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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0051615

Facility Name: CHALET LIVING & REHAB CTR

Address: 7350 N SHERIDAN RD (Number) CHICAGO (City) 60626 (Zip Code)

County: COOK

Telephone Number: (773) 274-1000 **Fax #** (773) 274-0153

HFS ID Number:

Date of Initial License for Current Owners: 10/01/11

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			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 01/01/2013 to 12/31/2013 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) KBKB, LTD., 8140 RIVER DRIVE, MORTON GROVE, IL 60053
(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 CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	219	Skilled (SNF)	219	79,935	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	219	TOTALS	219	79,935	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	56,014	3,777	6,389	66,180	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	56,014	3,777	6,389	66,180	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.79%

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 10/01/11

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/11/11 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 219 and days of care provided 6,213

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: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	371,454	26,621	15,594	413,669		413,669		413,669			1
2	Food Purchase		365,108		365,108	(34,536)	330,572	27	330,599			2
3	Housekeeping	126,929	60,726		187,655		187,655	1,411	189,066			3
4	Laundry	64,625	27,118		91,743		91,743		91,743			4
5	Heat and Other Utilities			206,600	206,600		206,600	1,632	208,232			5
6	Maintenance	137,757	54,441	162,111	354,309		354,309	4,475	358,784			6
7	Other (specify):* SECURITY	47,750		28,901	76,651		76,651		76,651			7
8	**TOTAL General Services**	748,515	534,014	413,206	1,695,735	(34,536)	1,661,199	7,545	1,668,744			8
	B. Health Care and Programs											
9	Medical Director			57,600	57,600		57,600		57,600			9
10	Nursing and Medical Records	3,049,672	214,729	184,016	3,448,417		3,448,417	(22,430)	3,425,987			10
10a	Therapy	130,169			130,169		130,169		130,169			10a
11	Activities	125,713	9,535	2,288	137,536		137,536		137,536			11
12	Social Services	175,529		4,240	179,769		179,769	7,314	187,083			12
13	CNA Training											13
14	Program Transportation			22,097	22,097		22,097	(2,535)	19,562			14
15	Other (specify):*							358	358			15
16	**TOTAL Health Care and Programs**	3,481,083	224,264	270,241	3,975,588		3,975,588	(17,293)	3,958,295			16
	C. General Administration											
17	Administrative	227,562		925,790	1,153,352		1,153,352	(745,733)	407,619			17
18	Directors Fees											18
19	Professional Services			236,219	236,219		236,219	16,556	252,775			19
20	Dues, Fees, Subscriptions & Promotions			206,503	206,503		206,503	(183,284)	23,219			20
21	Clerical & General Office Expenses	193,173	58,342	495,002	746,517		746,517	(141,677)	604,840			21
22	Employee Benefits & Payroll Taxes			870,851	870,851	34,536	905,387		905,387			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,475	5,475		5,475	1,823	7,298			24
25	Other Admin. Staff Transportation			8,946	8,946		8,946	(6,496)	2,450			25
26	Insurance-Prop.Liab.Malpractice			123,320	123,320		123,320	1,497	124,817			26
27	Other (specify):*			242,376	242,376		242,376	(199,789)	42,587			27
28	**TOTAL General Administration**	420,735	58,342	3,114,482	3,593,559	34,536	3,628,095	(1,257,103)	2,370,992			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,650,333	816,620	3,797,929	9,264,882		9,264,882	(1,266,851)	7,998,031			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#: CHALET LIVING & REHAB CTR **#0051615** **Report Period Beginning: 01/01/2013** **Ending: 12/31/2013**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	15,594	
	REPAIRS & MAINTENANCE		0	
			0	15,594
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		63,657	
	ELECTRICITY		79,709	
	WATER		52,941	
	CABLE TV - LOBBY		10,293	
			0	206,600
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		27,307	
	PAINTING & DECORATING		2,990	
	BUILDING REPAIRS		11,345	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		34,216	
	ELEVATOR MAINTENANCE & REPAIR		17,627	
	OUTSIDE LABOR		250	
	EXTERMINATING SERVICE		8,725	
	FIRE SERVICE		9,421	
	PROPERTY SPECIALIST - LEGACY		50,230	
			0	
			0	
			0	162,111
7	**OTHER**			
	SCAVENGER		28,401	
	SECURITY SERVICE		500	
			0	
			0	28,901
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	57,600	57,600

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		18,475	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	1,230	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,512	
	PHARMACY CONSULTANT	XVIII B 39-2	16,294	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	NURSING CONSULTANT	XVIII B 38-2	18,000	
	LEGACY PROGRESSIVE		60,014	
	NURSING PROGRAM CONSULTANT ,CI		65,491	184,016
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	2,288	
			0	2,288
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	4,240	
				4,240
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number CHALET LIVING & REHAB CTR **#0051615** **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		22,097	22,097
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES & OTHER ADMIN FEES	XIX B	925,790	925,790
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	44,043	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	192,176	
			0	236,219
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	65,161	
	EMPLOYEE WANT ADS	XIX F	421	
	CONTRIBUTIONS	VI 20 XIX F	107,076	
	DUES & SUBSCRIPTIONS	XIX F	11,575	
	LICENSES & PERMITS	XIX F	0	
	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	11,866	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	10,404	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				206,503
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		9,012	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		264,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	62,245	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		38,452	
	MESSENGER SERVICE		0	
	LEGACY -PROGRESSIVE & HEALTHCARE		121,293	495,002

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	347,203	
	UNEMPLOYMENT COMPENSATION	XIX D	108,024	
	WORKERS COMPENSATION INSURANC	XIX D	131,712	
	HOSPITALIZATION INSURANCE	XIX D	205,049	
	EMPLOYEE BENEFITS - OTHER	XIX D	18,928	
	EMPLOYEE PHYSICAL EXAMS	XIX D	5,310	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	15,537	
	CHICAGO HEAD TAX	XIX D	2,068	
	PAYROLL TAXES - LEGACY/PROGRESSIVE		37,020	870,851
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	
				0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	5,475	
	TRAVEL	XIX G	0	
				5,475
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		8,946	
				8,946
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		123,320	
				123,320
27	**OTHER**			
	BAD DEBTS	VI 24	242,376	
				242,376

GRAND TOTAL COLUMN 3 OTHER **3,797,929**

CHALET LIVING & REHAB CTR
SCHEDULES
12/31/2013

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

TOTAL FOOD PURCHASE	365,108
LESS SALES TAX	0
NET FOOD	365,108
TOTAL PATIENT CENSUS	66,180
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	198,540
ADD # EMPLOYEE MEALS/DAY	57
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	20,805
PATIENT MEALS	198,540
ADD EMPLOYEE MEALS	20,805
TOTAL MEALS/YEAR	219,345
NET FOOD	365,108
DIVIDE TOTAL MEALS/YEAR	219,345
COST PER MEAL	1.66
TIMES EMPLOYEE MEALS	20,805
EMPLOYEE MEAL RECLASSIFICATION	**34,536**

HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??

Facility Name & ID Number CHALET LIVING & REHAB CTR #0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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			4,427	4,427		4,427	149,922	154,349			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			128,235	128,235		128,235	7,702	135,937			32
33	Real Estate Taxes					183,797	183,797	4,368	188,165			33
34	Rent-Facility & Grounds			1,620,894	1,620,894	(183,797)	1,437,097	(430,168)	1,006,929			34
35	Rent-Equipment & Vehicles			39,696	39,696		39,696		39,696			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,793,252	1,793,252		1,793,252	(268,176)	1,525,076			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		263,862	880,603	1,144,465		1,144,465		1,144,465			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			478,359	478,359		478,359		478,359			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		263,862	1,358,962	1,622,824		1,622,824		1,622,824			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,650,333	1,080,482	6,950,143	12,680,958		12,680,958	(1,535,027)	11,145,931			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 CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	(142,966)	30		9
10	Interest and Other Investment Income	(1,010)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest	(453)	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	(62,245)	21		18
19	Entertainment		20		19
20	Contributions	(118,942)	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	(242,376)	27		24
25	Fund Raising, Advertising and Promotional	(65,161)	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	(24,982)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (658,135)		$	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)	(876,892)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (876,892)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,535,027)		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

CHALET LIVING & REHAB CTR

ID# 0051615

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	LIFELINE AMBULANCE	$ (2,535)	14	1
2	YAIR ZUCKERMAN- NON ALLOW SALARY	(15,951)	17	2
3	NON ALLOWABLE STAFF TRANSPORTATION	(6,496)	25	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(24,982)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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	0	0	27	0	0	0	0	0	0	0	0	27	2
3	Housekeeping	0	0	1,411	0	0	0	0	0	0	0	0	1,411	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,632	0	0	0	0	0	0	0	0	1,632	5
6	Maintenance	0	0	4,475	0	0	0	0	0	0	0	0	4,475	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	7,545	0	0	0	0	0	0	0	0	7,545	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	(22,430)	0	0	0	0	0	0	(22,430)	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	7,314	0	0	0	0	0	0	7,314	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(2,535)	0	0	0	0	0	0	0	0	0	0	(2,535)	14
15	Other (specify):*	0	0	0	0	358	0	0	0	0	0	0	358	15
16	**TOTAL Health Care and Programs**	(2,535)	0	0	0	(14,758)	0	0	0	0	0	0	(17,293)	16
	C. General Administration													
17	Administrative	(15,951)	0	(748,955)	0	19,173	0	0	0	0	0	0	(745,733)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,750	11,370	0	436	0	0	0	0	0	0	16,556	19
20	Fees, Subscriptions & Promotions	(184,103)	0	747	36	36	0	0	0	0	0	0	(183,284)	20
21	Clerical & General Office Expenses	(62,245)	0	(81,803)	0	2,371	0	0	0	0	0	0	(141,677)	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	1,742	0	81	0	0	0	0	0	0	1,823	24
25	Other Admin. Staff Transportation	(6,496)	0	0	0	0	0	0	0	0	0	0	(6,496)	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,497	0	0	0	0	0	0	0	0	1,497	26
27	Other (specify):*	(242,376)	0	41,669	0	918	0	0	0	0	0	0	(199,789)	27
28	**TOTAL General Administration**	(511,171)	4,750	(773,733)	36	23,015	0	0	0	0	0	0	(1,257,103)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(513,706)	4,750	(766,188)	36	8,257	0	0	0	0	0	0	(1,266,851)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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	(142,966)	284,474	3,459	4,955	0	0	0	0	0	0	0	149,922	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,463)	5,000	24	4,141	0	0	0	0	0	0	0	7,702	32
33	Real Estate Taxes	0	0	0	4,368	0	0	0	0	0	0	0	4,368	33
34	Rent-Facility & Grounds	0	(430,168)	13,077	(13,077)	0	0	0	0	0	0	0	(430,168)	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	(144,429)	(140,694)	16,560	387	0	0	0	0	0	0	0	(268,176)	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)	(658,135)	(135,944)	(749,628)	423	8,257	0	0	0	0	0	0	(1,535,027)	45

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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
CHAIM RAJCHENBACH	28.60	THE GROVE AT LINCOLN PARK	CHICAGO	GROVE HC PROP	CHICAGO	REAL ESTATE
MENCAHEM SHABAT	28.60	THE GROVE OF NORTHBROOK	CHICAGO	LEGACY HC		
JACK RAJCHENBACH FAMILY TRST	14.00	ASTORIA PLACE LIVING & REHAB CENTER	CHICAGO	FINANCIAL SERV	LINCOLNWOOD	MGMT
RONALD SHABAT	14.00	THE GROVE OF EVANSTON	EVANSTON	LEGACY REAL PRO	LINCOLNWOOD	REAL ESTATE
JAIME DLATT	5.00	ELMBROOK NURSING	ELMHURST	ASTORIA HEALTH		
YAIR ZUCKERMAN	5.00	PETERSON PARK	CHICAGO	CARE PROP	CHICAGO	REAL ESTATE
NATHAN DAVID	4.80	LAKEFRONT NURSING	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	34	RENT	$ 1,620,894	THE CHALET REAL PROPERTY,LLC		$	$ (1,620,894)	1
2	V	19	PROFESSIONAL FEES		THE CHALET REAL PROPERTY,LLC		4,750	4,750	2
3	V	30	DEPRECIATION		THE CHALET REAL PROPERTY,LLC		284,474	284,474	3
4	V	32	INTEREST		THE CHALET REAL PROPERTY,LLC		5,000	5,000	4
5	V	34	RENT		THE CHALET REAL PROPERTY,LLC		1,190,726	1,190,726	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			$ 1,620,894			$ 1,484,950	$ * (135,944)	14

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	ELMHURST	REAL ESTATE	1
2			THE GROVE AT THE LAKE	ZION	HEALTHCARE RLT	CHICAGO	REAL ESTATE	2
3			THE GROVE OF SKOKIE	SKOKIE	PETERSON PK RLTY			3
4			PARK VILLA NURSING & REHAB	PALOS HEIGHTS	GROVE LAGRANGE	LAGRANGE PK	REAL ESTATE	4
5			THE VILLA AT WINDSOR PARK	CHICAGO	REALTY			5
6					GROVE AT THE	ZION	REAL ESTATE	6
7					LAKE REALTY			7
8					CHALET REAL	CHICAGO	REAL ESTATE	8
9					PROPERTY	PALOS HGTS	REAL ESTATE	9
10					PARK VILLA RLTY			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 CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$ 788,440	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		$	$ (788,440)	15
16	V	21	OUTSIDE CLERICAL	264,000	LEGACY HEALTHCARE FINANCIAL SERVICES LLC			(264,000)	16
17	V	2	FOOD		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		27	27	17
18	V	3	HOUSEKEEPING		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		1,411	1,411	18
19	V	5	UTILITIES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		1,632	1,632	19
20	V	6	GROUNDS & MAINTENANCE		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		4,475	4,475	20
21	V	17	MANAGEMENT FEES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		39,485	39,485	21
22	V	19	PROFESSIONAL FEES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		11,370	11,370	22
23	V	20	FEES,SUBSCRIPTIONS		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		747	747	23
24	V	21	CLERICAL & GENERAL		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		182,197	182,197	24
25	V	24	SEMINARS		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		1,742	1,742	25
26	V	26	INSURANCE		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		1,497	1,497	26
27	V	27	EMPL BENEFITS-GEN ADMIN		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		28,540	28,540	27
28	V	27	EMPL BENEFITS-OWNERS		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		13,129	13,129	28
29	V	30	DEPRECIATION		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		3,459	3,459	29
30	V	32	INTEREST		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		24	24	30
31	V	34	RENT		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		13,077	13,077	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,052,440			$ 302,812	$ * (749,628)	39

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$ 13,077	LEGACY REAL PROPERTIES LLC		$	$ (13,077)	15
16	V	20	DUES AND SUBSCRIPTIONS		LEGACY REAL PROPERTIES LLC		36	36	16
17	V	30	DEPRECIATION		LEGACY REAL PROPERTIES LLC		4,955	4,955	17
18	V	32	INTEREST EXPENSE		LEGACY REAL PROPERTIES LLC		4,141	4,141	18
19	V	33	REAL ESTATE TAXES		LEGACY REAL PROPERTIES LLC		4,368	4,368	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			$ 13,077			$ 13,500	$ * 423	39

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$ 36,000	PROGRESSIVE HEALTHCARE CONSULTING		$	$ (36,000)	15
16	V	10	NURSING SALARIES		PROGRESSIVE HEALTHCARE CONSULTING		13,570	13,570	16
17	V	12	CLERGY SALARY		PROGRESSIVE HEALTHCARE CONSULTING		896	896	17
18	V	12	ADMISSIONS SALARY		PROGRESSIVE HEALTHCARE CONSULTING		6,418	6,418	18
19	V	15	EMPL BENEFIT- NURSING		PROGRESSIVE HEALTHCARE CONSULTING		358	358	19
20	V	17	ADMIN SAL-NON OWNERS		PROGRESSIVE HEALTHCARE CONSULTING		19,173	19,173	20
21	V	19	PROSFESSIONAL FEES		PROGRESSIVE HEALTHCARE CONSULTING		436	436	21
22	V	20	FEES, SUBSCRIPTIONS		PROGRESSIVE HEALTHCARE CONSULTING		36	36	22
23	V	21	CLERICAL & GEN OFFICE		PROGRESSIVE HEALTHCARE CONSULTING		2,371	2,371	23
24	V	24	SEMINARS		PROGRESSIVE HEALTHCARE CONSULTING		81	81	24
25	V	27	AUTO AND TRAVEL		PROGRESSIVE HEALTHCARE CONSULTING		918	918	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			$ 36,000			$ 44,257	$ * 8,257	39

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	6	PLANT ENGINEER	$ 50,230	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		$ 50,230	$	15
16	V	10	DIRECTOR OF NURSING	16,873	PROGRESSIVE HEALTHCARE CONSULTING		16,873		16
17	V	10	CLINICAL NURSE	10,686	PROGRESSIVE HEALTHCARE CONSULTING		10,686		17
18	V	10	MDS COORDINATOR	16,839	PROGRESSIVE HEALTHCARE CONSULTING		16,839		18
19	V	10	E.H.R. IMPLEMENTATION	15,616	PROGRESSIVE HEALTHCARE CONSULTING		15,616		19
20	V	17	ADMINISTRATOR	125,211	PROGRESSIVE HEALTHCARE CONSULTING		125,211		20
21	V	17	ASST ADMINISTRATOR	12,139	PROGRESSIVE HEALTHCARE CONSULTING		12,139		21
22	V	21	AR FIELD COORDINATOR	11,525	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		11,525		22
23	V	21	IN-HOUSE COUNSEL	12,174	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		12,174		23
24	V	21	CORPORATE IT DIRECTOR	3,971	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		3,971		24
25	V	21	CORPORATE TRAINOR	9,088	PROGRESSIVE HEALTHCARE CONSULTING		9,088		25
26	V	21	PERSONNEL	850	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		850		26
27	V	21	ADMITTING	83,907	PROGRESSIVE HEALTHCARE CONSULTING		83,907		27
28	V	21	PURCHASING DIRECTOR	(222)	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		(222)		28
29	V	22	PAYROLL TAXES	7,853	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		7,853		29
30	V	22	PAYROLL TAXES	29,167	PROGRESSIVE HEALTHCARE CONSULTING		29,167		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			$ 405,907			$ 405,907	$ *	39

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	CHAIM RAJCHENBACH	RELATIVE	ADMINISTRATIV	28.60	SEE ATTACHED				$ 19,742	17-7	1
2											2
3											3
4	MENAHEM SHABAT	OWNER	ADMINISTRATIV	28.60	SEE ATTACHED				19,742	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 39,484		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 CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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 CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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	809,780	17	$ 271	$	79,935	$ 27	1
2	3	HOUSEKEEPING	Bed Days Available	809,780	17	14,291	12,745	79,935	1,411	2
3	5	UTILITIES	Bed Days Available	809,780	17	16,531		79,935	1,632	3
4	6	GROUNDS & MAINTENANCE	Bed Days Available	809,780	17	45,337		79,935	4,475	4
5	17	MANAGEMENT FEES	Bed Days Available	809,780	17	400,000	400,000	79,935	39,485	5
6	19	PROFESSIONAL FEES	Bed Days Available	809,780	17	115,181		79,935	11,370	6
7	20	FEES,SUBSCRIPTIONS	Bed Days Available	809,780	17	7,563		79,935	747	7
8	21	CLERICAL & GENERAL	Bed Days Available	809,780	17	1,845,746	1,700,817	79,935	182,197	8
9	24	SEMINARS	Bed Days Available	809,780	17	17,652		79,935	1,742	9
10	26	INSURANCE	Bed Days Available	809,780	17	15,170		79,935	1,497	10
11	27	EMPL BENEFITS-GEN ADMIN	Bed Days Available	809,780	17	289,128		79,935	28,540	11
12	27	EMPL BENEFITS-OWNERS	Bed Days Available	809,780	17	133,004		79,935	13,129	12
13	30	DEPRECIATION	Bed Days Available	809,780	17	35,039		79,935	3,459	13
14	32	INTEREST	Bed Days Available	809,780	17	242		79,935	24	14
15	34	RENT	Bed Days Available	809,780	17	132,473		79,935	13,077	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,067,628	$ 2,113,562		$ 302,812	25

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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 AND SUBSCRIPTIONS	Bed Days Available	809,780	17	$ 368	$	79,935	$ 36	1
2	30	DEPRECIATION	Bed Days Available	809,780	17	50,196		79,935	4,955	2
3	32	INTEREST EXPENSE	Bed Days Available	809,780	17	41,954		79,935	4,141	3
4	33	REAL ESTATE TAXES	Bed Days Available	809,780	17	44,250		79,935	4,368	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					$ 136,768	$		$ 13,500	25

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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: PROGRESSIVE HEALTHCARE CONSULTINC
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	NURSING SALARIES	Bed Days Available	550,071	11	$ 93,385	$ 93,385	79,935	$ 13,570	1
2	12	CLERGY SALARY	Bed Days Available	550,071	11	6,165	6,165	79,935	896	2
3	12	ADMISSIONS SALARY	Bed Days Available	550,071	11	44,165	44,165	79,935	6,418	3
4	15	EMPL BENEFIT- NURSING	Bed Days Available	550,071	11	2,467		79,935	358	4
5	17	ADMIN SAL-NON OWNERS	Bed Days Available	550,071	11	131,937	131,937	79,935	19,173	5
6	19	PROSFESSIONAL FEES	Bed Days Available	550,071	11	3,003		79,935	436	6
7	20	FEES, SUBSCRIPTIONS	Bed Days Available	550,071	11	250		79,935	36	7
8	21	CLERICAL & GEN OFFICE	Bed Days Available	550,071	11	16,314		79,935	2,371	8
9	24	SEMINARS	Bed Days Available	550,071	11	560		79,935	81	9
10	27	AUTO AND TRAVEL	Bed Days Available	550,071	11	6,314		79,935	918	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					$ 304,560	$ 275,652		$ 44,257	25

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	LOAN COSTS- real property		X	AMORTIZE OVER LIFE OF LOAN							5,000	2
3												3
4	rel party										4,165	4
5												5
	Working Capital											
6	PRIVATE BANK		X	LINE OF CREDIT	INT		2,000,000	1,320,000	9/29/14		50,197	6
7	INSURANCE POLICY FIN		X	INS POLICY FINANCE							2,250	7
8	PRIVATE BANK		X	CAPITAL EXPENDITURES	INT ONLY			1,118,395			75,335	8
9	TOTAL Facility Related						$ 2,000,000	$ 2,438,395			$ 136,947	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11	LOCAL 4		X								453	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 453	14
15	TOTALS (line 9+line14)						$ 2,000,000	$ 2,438,395			$ 137,400	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 CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 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.)		$ 188,105	2
3. Under or (over) accrual (line 2 minus line 1).		$ 188,105	3
4. Real Estate Tax accrual used for 2013 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.		$ 188,105	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2008		8
2009		9
2010		10
2011	193,231	11
2012	188,105	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 2012 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CHALET LIVING & REHAB CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0051615

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

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 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-29-314-026-0000	NURSING HOME	$ 6,681.52	$ 6,681.52
2.	11-29-314-027-0000	NURSING HOME	$ 5,645.17	$ 5,645.17
3.	11-29-314-028-0000	NURSING HOME	$ 85,868.03	$ 85,868.03
4.	11-29-314-029-0000	NURSING HOME	$ 85,602.66	$ 85,602.66
5.			$	$
6.	10-35-104-076-0000	HOME OFFICE ALLOCATION	$ 44,384.14	$ 4,308.00
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 228,181.52	$ 188,105.38

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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 CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 76,920 B. General Construction Type: Exterior MASONRY Frame _____ Number of Stories 4 WITH BASEMENT

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? [ ] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	ALLOC FR LEGACY RP		2009	$ 9,158	1
2					2
3	TOTALS			$ 9,158	3

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	2ND FLOOR BUILT IN NURSES STATION			2012	10,000	257	39	257		396	9
10	2nd floor built in cabinets for med room / nutrition room			2012	9,675	248	39	248		382	10
11	2ND FLOOR PAINTING			2012	84,566	16,913	5	16,913		25,370	11
12	2ND FLOOR LIGHTING			2012	15,030	386	39	386		595	12
13	2nd floor drop ceiling & cove lighting, crown molding			2012	24,600	631	39	631		973	13
14	2ND FLOOR RESILIENT FLOORING			2012	46,620	1,196	39	1,196		1,844	14
15	2ND FLOOR PANELS, ROOM DIVIDERS, LIGHT COVERS			2012	37,350	958	39	958		1,477	15
16	3RD FLOOR BUILT IN NURSES STATION			2012	10,000	257	39	257		396	16
17	3rd floor built in cabinets for med room / nutrition room			2012	9,675	248	39	248		382	17
18	3RD FLOOR PAINTING			2012	83,712	16,743	5	16,743		25,114	18
19	3RD FLOOR LIGHTING			2012	2,500	64	39	64		99	19
20	3RD FLOOR BATHROOM REMODELING			2012	19,500	500	39	500		771	20
21	3RD FLOOR RESILIENT FLOORING			2012	46,620	1,196	39	1,196		1,843	21
22	INSTALL 76 OUTLETS ON THE 3RD FLOOR			2012	5,490	141	39	141		217	22
23	3RD FLOOR ELECTRICAL WORK			2012	3,235	83	39	83		128	23
24	3RD FLOOR DROP CEILING / CROWN MOLDING			2012	8,282	212	39	212		327	24
25	3RD FLOOR CABLE AND WIRING			2012	8,325	213	39	213		329	25
26	SECURITY WIRING			2012	6,150	158	39	158		243	26
27	CUBICLE TRACKS AND CURTAINS			2012	24,687	3,023	7	3,527	504	5,290	27
28	WALLCOVERINGS			2012	19,527	3,905	5	3,905		5,858	28
29	18 ELECTRICAL OUTLETS			2012	1,950	50	39	50		77	29
30	EXTERIOR SIGNAGE			2012	11,303	290	39	290		447	30
31	SPRINKLERS ELEVATOR ROOM & SHAFT			2012	5,625	144	39	144		222	31
32	2ND & 3RD FLOOR DESIGNER FEE			2012	25,000	641	39	641		988	32
33	WANDER GUARD SECURITY SYSTEM			2012	32,619	836	39	836		1,289	33
34	3RD FLOOR RENOVATIONS			2012	6,565	168	39	168		259	34
35	Wiring & installation material for communication system			2012	8,345	214	39	214		330	35
36	2ND FLOOR RENOVATION			2012	22,730	583	39	583		899	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 CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	CABLE INSTALLATION	2012	$ 4,750	$ 122	39	$ 122	$	$ 137	37
38	ARCHITECT FEES	2012	8,944	229	39	229		258	38
39	1ST FLOOR ELECTRICAL & MECHANICAL ENGINEERING	2012	5,000	128	39	128		144	39
40	PLUMBING FOR SPRINKLER SYSTEM, CLEAN UP DRAIN								40
41	LINE IN ROOM 220 AND 221, INSTALL CERAMIC TILES								41
42	IN THREE HALLWAY BATHROOMS, REPAIR VINYL TILES								42
43	IN THE ROOMS ON SECOND FLLOR, INSTALL DROP								43
44	CEILING LIGHT FIXTURES ON THIRD FLOOR, REPAIR								44
45	DROP CEILING ON THIRD FLOOR, INSTALL NEW ELEC-								45
46	TRICAL OUTLETS FOR AIR FRESHENERS ON 2TH AND								46
47	3RD FLOORS, REPLACE CONTROL BOX FOR EXHAUST								47
48	ROOF FAN	2012	13,570	348	39	348		391	48
49	WOODWORK FOR FRONT DESK, COLUMNS, LIBRARY.								49
50	AND TABLES	2012	5,000	128	39	128		144	50
51	SIGNAGE	2012	11,527	296	39	296		333	51
52	TILING FOR FIRST FLOOR LOBBY	2012	14,045	360	39	360		405	52
53	TILING IN THE SECOND FLOOR SHOWER ROOM	2012	5,046	129	39	129		145	53
54	walk in bath tub with plumbing in 2nd floor shower room	2012	4,477	115	39	115		129	54
55	elec work for dishwasher, light fixt for drop ceil(kitch + 4th floor)	2012	4,525	116	39	116		131	55
56	install toilets and sinks, tiles,electrical work and woodwork	2012	16,358	419	39	419		471	56
57	FIRE SPRINKLER SYSTEM AND DESIGN FEE	2012	10,500	269	39	269		303	57
58	flooring in 4th floor dining room and in shower room	2012	8912	229	39	229		258	58
59	WATER HEATER	2012	15290	392	39	392		441	59
60	FIRST FLOOR ELECTRIC (BARBER-SHOP, LIBRARY,								60
61	DOCTORS LUNCH ROOM, ADMINISTRATOR OFFICE,								61
62	OFFICE, 3 BATHROOMS. FOURTH FLOOR ELECTRIC-								62
63	ELECTRICAL OUTLETS, FIRE RATED DISCONNECT AND								63
64	TRASH 8 OLD LIGHT FIXTURES, PROVIDE AND INSTALL								64
65	1 ELECTRICAL OUTLETS AND LEVITON 20AMP 125V								65
66	DUPLEX RECEPTACLE, PROVIDE AND INSTALL 1 TV								66
67	OUTLETS. FOURTH FLOOR ELECTRIC- PROVIDE AND								67
68	INSTALL NEW 150 WATT LED LIGHTS FIXTURES. PROVIDE								68
69	AND INSTALL NEW LIGHTS COVER.	2012	14,350	368	39	368		414	69
70	TOTAL (lines 4 thru 69)		$ 731,975	$ 53,906		$ 54,410	$ 504	$ 80,649	70

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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		$ 731,975	$ 53,906		$ 54,410	$ 504	$ 80,649	1
2	4TH FLOOR NURSE STATION	2012	10,000	256	39	256		288	2
3	3rd floor bathroom mirrors, lights, and toilet paper holders	2012	3,124	80	39	80		90	3
4	WALK IN FREEZER	2012	8,349	214	39	214		241	4
5	SMOKE DETECTOR	2012	3,020	77	39	77		87	5
6	RAMP WALK AND LANDSCAPE WORK	2012	24,120	1,608	15	1,608		2,412	6
7	IRRIGATION SYSTEM	2012	20,900	1,393	15	1,393		2,090	7
8	3rd floor dining room drapes, rods,blinds,cornice boards,								8
9	and shades	2012	33,803	4,139	7	4,829	690	6,209	9
10	1st floor carpeting for conference room and dining room	2012	11,656	1,427	7	1,665	238	2,498	10
11	WALLCOVERINGS FOR FIRST FLOOR	2012	11,856	2,371	5	2,371		2,964	11
12	1ST FLLOR RENOVATION: DEMO, FRAMING, DRYWALL,								12
13	DOORS, HARDWARE, GLASS, HANDRAIL, HVAC,								13
14	ACOUSTICAL CEILING, ARCHITECTURAL FEES & PERMITS	2013	231,066	3,209	39	3,209		3,209	14
15	THERAPY ROOM, COMPUTER ROOM, ADMIN OFFICE, PART								15
16	OF HALLWAY 1ST FLOOR-INSTALL THE TILES AND CARPET	2013	24,262	13,865	7	1,733	(12,132)	1,733	16
17	TWO STAFF BATHROOMS, HALLWAY,BEAUTY SALON-								17
18	INSTALL NEW TOILETS,CERAMIC TILES,LIGHTS FIXTURES,								18
19	CROWN MOLDINGS	2013	15,778	219	39	219		219	19
20	SHOWER ROOM RENOVATION-REPLACE LIGHT FIXTURES,								20
21	DROP CEILING,INSTALL CERAMIC TILES, TOILETS, SINK,								21
22	PAINT ENTIRE SHOWER ROOM	2013	28,801	400	39	400		400	22
23	1ST FLOOR REHAB PROJECT:PAINTING OF THE NEW								23
24	INSTALLED SOFFITS, CROWN MOLDING, VINYL WALL-								24
25	COVERING, ADDITIONAL PATCHING & SKIMMING,								25
26	CEILING FIXTURE, CEILING DECORATIVE CIRCLE	2013	57,334	5,834	5	5,733	(101)	5,733	26
27	ELECTRICAL DEMOLITION WORK: INSTALL EXIT LIGHTS,								27
28	OUTLETS, RECESSED FIXTURES WITH TRIM AND BULBS;								28
29	CERAMIC TILES, PLUMBING, MILLWORK	2013	41,871	582	39	582		582	29
30	4TH FLOOR: GUEST ROOMS & BATHS, CORRIDORS,								30
31	PATIENT BATHROOMS, DINING ROOMS, ENTRY DOORS-								31
32	STRIPPED & WAXED ALL FLOORS, INSTALL BASEBOARD,								32
33	VINYL WALLCOVERING, PAINTING	2013	100,350	10,957	5	10,035	(922)	10,035	33
34	TOTAL (lines 1 thru 33)		$ 1,358,265	$ 100,537		$ 88,814	$ (11,723)	$ 119,439	34

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,358,265	$ 100,537		$ 88,814	$ (11,723)	$ 119,439	1
2	KITCHEN CABINETS INSTALLATION, DROP CEILING IN								2
3	LIVING ROOM	2013	11,650	162	39	162		162	3
4	ELEVATOR-REPLACED SUBMERSIBLE PUMP MOTOR	2013	5,716	80	39	80		80	4
5	INSTALLATION OF FIRE ALARM SYSTEM DEVICES,								5
6	SMOKE DETECTORS	2013	12,392	172	39	172		172	6
7	HOT WATER HEATER PERLACEMENT	2013	10,898	174	39	174		174	7
8	FIRE DAMPERS REPLACEMENT	2013	5,967	83	39	83		83	8
9	REWORKED EXISTING SPRINKLERS ON 1ST FLOOR AND								9
10	LOBBY AREA, REPAIR LEAKING ANTI-FREEZE SYSTEM IN								10
11	CONNECTION WITH RENOVATION	2013	20,542	285	39	285		285	11
12	ARCHITECTUAL FEESAND PERMITS, MATERIALS AND								12
13	SHOP DRAWINGS	2013	14,000	165	39	165		165	13
14	FOURTH FLOOR ROOMS RENOVATION- INSTALL NEW								14
15	ELECTRICAL OUTLETS AND CABLE WIRING FOR TV'S								15
16	INSTALL NEW CURTAINS, INSTALL TV, REPLACE ALL								16
17	NECESSSARY ELECTRICAL OUTLETS, SWITCHES AND								17
18	PLATES. BATHROOMS PAPER AND SOAP DISPENSER								18
19	INSTALLATION	2013	18,000	212	39	212		212	19
20	ELECTRIC- FIRST FLOOR ENTRANCE	2013	6,175	72	39	72		72	20
21	TILING	2013	3,317	39	39	39		39	21
22	PCC WIRE/WIRELESS INSTALLED	2013	48,016	564	39	564		564	22
23	CUBLICLE CURTAINS AND DESIGN FEE FOR BASEMENT	2013	39,905	22,804	7	2,850	(19,954)	2,850	23
24	FIRE PUMP REPAIRS AND FIRE DAMPERS INSTALLED	2013	15,360	181	39	181		181	24
25	BASEMENT REHAB- DEMO, CARPENTRY, DUMPSTERS,								25
26	DRYWALL, DOOR, CEILING TILES, BATH ACCESSOR,								26
27	CLEAN UP, PROJECT MANAGEMENT,PROFIT OVERHEA	2013	28,264	332	39	332		332	27
28	NEW FLOORING/TILING	2013	41,430	487	39	487		487	28
29	NEW THERAPY ROOM AC INSTALLATION	2013	17,268	166	39	166		166	29
30	BASEMENT WORK- TWO STAFF BATHROOMS, ACTIVITY								30
31	ROOM BATHROOM AND ELECTRIC WORK IN THE								31
32	BASEMENT	2013	17,010	164	39	164		164	32
33	ELECTRIC WORK ON FOURTH FLOOR	2013	16,602	160	39	160		160	33
34	TOTAL (lines 1 thru 33)		$ 1,690,777	$ 126,839		$ 95,162	$ (31,677)	$ 125,787	34

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,690,777	$ 126,839		$ 95,162	$ (31,677)	$ 125,787	1
2	INSTALLATION RENOVATION OF THERAPY ROOM,								2
3	LIBRARY AND BEAUTY SALON, CONFERENCE ROOM,								3
4	HALLWAY AND OTHER WORK	2013	42,550	318	39	318		318	4
5	PLUMBING AND VCT FLOOR IN BASEMENT	2013	13,950	104	39	104		104	5
6	FURNISH AND INSTALL AUTOMATIC DOOR	2013	4,300	23	39	23		23	6
7	SECURITY- EGRESSABLE MAG LOCK WITH RESET								7
8	SWITCH, EXIT PAD PRESSURE SENSITIVE	2013	10,970	12	39	12		12	8
9	INSTALL NEW TV ON THE CEILING, REPAIR WALL IN THE								9
10	KITCHEN, INSTALL DOOR CLOSERS, INSTALL WET								10
11	CHAIR FOR BEAUTY SHOP	2013	5,650	6	39	6		6	11
12	NEW PUMP FOR CHILLER	2013	8,699	65	39	65		65	12
13	BASEMENT LIGHT FIXTURE	2013	3,360	39	39	39		39	13
14	TILE	2013	5,509	65	39	65		65	14
15	CUBILCE CURTAINS	2013	19,443	11,111	7	1,389	(9,722)	1,389	15
16	PAINTING	2013	10,685	534	5	534		534	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,815,893	$ 139,116		$ 97,717	$ (41,399)	$ 128,342	34

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 12D, Carried Forward		$ 1,815,893	$ 139,116		$ 97,717	$ (41,399)	$ 128,342	1
2									2
3									3
4	RELATED PARTY INFORMATION								4
5	BUILDINGS:								5
6	ALLOCATED FROM LEGACY RP	2009	62,570	2,086	30	2,086			6
7									7
8									8
9									9
10	LEASEHOLD IMPROVEMENTS:								10
11	ALLOCATED FROM LEGACY RP	2009	35,533	888	20	1,777	889		11
12	ALLOCATED FROM LEGACY RP	2010	10,805	352	20	433	81		12
13	ALLOCATED FROM LEGACY RP	2011	15,357		20	768	768		13
14									14
15									15
16									16
17									17
18									18
19									19
20	ALLOCATED FROM LEGACY HEALTHCARE FINANCIAL	2012	2,815	296	20	141	(155)		20
21	ALLOCATED FROM LEGACY HEALTHCARE FINANCIAL	2013	9,003	946	20	450	(496)		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)		$ 1,951,976	$ 143,684		$ 103,372	$ (40,312)	$ 128,342	34

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$ 29,631	$ 4,427	$ 4,427	$	5-10 YRS	$ 9,960	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	RELATED PARTY		149,204	46,550	(102,654)			74
75	TOTALS	$ 29,631	$ 153,631	$ 50,977	$ (102,654)		$ 9,960	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)	$ 1,990,765	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 297,315	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 154,349	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (142,966)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 138,302	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 CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ 1,620,894			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 1,620,894 **			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.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 37,603 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				2,093	18
19					19
20					20
21	TOTAL		$	$ 2,093	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 CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$		$ 343,267	$		$ 343,267	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			175,197			175,197	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			362,139			362,139	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				263,862		263,862	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			$		$ 880,603	$ 263,862		$ 1,144,465	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 CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013 (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	$ 162,162	$ 284,118	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (243,825))	4,019,002	4,019,002	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	56,361	56,361	6
7	Other Prepaid Expenses	114,078	114,078	7
8	Accounts Receivable (owners or related parties)	2,349,480		8
9	Other(specify): replacement reserve		261,445	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,701,083	$ 4,735,004	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		1,815,893	15
16	Equipment, at Historical Cost	29,631	468,258	16
17	Accumulated Depreciation (book methods)	(9,960)	(507,002)	17
18	Deferred Charges		3,750	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe opt dep/dep on asset		575,523	22
23	Other(specify): Lease Cost	77,476	77,476	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 97,147	$ 2,433,898	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,798,230	$ 7,168,902	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 660,964	$ 703,839	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,438,395	2,438,395	29
30	Accrued Salaries Payable	395,756	395,756	30
31	Accrued Taxes Payable (excluding real estate taxes)	28,060	28,060	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		4,815	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO RELATED PARTY		100,000	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,523,175	$ 3,670,865	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)**	$ 3,523,175	$ 3,670,865	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,275,055	$ 3,498,037	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,798,230	$ 7,168,902	48

*(See instructions.)

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,057,405	1	
2	Restatements (describe):		2	
3		3	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,057,408	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,317,647	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	(100,000)	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)**	$ 1,217,647	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)**	$ 3,275,055	24	*

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$ 13,983,862	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,983,862	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***	1,010	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,010	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS EARNED	13,733	28
28a	PAID TIME OFF		28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,733	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,998,605	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,695,735	31
32	Health Care	3,975,588	32
33	General Administration	3,593,559	33
	B. Capital Expense		
34	Ownership	1,793,252	34
	C. Ancillary Expense		
35	Special Cost Centers	1,144,465	35
36	Provider Participation Fee	478,359	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,680,958	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,317,647	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,317,647	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 9,365,555	44
45	Private Pay - Net Inpatient Revenue	672,498	45
46	Medicare - Net Inpatient Revenue	3,861,775	46
47	Other-(specify) INSURANCE	84,034	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 13,983,862	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.**

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	2,205	2,478	$ 142,541	$ 57.52	1
2	Assistant Director of Nursing	2,045	2,254	83,688	37.13	2
3	Registered Nurses	43,754	45,868	1,324,452	28.88	3
4	Licensed Practical Nurses	19,184	20,194	488,459	24.19	4
5	CNAs & Orderlies	85,513	89,628	871,110	9.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,873	8,431	130,169	15.44	8
9	Activity Director	1,764	1,879	33,938	18.06	9
10	Activity Assistants	8,207	8,778	91,775	10.46	10
11	Social Service Workers	8,131	8,624	175,529	20.35	11
12	Dietician					12
13	Food Service Supervisor	3,718	4,028	86,073	21.37	13
14	Head Cook	5,752	6,166	73,556	11.93	14
15	Cook Helpers/Assistants	19,072	20,743	211,825	10.21	15
16	Dishwashers					16
17	Maintenance Workers	6,717	7,500	137,757	18.37	17
18	Housekeepers	16,401	17,639	174,679	9.90	18
19	Laundry	6,217	6,692	64,625	9.66	19
20	Administrator	1,917	2,086	123,393	59.15	20
21	Assistant Administrator	2,019	2,271	104,169	45.87	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,833	10,344	147,258	14.24	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,158	2,295	54,727	23.85	31
32	Other Health C: care plan,ward cle	3,017	3,184	84,695	26.60	32
33	Other(specify) ADMITTING	1,957	2,029	45,915	22.63	33
34	TOTAL (lines 1 - 33)	257,454	273,111	$ 4,650,333 *	$ 17.03	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	M	$ 15,594	1-3	35
36	Medical Director	O	57,600	9-3	36
37	Medical Records Consultant	N	4,512	10-3	37
38	Nurse Consultant	T	19,230	10-3	38
39	Pharmacist Consultant	H	16,294	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,288	11-3	44
45	Social Service Consultant	E	4,240	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 119,758		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 CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SCOTT SKLAR	ADMINISTRATOR		$ 123,393
YOSEF NATHAN	ASST ADMIN		104,169
	OTHER ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 227,562

B. Administrative - Other

Description	Amount
MANAGEMENT FEES- LEGACY	$ 788,440
LEGACY HEALTHCARE FINANCIAL SERVICES	137,350
TOTAL (agree to Schedule V, line 17, col. 3)	$ 925,790
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		236,219
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 236,219

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 131,712
Unemployment Compensation Insurance	108,024
FICA Taxes	347,203
Employee Health Insurance	205,049
Employee Meals	34,536
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	18,928
EMPLOYEE PHYSICAL EXAMS	5,310
PENSION/PROFIT SHARING PLANS	15,537
CHICAGO HEAD TAX	2,068
INSURANCE - EXECUTIVE LIFE	0
PAYROLL TAXES-LEGACY/PROGRESSIVE	37,020
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 905,387

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	421
Health Care Worker Background Check	10,404
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	118,942
MARKETING/ADV/PROMO	65,161
LICENSES/DUES/SUBSCRIPTIONS	11,575
MGMT CO ALLOC	819
TRUST/FRANCHISE/CONTRIB/ETC	(118,942)
Less: Public Relations Expense	(0)
Non-allowable advertising	(65,161)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,219

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	5,475
RELATED PARTY	1,823
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,298

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ILL COUN LONG TERM CARE $ 10,722

(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? _____ 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. $ 26,004 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. $ 478,359
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. $ 34,536 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 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.