
	FIRE SERVICE		3,988	
			0	
			0	
			0	
			0	43,772
7	**OTHER**			
	SCAVENGER		6,356	
	SECURITY SERVICE		8,288	
			0	
			0	14,644
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	19,800	19,800

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		5,602	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	5,792	
	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	56,394
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	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	2,448	
			0	2,448
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,625	
				2,625
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number LAKEFRONT NSG & REHAB CTR **#0047779** **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		650	650
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES & OTHER ADMIN FEES	XIX B	370,208	370,208
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	31,823	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	47,121	
			0	78,944
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	828	
	EMPLOYEE WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	89,391	
	DUES & SUBSCRIPTIONS	XIX F	5,066	
	LICENSES & PERMITS	XIX F	4,582	
	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	5,081	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	540	
	PATIENT BACKGROUND CHECKS	XIX F	4,202	
				109,690
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		51	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		152,927	
	PENALTIES / OVERDRAFT CHARGES	VI 18	1,388	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		20,867	
	MESSENGER SERVICE		0	
	LEGACY SPECIFIC SALARIES		13,125	188,358

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	174,156	
	UNEMPLOYMENT COMPENSATION	XIX D	68,591	
	WORKERS COMPENSATION INSURANC	XIX D	61,868	
	HOSPITALIZATION INSURANCE	XIX D	143,126	
	EMPLOYEE BENEFITS - OTHER	XIX D	3,968	
	EMPLOYEE PHYSICAL EXAMS	XIX D	1,890	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	24,256	
	CHICAGO HEAD TAX	XIX D	2,028	
	PAYROLL TAXES - LEGACY AND		5,045	484,928
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,701	
				1,701
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		1,834	
				1,834
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		74,345	
				74,345
27	**OTHER**			
	BAD DEBTS	VI 24	90,349	
				90,349

GRAND TOTAL COLUMN 3 OTHER **1,651,399**

LAKEFRONT NSG & REHAB CTR
SCHEDULES
12/31/2012

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

TOTAL FOOD PURCHASE	180,460
LESS SALES TAX	(706)
NET FOOD	179,754
TOTAL PATIENT CENSUS	34,295
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	102,885
ADD # EMPLOYEE MEALS/DAY	40
TIMES # DAYS	366
TOTAL EMPLOYEE MEALS	14,640
PATIENT MEALS	102,885
ADD EMPLOYEE MEALS	14,640
TOTAL MEALS/YEAR	117,525
NET FOOD	179,754
DIVIDE TOTAL MEALS/YEAR	117,525
COST PER MEAL	1.53
TIMES EMPLOYEE MEALS	14,640
EMPLOYEE MEAL RECLASSIFICATION	**22,399**

Facility Name & ID Number LAKEFRONT NSG & REHAB CTR #0047779 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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			21,611	21,611		21,611	2,749	24,360			30
31	Amortization of Pre-Op. & Org.			1,774	1,774		1,774		1,774			31
32	Interest			19,615	19,615		19,615	692	20,307			32
33	Real Estate Taxes					100,507	100,507	2,239	102,746			33
34	Rent-Facility & Grounds			611,752	611,752	(100,507)	511,245		511,245			34
35	Rent-Equipment & Vehicles			22,135	22,135		22,135	73	22,208			35
36	Other (specify):*											36
37	**TOTAL Ownership**			676,887	676,887		676,887	5,753	682,640			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		105,682	251,945	357,627		357,627		357,627			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			350,863	350,863		350,863		350,863			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		105,682	602,808	708,490		708,490		708,490			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,321,867	433,001	2,931,094	5,685,962		5,685,962	(529,696)	5,156,266			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 NSG & REHAB CTR # 0047779 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	847	30		9
10	Interest and Other Investment Income	(1,613)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(706)	2		13
14	Non-Care Related Interest		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	(1,388)	21		18
19	Entertainment		20		19
20	Contributions	(94,472)	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	(90,349)	27		24
25	Fund Raising, Advertising and Promotional	(828)	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	(54,051)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (242,560)		$	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)	(287,136)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (287,136)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (529,696)		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

LAKEFRONT NSG & REHAB CTR

ID# 0047779

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	BANK CHARGES	$ (51)	21	1
2	CHAIM RAJCHENBACH MNGMNT FEES	(27,000)	17	2
3	JACK RAJCHENBACH MNGMNT FEES	(13,500)	17	3
4	RONALD SHABAT MNGMNT FEES	(13,500)	17	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**	(54,051)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LAKEFRONT NSG & REHAB CTR **#** 0047779 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	Operating Expenses	PAGES 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	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(706)	0	14	0	0	0	0	0	0	0	0	(692)	2
3	Housekeeping	0	0	612	0	0	0	0	0	0	0	0	612	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	887	0	0	0	0	0	0	0	0	887	5
6	Maintenance	0	0	1,447	0	0	0	0	0	0	0	0	1,447	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(706)	0	2,960	0	0	0	0	0	0	0	0	2,254	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	(17,589)	0	0	0	0	0	0	(17,589)	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	1,327	0	0	0	0	0	0	1,327	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	868	0	0	0	0	0	0	868	15
16	**TOTAL Health Care and Programs**	0	0	0	0	(15,394)	0	0	0	0	0	0	(15,394)	16
	C. General Administration													
17	Administrative	(54,000)	0	(248,000)	0	13,525	0	0	0	0	0	0	(288,475)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	3,392	0	88	0	0	0	0	0	0	3,480	19
20	Fees, Subscriptions & Promotions	(95,300)	0	32	0	0	0	0	0	0	0	0	(95,268)	20
21	Clerical & General Office Expenses	(1,439)	0	(73,791)	0	149	0	0	0	0	0	0	(75,081)	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	111	0	0	0	0	0	0	0	0	111	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	0	389	0	0	0	0	0	0	0	0	389	26
27	Other (specify):*	(90,349)	0	22,884	0	0	0	0	0	0	0	0	(67,465)	27
28	**TOTAL General Administration**	(241,088)	0	(294,983)	0	13,762	0	0	0	0	0	0	(522,309)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(241,794)	0	(292,023)	0	(1,632)	0	0	0	0	0	0	(535,449)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKEFRONT NSG & REHAB CTR # 0047779 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	847	0	632	1,270	0	0	0	0	0	0	0	2,749	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,613)	0	3	2,302	0	0	0	0	0	0	0	692	32
33	Real Estate Taxes	0	0	0	2,239	0	0	0	0	0	0	0	2,239	33
34	Rent-Facility & Grounds	0	0	6,753	(6,753)	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	73	0	0	0	0	0	0	73	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(766)	0	7,388	(942)	73	0	0	0	0	0	0	5,753	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)**	(242,560)	0	(284,635)	(942)	(1,559)	0	0	0	0	0	0	(529,696)	45

Facility Name & ID Number LAKEFRONT NSG & REHAB CTR # 0047779 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	99.00	THE GROVE AT LINCOLN PARK	CHICAGO	GROVE HC PROP	CHICAGO	REAL ESTATE
AHUVA SHABAT	1.00	THE GROVE OF NORTHBROOK	CHICAGO	LEGACY HC		
		ASTORIA PLACE LIVING & REHAB CENTER	CHICAGO	FINANCIAL SERV	LINCOLNWOOD	MGMT
		THE GROVE OF EVANSTON	EVANSTON	LEGACY REAL PRO	LINCOLNWOOD	REAL ESTATE
		ELMBROOK NURSING	ELMHURST	ASTORIA HEALTH		
		PETERSON PARK	CHICAGO	CARE PROP	CHICAGO	REAL ESTATE
		CHALET LIVING & REHAB	CHICAGO	EVANSTON HC RLT	EVANSTON	REAL ESTATE

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 NSG & REHAB CTR # 0047779 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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			THE GROVE OF LAGRANGE	LAGRANGE PARK	ELMBROOK			1
2			THE GROVE AT THE LAKE	ZION	HEALTHCARE RLT	ELMHURST	REAL ESTATE	2
3			THE GROVE OF SKOKIE	SKOKIE	PETERSON PK RLTY	CHICAGO	REAL ESTATE	3
4			PARK VILLA NURSING & REHAB	PALOS HEIGHTS	GROVE LAGRANGE			4
5			THE VILLA AT WINDSOR PARK	CHICAGO	REALTY	LAGRANGE PK	REAL ESTATE	5
6					GROVE AT THE			6
7					LAKE REALTY	ZION	REAL ESTATE	7
8					CHALET REAL			8
9					PROPERTY	CHICAGO	REAL ESTATE	9
10					PARK VILLA RLTY	PALOS HGTS	REAL ESTATE	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 NSG & REHAB CTR # 0047779 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$ 288,000	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		$	$ (288,000)	15
16	V	21	OUTSIDE CLERICAL	152,927	LEGACY HEALTHCARE FINANCIAL SERVICES LLC			(152,927)	16
17	V	2	FOOD		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		14	14	17
18	V	3	HOUSEKEEPING		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		612	612	18
19	V	5	UTILITIES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		887	887	19
20	V	6	GROUNDS & MAINTENANCE		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		1,447	1,447	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		3,392	3,392	22
23	V	20	FEES,SUBSCRIPTIONS		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		32	32	23
24	V	21	CLERICAL & GENERAL		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		79,136	79,136	24
25	V	24	SEMINARS		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		111	111	25
26	V	26	INSURANCE		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		389	389	26
27	V	27	EMPL BENEFITS-GEN ADMIN		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		11,584	11,584	27
28	V	27	EMPL BENEFITS-OWNERS		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		11,300	11,300	28
29	V	30	DEPRECIATION		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		632	632	29
30	V	32	INTEREST		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		3	3	30
31	V	34	RENT		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		6,753	6,753	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 440,927			$ 156,292	$ * (284,635)	39

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

Facility Name & ID Number LAKEFRONT NSG & REHAB CTR # 0047779 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$ 6,753	LEGACY REAL PROPERTIES LLC		$	$ (6,753)	15
16	V	20	DUES & SUBSCRIPTIONS		LEGACY REAL PROPERTIES LLC				16
17	V	30	DEPRECIATION		LEGACY REAL PROPERTIES LLC		1,270	1,270	17
18	V	32	INTEREST EXPENSE		LEGACY REAL PROPERTIES LLC		2,302	2,302	18
19	V	33	REAL ESTATE TAXES		LEGACY REAL PROPERTIES LLC		2,239	2,239	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			$ 6,753			$ 5,811	$ * (942)	39

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

Facility Name & ID Number LAKEFRONT NSG & REHAB CTR # 0047779 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 CONSULTANT	$ 24,000	PROGRESSIVE HEALTHCARE CONSULTING		$	$ (24,000)	15
16	V	10	RN SALARIES		PROGRESSIVE HEALTHCARE CONSULTING		6,411	6,411	16
17	V	12	CLERGY SALARY		PROGRESSIVE HEALTHCARE CONSULTING		1,327	1,327	17
18	V	15	EMPLOYEE BENEFITS		PROGRESSIVE HEALTHCARE CONSULTING		868	868	18
19	V	17	ADMIN		PROGRESSIVE HEALTHCARE CONSULTING		13,525	13,525	19
20	V	19	PROFESSIONAL FEES		PROGRESSIVE HEALTHCARE CONSULTING		88	88	20
21	V	21	CLERICAL AND GENERAL		PROGRESSIVE HEALTHCARE CONSULTING		149	149	21
22	V	35	AUTO RENTAL		PROGRESSIVE HEALTHCARE CONSULTING		73	73	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			$ 22,441	$ * (1,559)	39

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

Facility Name & ID Number LAKEFRONT NSG & REHAB CTR # 0047779 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	3	PROPERTY SPECIALIST	$ 9,972	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		$ 9,972	$	15
16	V	21	AR FIELD COORDINATOR	5,323	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		5,323		16
17	V	21	IN-HOUSE COUNSEL	3,029	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		3,029		17
18	V	21	PURCHASING DIRECTOR	2,593	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		2,593		18
19	V	21	CORPORATE IT DIRECTOR	2,180	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		2,180		19
20	V	22	PAYROLL TAXES	2,224	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		2,224		20
21	V	17	ADMINISTRATOR	28,208	PROGRESSIVE HEALTHCARE CONSULTING		28,208		21
22	V	22	PAYROLL TAXES	2,821	PROGRESSIVE HEALTHCARE CONSULTING		2,821		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			$ 56,350			$ 56,350	$ *	39

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

Facility Name & ID Number LAKEFRONT NSG & REHAB CTR # 0047779 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 SHABT	MEMBER	ADMINISTRATIV	99.00	SEE ATTACHED			MGMT FEE	$ 20,000	17-7	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 NSG & REHAB CTR # 0047779 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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 NSG & REHAB CTR # 0047779 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	716,018	13	$ 270	$	36,234	$ 14	1
2	3	HOUSEKEEPING	Bed Days Available	716,018	13	12,097		36,234	612	2
3	5	UTILITIES	Bed Days Available	716,018	13	17,526		36,234	887	3
4	6	GROUNDS & MAINTENANCE	Bed Days Available	716,018	13	28,596		36,234	1,447	4
5	17	MANAGEMENT FEES	WEIGHTED AVERAGE	100	12	400,000	400,000	10	40,000	5
6	19	PROFESSIONAL FEES	Bed Days Available	716,018	13	67,029		36,234	3,392	6
7	20	FEES,SUBSCRIPTIONS	Bed Days Available	716,018	13	625		36,234	32	7
8	21	CLERICAL & GENERAL	Bed Days Available	716,018	13	1,563,793		36,234	79,136	8
9	24	SEMINARS	Bed Days Available	716,018	13	2,200		36,234	111	9
10	26	INSURANCE	Bed Days Available	716,018	13	7,687		36,234	389	10
11	27	EMPL BENEFITS-GEN ADMIN	Bed Days Available	716,018	13	228,907		36,234	11,584	11
12	27	EMPL BENEFITS-OWNERS	Bed Days Available	100	12	113,000		10	11,300	12
13	30	DEPRECIATION	Bed Days Available	716,018	13	12,480		36,234	632	13
14	32	INTEREST	Bed Days Available	716,018	13	51		36,234	3	14
15	34	RENT	Bed Days Available	716,018	13	133,442		36,234	6,753	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,587,703	$ 400,000		$ 156,292	25

Facility Name & ID Number LAKEFRONT NSG & REHAB CTR # 0047779 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	30	DEPRECIATION	Bed Days Available	716,018	13	$ 25,098	$	36,234	$ 1,270	1
2	32	INTEREST EXPENSE	Bed Days Available	716,018	13	45,486		36,234	2,302	2
3	33	REAL ESTATE TAXES	Bed Days Available	716,018	13	44,250		36,234	2,239	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					$ 114,834	$		$ 5,811	25

Facility Name & ID Number LAKEFRONT NSG & REHAB CTR # 0047779 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	498,858	9	$ 88,262	$ 88,262	36,234	$ 6,411	1
2	12	CLERGY SALARY	Bed Days Available	498,858	9	18,263	18,263	36,234	1,327	2
3	15	EMPLOYEE BENEFITS	Bed Days Available	498,858	9	11,955		36,234	868	3
4	17	ADMIN	Bed Days Available	498,858	9	186,212		36,234	13,525	4
5	19	PROFESSIONAL FEES	Bed Days Available	498,858	9	1,215		36,234	88	5
6	21	CLERICAL AND GENERAL	Bed Days Available	498,858	9	2,058		36,234	149	6
7	35	AUTO RENTAL	Bed Days Available	498,858	9	999		36,234	73	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					$ 308,964	$ 106,525		$ 22,441	25

Facility Name & ID Number LAKEFRONT NSG & REHAB CTR # 0047779 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2	RELATED PARTY										2,305	2
3												3
4												4
5												5
	Working Capital											
6	BANK FINANCIAL		X	CONSTRUCTION LOAN	$1,830.75	12/14/07	100,000				354	6
7	BANK FINANCIAL		X	WORKING CAPITAL	INTEREST			33,563	REVOLV	prime +	17,890	7
8				INSURANCE							1,371	8
9	TOTAL Facility Related				$1,830.75		$ 100,000	$ 33,563			$ 21,920	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 100,000	$ 33,563			$ 21,920	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 NSG & REHAB CTR # 0047779 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 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.)		$ 102,640	2
3. Under or (over) accrual (line 2 minus line 1).		$ 102,640	3
4. Real Estate Tax accrual used for 2012 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.		$ 102,640	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	107,410	8
	2008	107,599	9
	2009	96,716	10
	2010	103,431	11
	2011	102,640	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2011 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LAKEFRONT NSG & 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 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-29-108-011-0000	NURSING HOME	$ 50,253.31	$ 50,253.31
2.	11-29-108-012-0000	NURSING HOME	$ 50,253.31	$ 50,253.31
3.			$	$
4.	10-35-104-076-0000	HOME OFFICE ALLOCATION	$ 42,154.05	$ 2,133.20
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 142,660.67	$ 102,639.82

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number LAKEFRONT NSG & REHAB CTR # 0047779 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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. [X] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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: 1,774 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	4,140	2
3	TOTALS			$ 4,140	3

Facility Name & ID Number LAKEFRONT NSG & REHAB CTR # 0047779 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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		274	9
10	EXHAUST FAN			2006	2,400	87	27.5	87		428	10
11	SECURITY SYSTEM			2006	27,540	1,001	27.5	1,001		4,924	11
12	ELEVATOR REHAB			2006	17,126	623	27.5	623		3,062	12
13	WATER PUMP			2006	4,500	164	27.5	164		806	13
14	ELECTRICAL WORK			2006	2,175	79	27.5	79		388	14
15	NURSE CALL SYSTEM			2007	9,378	341	27.5	341		1,719	15
16	DOOR			2007	5,365	195	27.5	195		804	16
17	WIRING FOR CABLE			2007	6,200	225	27.5	225		1,413	17
18	PAINTING & WALLPAPER			2007	25,660	1,478	5	(1,539)	(3,017)	25,660	18
19	LIGHT FIXTURES			2007	6,431	234	27.5	234		1,043	19
20	CUSTOM NURSE STATION			2007	11,517	419	27.5	419		1,868	20
21	COVE BASE, VCT, VINYL SHEET			2007	22,486	818	27.5	818		3,647	21
22	HAND RAILS & BUMPERS			2007	6,434	234	27.5	234		1,043	22
23	DRAPERIES			2007	3,063	111	27.5	111		495	23
24	WALLCOVERINGS			2007	4,121	150	27.5	150		669	24
25	SHOWER REHAB			2008	4,600	167	27.5	167		578	25
26	BOILER			2008	10,700	389	27.5	389		1,345	26
27	FIRE DOORS			2009	47,687	1,734	27.5	1,734		5,346	27
28	handrails, flooring, wallpaper,drywall,wallguards less 65,529 ins			2009	10,326	375	27.5	375		1,156	28
29	FIRE ALARM SYSTEM			2009	54,000	1,964	27.5	1,964		6,056	29
30	SIGN			2009	4,558	166	27.5	166		512	30
31	PUMP,CONDENSOR,COIL FOR CHILLER			2010	4,600	167	27.5	167		564	31
32	KITCHEN CABINETS,FLOORING,COUNTER TOPS AND PLUMBIN			2011	10,290	374	27.5	374		515	32
33	FIRE DAMPERS			2011	6,700	244	27.5	244		335	33
34	FIRE SPRINKLER			2011	4,250	154	27.5	154		212	34
35	BURGLAR/FIRE ARARM SYSTEM			2012	5,966	63	27.5	63		63	35
36	PED DR,FRAME,SIDELIGHT, & TRANSOM- PATIO NORTH			2012	9,060	96	27.5	96		96	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 NSG & REHAB CTR # 0047779 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	NEW EJECTOR PUMPS	2012	$ 6,975	$ 74	27.5	$ 74	$	$ 74	37
38	EXHAUST FAN	2012	5,550	59	27.5	59		59	38
39	new walls,fire preventive work & plumbing-various locations	2012	7,675	81	27.5	81		81	39
40	CHILLER 15 TON COMPRESSOR	2012	18,402	195	27.5	195		195	40
41	EXHAUST FAN	2012	8,287	88	27.5	88		88	41
42	CHIMNEY WITH STAINLESS STEEL LINER AND TOP	2012	2,998	32	27.5	32		32	42
43	NEW RAMP	2012	1,245	10	15	10		10	43
44	CONCRETE	2012	34,100	285	15	285		285	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 413,893	$ 12,932		$ 9,915	$ (3,017)	$ 65,845	70

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

Facility Name & ID Number LAKEFRONT NSG & REHAB CTR # 0047779 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 413,893	$ 12,932		$ 9,915	$ (3,017)	$ 65,845	1
2									2
3									3
4	RELATED PARTY INFORMATION								4
5	BUILDINGS:								5
6	ALLOCATED FROM LEGACY RP	2009	32,077		30	595	595		6
7									7
8									8
9									9
10	LEASEDHOLD IMPROVEMENTS:								10
11	ALLOCATED FROM LEGACY RP	2009	18,216		20	147	147		11
12	ALLOCATED FROM LEGACY RP	2010	5,539		20	45	45		12
13	ALLOCATED FROM LEGACY RP	2011	7,873		20	64	64		13
14									14
15									15
16									16
17									17
18									18
19									19
20	ALLOCATED FROM LEGACY HEALTHCARE FINANCIAL	2012	1,443		20	110	110		20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 479,041	$ 12,932		$ 10,876	$ (2,056)	$ 65,845	34

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

Facility Name & ID Number LAKEFRONT NSG & REHAB CTR # 0047779 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$ 112,022	$ 4,702	$ 11,203	$ 6,501	10 YRS	$ 66,085	71
72	Current Year Purchases	7,575	3,977	379	(3,598)	10 YRS	379	72
73	Fully Depreciated Assets							73
74	REL PARTY		941	941				74
75	TOTALS	$ 119,597	$ 9,620	$ 12,523	$ 2,903		$ 66,464	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)	$ 602,778	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 22,552	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 23,399	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 847	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 132,309	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 NSG & REHAB CTR # 0047779 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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		$ 611,752			3
4	Additions							4
5								5
6								6
7	TOTAL		99		$ 611,752 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 22,135 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 NSG & REHAB CTR # 0047779 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

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

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 NSG & REHAB CTR # 0047779 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 107,568	$		$ 107,568	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			52,113			52,113	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			92,264			92,264	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				105,682		105,682	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			$		$ 251,945	$ 105,682		$ 357,627	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 LAKEFRONT NSG & REHAB CTR # 0047779 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 192,790	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (318,841))	892,641		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	76,596		6
7	Other Prepaid Expenses	33,759		7
8	Accounts Receivable (owners or related parties)	2,115		8
9	Other(specify): Refund due from irs	6,557		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,204,458	$	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	388,233		15
16	Equipment, at Historical Cost	177,552		16
17	Accumulated Depreciation (book methods)	(217,932)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	26,610		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(11,975)		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)**	$ 362,488	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,566,946	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 481,606	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,353		28
29	Short-Term Notes Payable	33,563		29
30	Accrued Salaries Payable	61,862		30
31	Accrued Taxes Payable (excluding real estate taxes)	37,156		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 NORTH MAIN	65,214		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 694,754	$	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)**	$ 694,754	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 872,192	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,566,946	$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 331,637	1
2	Restatements (describe):		2
3	POST CLOSING	195,834	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 527,471	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	380,721	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	(36,000)	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)**	$ 344,721	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)**	$ 872,192	24 *

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

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,000,168	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,000,168	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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***	1,613	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,613	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)**	$ 6,001,781	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	912,149	31
32	Health Care	1,781,402	32
33	General Administration	1,607,034	33
	B. Capital Expense		
34	Ownership	676,887	34
	C. Ancillary Expense		
35	Special Cost Centers	357,627	35
36	Provider Participation Fee	350,863	36
	D. Other Expenses (specify):		
37			37
38	OTHER EXPENSE ADJUSTMENT	(64,902)	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,621,060	40
41	**Income before Income Taxes (line 30 minus line 40)****	380,721	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 380,721	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,541,312	44
45	Private Pay - Net Inpatient Revenue	1,037	45
46	Medicare - Net Inpatient Revenue	1,317,144	46
47	Other-(specify) VETERAN	140,114	47
48	Other-(specify) INSURANCE	561	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,000,168	49

****TAX RETURN PREPARED ON CASH BASIS**

* **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.**

*** **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.**

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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	2,017	2,251	$ 103,958	$ 46.18	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,805	13,161	343,202	26.08	3
4	Licensed Practical Nurses	14,396	16,006	349,160	21.81	4
5	CNAs & Orderlies	49,552	54,332	560,925	10.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,969	2,131	33,570	15.75	9
10	Activity Assistants	4,365	4,877	62,287	12.77	10
11	Social Service Workers	5,115	5,461	98,078	17.96	11
12	Dietician	2,025	2,203	39,662	18.00	12
13	Food Service Supervisor					13
14	Head Cook	31	31	267	8.61	14
15	Cook Helpers/Assistants	15,423	16,904	156,779	9.27	15
16	Dishwashers					16
17	Maintenance Workers	9,640	10,328	119,106	11.53	17
18	Housekeepers	12,957	14,355	140,249	9.77	18
19	Laundry	4,623	4,992	44,551	8.92	19
20	Administrator	2,025	2,291	128,650	56.15	20
21	Assistant Administrator	432	440	7,757	17.63	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,590	5,010	48,835	9.75	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)	2,106	2,304	27,453	11.92	30
31	Medical Records	2,015	2,131	57,378	26.93	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	145,086	159,208	$ 2,321,867 *	$ 14.58	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	$ 15,142	1-3	35
36	Medical Director	Monthly Fee	19,800	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	Monthly Fee	5,792	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	2,448	11-3	44
45	Social Service Consultant	Monthly Fee	2,625	12-3	45
46	Other(specify) NURSING	Monthly Fee	12,000	10-3	46
47	Nursing Program Consultant	Monthly Fee	33,000	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 90,807		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
AHARON ADLER	ADMINISTRATOR		$ 128,650
JAMIE DLATT	ASST ADMIN		7,757
	OTHER ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 136,407

B. Administrative - Other

Description	Amount
SEE ATTACHED SCHEDULE	$ 370,208
TOTAL (agree to Schedule V, line 17, col. 3)	$ 370,208
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		78,944
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 78,944

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 61,868
Unemployment Compensation Insurance	68,591
FICA Taxes	174,156
Employee Health Insurance	143,126
Employee Meals	22,399
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	3,968
EMPLOYEE PHYSICAL EXAMS	1,890
PENSION/PROFIT SHARING PLANS	24,256
CHICAGO HEAD TAX	2,028
INSURANCE - EXECUTIVE LIFE	0
PAYROLL TAX-LEGACY & PROGRESSIVE	5,045
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 507,327

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

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	0
Health Care Worker Background Check	540
(Indicate # of checks performed 54)	
Patient Background Checks 78	4,202
TRUST/FRANCHISE/CONTRIB/ETC	94,472
MARKETING/ADV/PROMO	828
LICENSES/DUES/SUBSCRIPTIONS	9,648
REL PARTY ALLOC	32
TRUST/FRANCHISE/CONTRIB/ETC	(94,472)
Less: Public Relations Expense	(0)
Non-allowable advertising	(828)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,422

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
RALATED PARTY	111
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 111

* Attach copy of IMRF notifications

**See instructions.

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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			$		$	$	$	$	$	$	$	$	$
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 NSG & REHAB CTR # 0047779 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ICLTC $ 4,571

(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. $ 5,978 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. $ 350,863
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. $ 22,399 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.