FOR BHF USE

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

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.

I. IDPH License ID Number: 0047779

Facility Name: LAKEFRONT NRSG & 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 01/01/2013 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 LAKEFRONT NRSG & REHAB CTR # 0047779 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	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,126		1,945	8,071	8
9	SNF/PED					9
10	ICF	25,306	299	949	26,554	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,432	299	2,894	34,625	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.82%

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 1,923

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 LAKEFRONT NRSG & REHAB CTR # 0047779 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	199,355	11,358	15,275	225,988		225,988		225,988			1
2	Food Purchase		169,995		169,995	(20,878)	149,117	(825)	148,292			2
3	Housekeeping	154,062	29,816	22,707	206,585		206,585	638	207,223			3
4	Laundry	28,130	5,326		33,456		33,456		33,456			4
5	Heat and Other Utilities			101,438	101,438		101,438	738	102,176			5
6	Maintenance	128,557	28,487	28,189	185,233		185,233	2,023	187,256			6
7	Other (specify):*			13,581	13,581		13,581		13,581			7
8	**TOTAL General Services**	510,104	244,982	181,190	936,276	(20,878)	915,398	2,574	917,972			8
	B. Health Care and Programs											
9	Medical Director			21,600	21,600		21,600		21,600			9
10	Nursing and Medical Records	1,479,630	54,864	100,131	1,634,625		1,634,625	(17,865)	1,616,760			10
10a	Therapy	48,005			48,005		48,005		48,005			10a
11	Activities	60,723	10,693	2,244	73,660		73,660		73,660			11
12	Social Services	64,234		4,974	69,208		69,208	3,306	72,514			12
13	CNA Training											13
14	Program Transportation			1,738	1,738		1,738	(208)	1,530			14
15	Other (specify):*							162	162			15
16	**TOTAL Health Care and Programs**	1,652,592	65,557	130,687	1,848,836		1,848,836	(14,605)	1,834,231			16
	C. General Administration											
17	Administrative	123,501		441,840	565,341		565,341	(369,484)	195,857			17
18	Directors Fees											18
19	Professional Services			108,639	108,639		108,639	4,694	113,333			19
20	Dues, Fees, Subscriptions & Promotions			113,084	113,084		113,084	(100,578)	12,506			20
21	Clerical & General Office Expenses	47,643	24,752	199,013	271,408		271,408	(82,797)	188,611			21
22	Employee Benefits & Payroll Taxes			473,764	473,764	20,878	494,642		494,642			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,750	2,750		2,750	825	3,575			24
25	Other Admin. Staff Transportation			2,736	2,736		2,736	(800)	1,936			25
26	Insurance-Prop.Liab.Malpractice			100,023	100,023		100,023	677	100,700			26
27	Other (specify):*			88,456	88,456		88,456	(69,204)	19,252			27
28	**TOTAL General Administration**	171,144	24,752	1,530,305	1,726,201	20,878	1,747,079	(616,667)	1,130,412			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,333,840	335,291	1,842,182	4,511,313		4,511,313	(628,698)	3,882,615			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 NRSG & REHAB CTR #0047779 **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	15,275	
	REPAIRS & MAINTENANCE		0	
			0	15,275
3	**HOUSEKEEPING**			
	PROPERTY SPECIALIST - LEGACY		22,707	
			0	22,707
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		38,597	
	ELECTRICITY		36,824	
	WATER		20,475	
	CABLE TV - LOBBY		5,542	
			0	101,438
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		1,142	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		5,821	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		12,931	
	ELEVATOR MAINTENANCE & REPAIR		2,700	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,165	
	FIRE SERVICE		1,430	
			0	
			0	
			0	28,189
7	**OTHER**			
	SCAVENGER		7,288	
	SECURITY SERVICE		6,293	
			0	
			0	13,581
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	21,600	21,600

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		3,308	
	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	6,761	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	CLERGY	XVIII B 38-2	2,173	
	NURSING		60,759	
	LEGACY - PROGRESSIVE		27,130	100,131
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	2,244	
			0	2,244
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	4,974	
				4,974
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number LAKEFRONT NRSG & REHAB CTR **#0047779** **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		1,738	1,738
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES & OTHER ADMIN FEES	XIX B	441,840	441,840
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	33,650	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	74,989	
			0	108,639
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	3,278	
	EMPLOYEE WANT ADS	XIX F	25	
	CONTRIBUTIONS	VI 20 XIX F	92,418	
	DUES & SUBSCRIPTIONS	XIX F	5,342	
	LICENSES & PERMITS	XIX F	2,786	
	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	5,251	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	3,984	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				113,084
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		419	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		165,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	813	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		15,781	
	MESSENGER SERVICE		0	
	LEGACY SPECIFIC SALARIES		17,000	199,013

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	174,887	
	UNEMPLOYMENT COMPENSATION	XIX D	70,823	
	WORKERS COMPENSATION INSURANC	XIX D	58,646	
	HOSPITALIZATION INSURANCE	XIX D	144,219	
	EMPLOYEE BENEFITS - OTHER	XIX D	2,798	
	EMPLOYEE PHYSICAL EXAMS	XIX D	925	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	8,521	
	CHICAGO HEAD TAX	XIX D	1,452	
	PAYROLL TAXES - LEGACY		11,493	473,764
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	
				0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	2,750	
	TRAVEL	XIX G	0	
				2,750
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		2,736	
				2,736
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		100,023	
				100,023
27	**OTHER**			
	BAD DEBTS	VI 24	88,456	
				88,456

GRAND TOTAL COLUMN 3 OTHER **1,842,182**

LAKEFRONT NRSG & REHAB CTR
SCHEDULES
12/31/2013

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

TOTAL FOOD PURCHASE	169,995
LESS SALES TAX	(837)
NET FOOD	169,158
TOTAL PATIENT CENSUS	34,625
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	103,875
ADD # EMPLOYEE MEALS/DAY	40
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	14,600
PATIENT MEALS	103,875
ADD EMPLOYEE MEALS	14,600
TOTAL MEALS/YEAR	118,475
NET FOOD	169,158
DIVIDE TOTAL MEALS/YEAR	118,475
COST PER MEAL	1.43
TIMES EMPLOYEE MEALS	14,600
EMPLOYEE MEAL RECLASSIFICATION	**20,878**

Facility Name & ID Number LAKEFRONT NRSG & REHAB CTR #0047779 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			21,303	21,303		21,303	12,044	33,347			30
31	Amortization of Pre-Op. & Org.			1,774	1,774		1,774		1,774			31
32	Interest			12,984	12,984		12,984	(1,658)	11,326			32
33	Real Estate Taxes					108,532	108,532	1,975	110,507			33
34	Rent-Facility & Grounds			614,938	614,938	(108,532)	506,406		506,406			34
35	Rent-Equipment & Vehicles			7,617	7,617		7,617		7,617			35
36	Other (specify):*											36
37	**TOTAL Ownership**			658,616	658,616		658,616	12,361	670,977			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		89,242	198,755	287,997		287,997		287,997			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			250,817	250,817		250,817		250,817			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		89,242	449,572	538,814		538,814		538,814			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,333,840	424,533	2,950,370	5,708,743		5,708,743	(616,337)	5,092,406			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 NRSG & REHAB CTR # 0047779 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	8,240	30		9
10	Interest and Other Investment Income	(546)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(837)	2		13
14	Non-Care Related Interest	(2,995)	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	(813)	21		18
19	Entertainment		20		19
20	Contributions	(97,669)	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	(88,456)	27		24
25	Fund Raising, Advertising and Promotional	(3,278)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		10		28
29	Other-Attach Schedule	(110,070)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (296,424)		$	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)	(319,913)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (319,913)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (616,337)		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 NRSG & REHAB CTR

ID# 0047779

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	BANK CHARGES	$ (419)	21	1
2	CHAIM RAJCHENBACH MNGMNT FEES	(54,000)	17	2
3	JACK RAJCHENBACH MNGMNT FEES	(27,000)	17	3
4	RONALD SHABAT MNGMNT FEES	(27,000)	17	4
5	DISALLOWED TRANSPORTATION	(800)	25	5
6	KALISH FAMILY CONSULTING	(643)	19	6
7	LIFELINE AMBULANCE	(208)	14	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**	(110,070)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LAKEFRONT NRSG & REHAB CTR # 0047779 **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	(837)	0	12	0	0	0	0	0	0	0	0	(825)	2
3	Housekeeping	0	0	638	0	0	0	0	0	0	0	0	638	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	738	0	0	0	0	0	0	0	0	738	5
6	Maintenance	0	0	2,023	0	0	0	0	0	0	0	0	2,023	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(837)	0	3,411	0	0	0	0	0	0	0	0	2,574	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	(17,865)	0	0	0	0	0	0	(17,865)	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	3,306	0	0	0	0	0	0	3,306	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(208)	0	0	0	0	0	0	0	0	0	0	(208)	14
15	Other (specify):*	0	0	0	0	162	0	0	0	0	0	0	162	15
16	**TOTAL Health Care and Programs**	(208)	0	0	0	(14,397)	0	0	0	0	0	0	(14,605)	16
	C. General Administration													
17	Administrative	(108,000)	0	(270,151)	0	8,667	0	0	0	0	0	0	(369,484)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(643)	0	5,140	0	197	0	0	0	0	0	0	4,694	19
20	Fees, Subscriptions & Promotions	(100,947)	0	337	16	16	0	0	0	0	0	0	(100,578)	20
21	Clerical & General Office Expenses	(1,232)	0	(82,637)	0	1,072	0	0	0	0	0	0	(82,797)	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	788	0	37	0	0	0	0	0	0	825	24
25	Other Admin. Staff Transportation	(800)	0	0	0	0	0	0	0	0	0	0	(800)	25
26	Insurance-Prop.Liab.Malpractice	0	0	677	0	0	0	0	0	0	0	0	677	26
27	Other (specify):*	(88,456)	0	18,837	0	415	0	0	0	0	0	0	(69,204)	27
28	**TOTAL General Administration**	(300,078)	0	(327,009)	16	10,404	0	0	0	0	0	0	(616,667)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(301,123)	0	(323,598)	16	(3,993)	0	0	0	0	0	0	(628,698)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKEFRONT NRSG & REHAB CTR # 0047779 **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	8,240	0	1,564	2,240	0	0	0	0	0	0	0	12,044	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,541)	0	11	1,872	0	0	0	0	0	0	0	(1,658)	32
33	Real Estate Taxes	0	0	0	1,975	0	0	0	0	0	0	0	1,975	33
34	Rent-Facility & Grounds	0	0	5,911	(5,911)	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	4,699	0	7,486	176	0	0	0	0	0	0	0	12,361	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)**	(296,424)	0	(316,112)	192	(3,993)	0	0	0	0	0	0	(616,337)	45

Facility Name & ID Number LAKEFRONT NRSG & REHAB CTR # 0047779 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
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 NRSG & REHAB CTR # 0047779 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			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 NRSG & REHAB CTR # 0047779 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	$ 288,000	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		$	$ (288,000)	15
16	V	21	OUTSIDE CLERICAL	165,000	LEGACY HEALTHCARE FINANCIAL SERVICES LLC			(165,000)	16
17	V	2	FOOD		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		12	12	17
18	V	3	HOUSEKEEPING		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		638	638	18
19	V	5	UTILITIES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		738	738	19
20	V	6	GROUNDS & MAINTENANCE		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		2,023	2,023	20
21	V	17	MANAGEMENT FEES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		17,849	17,849	21
22	V	19	PROFESSIONAL FEES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		5,140	5,140	22
23	V	20	FEES,SUBSCRIPTIONS		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		337	337	23
24	V	21	CLERICAL & GENERAL		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		82,363	82,363	24
25	V	24	SEMINARS		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		788	788	25
26	V	26	INSURANCE		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		677	677	26
27	V	27	EMPL BENEFITS-GEN ADMIN		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		12,902	12,902	27
28	V	27	EMPL BENEFITS-OWNERS		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		5,935	5,935	28
29	V	30	DEPRECIATION		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		1,564	1,564	29
30	V	32	INTEREST		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		11	11	30
31	V	34	RENT		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		5,911	5,911	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 453,000			$ 136,888	$ * (316,112)	39

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

Facility Name & ID Number LAKEFRONT NRSG & REHAB CTR # 0047779 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	$ 5,911	LEGACY REAL PROPERTIES LLC		$	$ (5,911)	15
16	V	20	DUES & SUBSCRIPTIONS		LEGACY REAL PROPERTIES LLC		16	16	16
17	V	30	DEPRECIATION		LEGACY REAL PROPERTIES LLC		2,240	2,240	17
18	V	32	INTEREST EXPENSE		LEGACY REAL PROPERTIES LLC		1,872	1,872	18
19	V	33	REAL ESTATE TAXES		LEGACY REAL PROPERTIES LLC		1,975	1,975	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			$ 5,911			$ 6,103	$ * 192	39

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

Facility Name & ID Number LAKEFRONT NRSG & REHAB CTR # 0047779 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	$ 24,000	PROGRESSIVE HEALTHCARE CONSULTING		$	$ (24,000)	15
16	V	10	NURSING SALARIES		PROGRESSIVE HEALTHCARE CONSULTING		6,135	6,135	16
17	V	12	CLERGY SALARY		PROGRESSIVE HEALTHCARE CONSULTING		405	405	17
18	V	12	ADMISSIONS SALARY		PROGRESSIVE HEALTHCARE CONSULTING		2,901	2,901	18
19	V	15	EMPL BENEFIT- NURSING		PROGRESSIVE HEALTHCARE CONSULTING		162	162	19
20	V	17	ADMIN SALARY-non owners		PROGRESSIVE HEALTHCARE CONSULTING		8,667	8,667	20
21	V	19	PROSFESSIONAL FEES		PROGRESSIVE HEALTHCARE CONSULTING		197	197	21
22	V	20	FEES, SUBSCRIPTIONS		PROGRESSIVE HEALTHCARE CONSULTING		16	16	22
23	V	21	CLERICAL & GEN OFFICE		PROGRESSIVE HEALTHCARE CONSULTING		1,072	1,072	23
24	V	24	SEMINARS		PROGRESSIVE HEALTHCARE CONSULTING		37	37	24
25	V	27	AUTO AND TRAVEL		PROGRESSIVE HEALTHCARE CONSULTING		415	415	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			$ 20,007	$ * (3,993)	39

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

Facility Name & ID Number LAKEFRONT NRSG & REHAB CTR # 0047779 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	3	PROPERTY SPECIALIST	$ 22,707	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		$ 22,707	$	15
16	V	10	DIRECTOR OF NURSING	7,628	PROGRESSIVE HEALTHCARE CONSULTING		7,628		16
17	V	10	CLINICAL NURSE	4,831	PROGRESSIVE HEALTHCARE CONSULTING		4,831		17
18	V	10	MDS COORDINATOR	7,612	PROGRESSIVE HEALTHCARE CONSULTING		7,612		18
19	V	10	E.H.R. IMPLEMENTATION	7,059	PROGRESSIVE HEALTHCARE CONSULTING		7,059		19
20	V	17	ADMINISTRATOR	40,353	PROGRESSIVE HEALTHCARE CONSULTING		40,353		20
21	V	17	ASST ADMINISTRATOR	5,487	PROGRESSIVE HEALTHCARE CONSULTING		5,487		21
22	V	21	AR FIELD COORDINATOR	5,210	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		5,210		22
23	V	21	IN-HOUSE COUNSEL	5,503	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		5,503		23
24	V	21	CORPORATE IT DIRECTOR	1,795	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		1,795		24
25	V	21	CORPORATE TRAINOR	4,108	PROGRESSIVE HEALTHCARE CONSULTING		4,108		25
26	V	21	PERSONNEL	384	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		384		26
27	V	22	PAYROLL TAXES	3,550	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		3,550		27
28	V	22	PAYROLL TAXES	7,943	PROGRESSIVE HEALTHCARE CONSULTING		7,943		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			$ 124,170			$ 124,170	$ *	39

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

Facility Name & ID Number LAKEFRONT NRSG & REHAB CTR # 0047779 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	MENACHEM SHABAT	MEMBER	ADMINISTRATIV	99.00	SEE ATTACHED			MGMT FEE	$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number LAKEFRONT NRSG & REHAB CTR # 0047779 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 LAKEFRONT NRSG & REHAB CTR # 0047779 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	$	36,135	$ 12	1
2	3	HOUSEKEEPING	Bed Days Available	809,780	17	14,291	12,745	36,135	638	2
3	5	UTILITIES	Bed Days Available	809,780	17	16,531		36,135	738	3
4	6	GROUNDS & MAINTENANCE	Bed Days Available	809,780	17	45,337		36,135	2,023	4
5	17	MANAGEMENT FEES	Bed Days Available	809,780	17	400,000	400,000	36,135	17,849	5
6	19	PROFESSIONAL FEES	Bed Days Available	809,780	17	115,181		36,135	5,140	6
7	20	FEES,SUBSCRIPTIONS	Bed Days Available	809,780	17	7,563		36,135	337	7
8	21	CLERICAL & GENERAL	Bed Days Available	809,780	17	1,845,746	1,700,817	36,135	82,363	8
9	24	SEMINARS	Bed Days Available	809,780	17	17,652		36,135	788	9
10	26	INSURANCE	Bed Days Available	809,780	17	15,170		36,135	677	10
11	27	EMPL BENEFITS-GEN ADMIN	Bed Days Available	809,780	17	289,128		36,135	12,902	11
12	27	EMPL BENEFITS-OWNERS	Bed Days Available	809,780	17	133,004		36,135	5,935	12
13	30	DEPRECIATION	Bed Days Available	809,780	17	35,039		36,135	1,564	13
14	32	INTEREST	Bed Days Available	809,780	17	242		36,135	11	14
15	34	RENT	Bed Days Available	809,780	17	132,473		36,135	5,911	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		$ 136,888	25

Facility Name & ID Number LAKEFRONT NRSG & REHAB CTR # 0047779 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	$	36,135	$ 16	1
2	30	DEPRECIATION	Bed Days Available	809,780	17	50,196		36,135	2,240	2
3	32	INTEREST EXPENSE	Bed Days Available	809,780	17	41,954		36,135	1,872	3
4	33	REAL ESTATE TAXES	Bed Days Available	809,780	17	44,250		36,135	1,975	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	$		$ 6,103	25

Facility Name & ID Number LAKEFRONT NRSG & REHAB CTR # 0047779 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	36,135	$ 6,135	1
2	12	CLERGY SALARY	Bed Days Available	550,071	11	6,165	6,165	36,135	405	2
3	12	ADMISSIONS SALARY	Bed Days Available	550,071	11	44,165	44,165	36,135	2,901	3
4	15	EMPL BENEFIT- NURSING	Bed Days Available	550,071	11	2,467		36,135	162	4
5	17	ADMIN SAL-NON OWNERS	Bed Days Available	550,071	11	131,937	131,937	36,135	8,667	5
6	19	PROSFESSIONAL FEES	Bed Days Available	550,071	11	3,003		36,135	197	6
7	20	FEES, SUBSCRIPTIONS	Bed Days Available	550,071	11	250		36,135	16	7
8	21	CLERICAL & GEN OFFICE	Bed Days Available	550,071	11	16,314		36,135	1,072	8
9	24	SEMINARS	Bed Days Available	550,071	11	560		36,135	37	9
10	27	AUTO AND TRAVEL	Bed Days Available	550,071	11	6,314		36,135	415	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		$ 20,007	25

Facility Name & ID Number LAKEFRONT NRSG & REHAB CTR # 0047779 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	RELATED PARTY										1,883	2
3												3
4												4
5												5
	Working Capital											
6												6
7	BANK FINANCIAL		X	WORKING CAPITAL	INTEREST			238,527	REVOLV	prime +	8,355	7
8				INSURANCE							1,634	8
9	TOTAL Facility Related						$	$ 238,527			$ 11,872	9
	B. Non-Facility Related*											
10	LOCAL 4										2,995	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 2,995	14
15	TOTALS (line 9+line14)						$	$ 238,527			$ 14,867	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 NRSG & REHAB CTR # 0047779 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.)		$ 110,507	2
3. Under or (over) accrual (line 2 minus line 1).		$ 110,507	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.		$ 110,507	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	107,599	8
	2009	96,716	9
	2010	103,431	10
	2011	102,640	11
	2012	110,507	12

	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 LAKEFRONT NRSG & REHAB CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0047779

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.	11-29-108-011-0000	NURSING HOME	$ 54,266.16	$ 54,266.16
2.	11-29-108-012-0000	NURSING HOME	$ 54,266.16	$ 54,266.16
3.			$	$
4.	10-35-104-076-0000	HOME OFFICE ALLOCATION	$ 44,384.00	$ 1,975.00
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 152,916.32	$ 110,507.32

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 LAKEFRONT NRSG & REHAB CTR # 0047779 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	RELATED PARTY LEGACY		2009	$ 5,009	1
2					2
3	TOTALS			$ 5,009	3

Facility Name & ID Number LAKEFRONT NRSG & REHAB CTR # 0047779 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	NEW FLOOR IN COOLER			2006	1,528	56	27.5	56		330	9
10	EXHAUST FAN			2006	2,400	87	27.5	87		515	10
11	SECURITY SYSTEM			2006	27,540	1,001	27.5	1,001		5,925	11
12	ELEVATOR REHAB			2006	17,126	623	27.5	623		3,685	12
13	WATER PUMP			2006	4,500	164	27.5	164		970	13
14	ELECTRICAL WORK			2006	2,175	79	27.5	79		467	14
15	NURSE CALL SYSTEM			2007	9,378	341	27.5	341		2,060	15
16	DOOR			2007	5,365	195	27.5	195		999	16
17	WIRING FOR CABLE			2007	6,200	225	27.5	225		1,638	17
18	PAINTING & WALLPAPER			2007	25,660		5			25,660	18
19	LIGHT FIXTURES			2007	6,431	234	27.5	234		1,277	19
20	CUSTOM NURSE STATION			2007	11,517	419	27.5	419		2,287	20
21	COVE BASE, VCT, VINYL SHEET			2007	22,486	818	27.5	818		4,465	21
22	HAND RAILS & BUMPERS			2007	6,434	234	27.5	234		1,277	22
23	DRAPERIES			2007	3,063	111	27.5	111		606	23
24	WALLCOVERINGS			2007	4,121	150	27.5	150		819	24
25	SHOWER REHAB			2008	4,600	167	27.5	167		745	25
26	BOILER			2008	10,700	389	27.5	389		1,734	26
27	FIRE DOORS			2009	47,687	1,734	27.5	1,734		7,080	27
28	handrails, flooring, wallpaper,drywall,wallguards less 65,529 ins			2009	10,326	375	27.5	375		1,531	28
29	FIRE ALARM SYSTEM			2009	54,000	1,964	27.5	1,964		8,020	29
30	SIGN			2009	4,558	166	27.5	166		678	30
31	PUMP,CONDENSOR,COIL FOR CHILLER			2010	4,600	167	27.5	167		731	31
32	KITCHEN CABINETS,FLOORING,COUNTER TOPS AND PLUMBIN			2011	10,290	374	27.5	374		889	32
33	FIRE DAMPERS			2011	6,700	244	27.5	244		579	33
34	FIRE SPRINKLER			2011	4,250	154	27.5	154		366	34
35	BURGLAR/FIRE ARARM SYSTEM			2012	5,966	217	27.5	217		280	35
36	PED DR,FRAME,SIDELIGHT, & TRANSOM- PATIO NORTH			2012	9,060	329	27.5	329		425	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 NRSG & REHAB CTR # 0047779 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	NEW EJECTOR PUMPS	2012	$ 6,975	$ 254	27.5	$ 254	$	$ 328	37
38	EXHAUST FAN	2012	5,550	202	27.5	202		261	38
39	new walls,fire preventive work & plumbing-various locations	2012	7,675	279	27.5	279		360	39
40	CHILLER 15 TON COMPRESSOR	2012	18,402	669	27.5	669		864	40
41	EXHAUST FAN	2012	8,287	301	27.5	301		389	41
42	CHIMNEY WITH STAINLESS STEEL LINER AND TOP	2012	2,998	109	27.5	109		141	42
43	NEW RAMP	2012	1,245	83	15	83		93	43
44	CONCRETE	2012	34,100	2,273	15	2,273		2,558	44
45	42" GUARD RAIL WITH 34" HAND RAIL	2013	16,000	315	27.5	315		315	45
46	CABINETS AND WORKSTATION	2013	3,750	74	27.5	74		74	46
47	1 ST AND 2ND FLOOR FIRE RATED CORRIDOR DOORS	2013	13,107	258	27.5	258		258	47
48	KITCHEN GARBAGE DISPOSAL	2013	7,977	157	27.5	157		157	48
49	NEW PATIO IN FRONT OF WALK	2013	4,975	166	15	166		166	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)		$ 459,702	$ 16,157		$ 16,157	$	$ 82,002	70

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

Facility Name & ID Number LAKEFRONT NRSG & REHAB CTR # 0047779 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		$ 459,702	$ 16,157		$ 16,157	$	$ 82,002	1
2									2
3									3
4	RELATED PARTY INFORMATION								4
5	BUILDINGS:								5
6	ALLOCATED FROM LEGACY RP	2009	28,285	943	30	943		4,243	6
7									7
8									8
9									9
10	LEASEDHOLD IMPROVEMENTS:								10
11	ALLOCATED FROM LEGACY RP	2009	16,063	402	20	803	401		11
12	ALLOCATED FROM LEGACY RP	2010	4,884	158	20	196	38		12
13	ALLOCATED FROM LEGACY RP	2011	6,942		20	347	347		13
14									14
15									15
16									16
17									17
18									18
19									19
20	ALLOCATED FROM LEGACY HEALTHCARE FINANCIAL	2012	1,272	134	20	64	(70)		20
21	ALLOCATED FROM LEGACY HEALTHCARE FINANCIAL	2013	4,070	428	20	203	(225)		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)		$ 521,218	$ 18,222		$ 18,713	$ 491	$ 86,245	34

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

Facility Name & ID Number LAKEFRONT NRSG & REHAB CTR # 0047779 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	$ 119,597	$ 3,393	$ 12,657	$ 9,264	10 YRS	$ 79,695	71
72	Current Year Purchases	4,742	1,753	238	(1,515)	10 YRS	238	72
73	Fully Depreciated Assets							73
74	RELATED PARTY		1,739	1,739				74
75	TOTALS	$ 124,339	$ 6,885	$ 14,634	$ 7,749		$ 79,933	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)	$ 650,566	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 25,107	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 33,347	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,240	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 166,178	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 NRSG & REHAB CTR # 0047779 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: 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		$ 614,938			3
4	Additions							4
5								5
6								6
7	TOTAL		99		$ 614,938 **			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: $ 7,617 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 NRSG & REHAB CTR # 0047779 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.

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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	$		$ 82,530	$		$ 82,530	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			35,703			35,703	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			80,361			80,361	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				89,242		89,242	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): I.V.					161			161	13
14	TOTAL			$		$ 198,755	$ 89,242		$ 287,997	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 NRSG & REHAB CTR # 0047779 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	$ 39,241	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (353,386))	764,687		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	84,304		6
7	Other Prepaid Expenses	106,086		7
8	Accounts Receivable (owners or related parties)	2,115		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 996,433	$	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	434,042		15
16	Equipment, at Historical Cost	182,294		16
17	Accumulated Depreciation (book methods)	(239,235)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	26,610		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(13,749)		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)**	$ 389,962	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,386,395	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 549,048	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,353		28
29	Short-Term Notes Payable	238,527		29
30	Accrued Salaries Payable	70,824		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,651		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	80,350		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 971,753	$	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)**	$ 971,753	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 414,642	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,386,395	$	48

***(See instructions.)**

Facility Name & ID Number LAKEFRONT NRSG & REHAB CTR # 0047779 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**	$ 872,192	1	
2	Restatements (describe):		2	
3		5	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 872,197	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(25,555)	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	(432,000)	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)**	$ (457,555)	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)**	$ 414,642	24	*

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

Facility Name & ID Number LAKEFRONT NRSG & REHAB CTR # 0047779 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	$ 5,682,196	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,682,196	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***	546	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 546	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,682,742	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	936,276	31
32	Health Care	1,848,836	32
33	General Administration	1,726,201	33
	B. Capital Expense		
34	Ownership	658,616	34
	C. Ancillary Expense		
35	Special Cost Centers	287,997	35
36	Provider Participation Fee	250,817	36
	D. Other Expenses (specify):		
37	OTHER EXPENSE ADJUSTMENTS	(1,799)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,706,944	40
41	**Income before Income Taxes (line 30 minus line 40)****	(24,202)	41
42	**Income Taxes**	(1,353)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (25,555)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,404,382	44
45	Private Pay - Net Inpatient Revenue	50,830	45
46	Medicare - Net Inpatient Revenue	1,088,014	46
47	Other-(specify) VETERAN	138,970	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,682,196	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	1,957	2,238	$ 101,183	$ 45.21	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,921	13,350	345,756	25.90	3
4	Licensed Practical Nurses	14,165	15,524	335,725	21.63	4
5	CNAs & Orderlies	49,818	55,967	576,848	10.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,572	2,735	48,005	17.55	8
9	Activity Director	1,973	2,126	38,097	17.92	9
10	Activity Assistants	1,848	1,969	22,626	11.49	10
11	Social Service Workers	3,442	3,660	64,234	17.55	11
12	Dietician					12
13	Food Service Supervisor	1,977	2,116	38,083	18.00	13
14	Head Cook	1,465	1,513	13,283	8.78	14
15	Cook Helpers/Assistants	13,721	15,543	147,989	9.52	15
16	Dishwashers					16
17	Maintenance Workers	9,722	10,763	128,557	11.94	17
18	Housekeepers	14,032	15,357	154,062	10.03	18
19	Laundry	2,671	2,973	28,130	9.46	19
20	Administrator	1,933	2,303	123,501	53.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,103	4,595	47,643	10.37	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)	2,007	2,285	28,081	12.29	30
31	Medical Records	2,007	2,206	61,378	27.82	31
32	Other Health C: NURSING CLERI	2,503	2,668	30,659	11.49	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	143,837	159,891	$ 2,333,840 *	$ 14.60	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	$ 15,275	1-3	35
36	Medical Director	O	21,600	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	2,173	10-3	38
39	Pharmacist Consultant	H	6,761	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	2,244	11-3	44
45	Social Service Consultant	E	4,974	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 53,027		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
AHARON ADLER	ADMINISTRATOR		$ 123,501
			0
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 123,501

B. Administrative - Other

Description	Amount
SEE ATTACHED SCHEDULE	$ 441,840
TOTAL (agree to Schedule V, line 17, col. 3)	$ 441,840
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		108,639
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 108,639

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,646
Unemployment Compensation Insurance	70,823
FICA Taxes	174,887
Employee Health Insurance	144,219
Employee Meals	20,878
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	2,798
EMPLOYEE PHYSICAL EXAMS	925
PENSION/PROFIT SHARING PLANS	8,521
CHICAGO HEAD TAX	1,452
INSURANCE - EXECUTIVE LIFE	0
PAYROLL TAX - LEGACY & PROGRESSIVE	11,493
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 494,642

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	25
Health Care Worker Background Check	3,984
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	97,669
MARKETING/ADV/PROMO	3,278
LICENSES/DUES/SUBSCRIPTIONS	8,128
MGMT CO ALLOC	369
TRUST/FRANCHISE/CONTRIB/ETC	(97,669)
Less: Public Relations Expense	(0)
Non-allowable advertising	(3,278)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,506

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	2,750
RELATED PARTY	825
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,575

* 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 NRSG & REHAB CTR # 0047779 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 $4,847**

(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. $ **7,552** 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. $ **250,817**
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. $ **20,878** 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.