FOR BHF USE

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0047779

Facility Name: LAKEFRONT NRSING & REHAB CTR

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

County: COOK

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: 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 01/01/2014 to 12/31/2014 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 NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

III. STATISTICAL DATA

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

	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			2,261	2,261	8
9	SNF/PED					9
10	ICF	30,868	259	1,138	32,265	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,868	259	3,399	34,526	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.55%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

I. On what date did you start providing long term care at this location?
Date started 04/01/06

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/06 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 99 and days of care provided 2,261

Medicare Intermediary NATIONAL GOVERNMENT SERVICE

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number LAKEFRONT NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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	200,565	13,360	17,722	231,647		231,647		231,647			1
2	Food Purchase		177,554		177,554	(21,900)	155,654	(819)	154,835			2
3	Housekeeping	129,563	22,846		152,409		152,409	458	152,867			3
4	Laundry	36,270	10,496		46,766		46,766		46,766			4
5	Heat and Other Utilities			100,719	100,719		100,719	913	101,632			5
6	Maintenance	150,619	31,036	36,921	218,576		218,576	(10,901)	207,675			6
7	Other (specify):*			14,351	14,351		14,351		14,351			7
8	TOTAL General Services	517,017	255,292	169,713	942,022	(21,900)	920,122	(10,349)	909,773			8
	B. Health Care and Programs											
9	Medical Director			21,600	21,600		21,600		21,600			9
10	Nursing and Medical Records	1,488,595	53,754	116,696	1,659,045		1,659,045	(21,890)	1,637,155			10
10a	Therapy	46,285			46,285		46,285		46,285			10a
11	Activities	60,524	12,438	2,448	75,410		75,410	187	75,597			11
12	Social Services	67,777		3,111	70,888		70,888	2,152	73,040			12
13	CNA Training											13
14	Program Transportation			2,245	2,245		2,245	(1,689)	556			14
15	Other (specify):*							85	85			15
16	TOTAL Health Care and Programs	1,663,181	66,192	146,100	1,875,473		1,875,473	(21,155)	1,854,318			16
	C. General Administration											
17	Administrative	125,415		425,380	550,795		550,795	(379,159)	171,636			17
18	Directors Fees											18
19	Professional Services			131,687	131,687		131,687	3,370	135,057			19
20	Dues, Fees, Subscriptions & Promotions			123,622	123,622		123,622	(106,617)	17,005			20
21	Clerical & General Office Expenses	47,127	17,833	221,349	286,309		286,309	(96,325)	189,984			21
22	Employee Benefits & Payroll Taxes			482,851	482,851	21,900	504,751		504,751			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,030	2,030		2,030	(502)	1,528			24
25	Other Admin. Staff Transportation			1,834	1,834		1,834		1,834			25
26	Insurance-Prop.Liab.Malpractice			115,050	115,050		115,050	436	115,486			26
27	Other (specify):*			64,777	64,777		64,777	(46,460)	18,317			27
28	TOTAL General Administration	172,542	17,833	1,568,580	1,758,955	21,900	1,780,855	(625,257)	1,155,598			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,352,740	339,317	1,884,393	4,576,450		4,576,450	(656,761)	3,919,689			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 NRSING & REHAB CTR #0047779 **Report Period Beginning: 01/01/2014** **Ending: 12/31/2014**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	17,578	
	REPAIRS & MAINTENANCE		0	
	DIETARY EQUIPMENT		144	17,722
3	**HOUSEKEEPING**			
			0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
				0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		35,463	
	ELECTRICITY		37,476	
	WATER		22,219	
	CABLE TV - LOBBY		5,561	
				100,719
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,558	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		20,218	
	ELEVATOR MAINTENANCE & REPAIR		7,432	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,250	
	FIRE SERVICE		1,463	
				36,921
7	**OTHER**			
	SCAVENGER		5,580	
	SECURITY SERVICE		8,771	
				14,351
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		7,837	
	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	7,722	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	NURSING-LEGACY/PROGRESSIVE	XVIII B __-2	35,271	
	CLERGY	XVIII B 38-2	1,685	
	NURSING		12,000	
	NURSING PROGRAM CONSULTANT		52,181	116,696
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,448	
				2,448
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	3,111	
				3,111
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number LAKEFRONT NRSING & REHAB CTR **#0047779** **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		2,245	
				2,245
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES & OTHER ADMIN FEES	XIX B	425,380	425,380
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	40,610	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	91,077	
				131,687
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	4,693	
	EMPLOYEE WANT ADS	XIX F	25	
	CONTRIBUTIONS	VI 20 XIX F	100,536	
	DUES & SUBSCRIPTIONS	XIX F	10,714	
	LICENSES & PERMITS	XIX F	2,390	
	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	1,649	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	3,615	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				123,622
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		244	
	EQUIPMENT REPAIR & MAINTENANCE		660	
	OUTSIDE CLERICAL SERVICES		165,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	36	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		19,100	
	MESSENGER SERVICE		0	
	LEGACY SPECIFIC SALARIES		36,309	221,349

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	175,325	
	UNEMPLOYMENT COMPENSATION	XIX D	50,544	
	WORKERS COMPENSATION INSURANC	XIX D	55,697	
	HOSPITALIZATION INSURANCE	XIX D	170,761	
	EMPLOYEE BENEFITS - OTHER	XIX D	328	
	EMPLOYEE PHYSICAL EXAMS	XIX D	1,578	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	17,671	
	CHICAGO HEAD TAX	XIX D	0	
	PAYROLL TAXES - LEGACY		10,947	482,851
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	
				0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	1,260	
	TRAVEL	XIX G	0	
	ENTERTAINMENT		770	
				2,030
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		1,834	
				1,834
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		115,050	
				115,050
27	**OTHER**			
	BAD DEBTS	VI 24	64,777	
				64,777

GRAND TOTAL COLUMN 3 OTHER **1,884,393**

LAKEFRONT NRSING & REHAB CTR
SCHEDULES
12/31/2014

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

TOTAL FOOD PURCHASE	177,554
LESS SALES TAX	(824)
NET FOOD	176,730
TOTAL PATIENT CENSUS	34,526
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	103,578
ADD # EMPLOYEE MEALS/DAY	40
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	14,600
PATIENT MEALS	103,578
ADD EMPLOYEE MEALS	14,600
TOTAL MEALS/YEAR	118,178
NET FOOD	176,730
DIVIDE TOTAL MEALS/YEAR	118,178
COST PER MEAL	1.50
TIMES EMPLOYEE MEALS	14,600
EMPLOYEE MEAL RECLASSIFICATION	**21,900**

Facility Name & ID Number LAKEFRONT NRSING & REHAB CTR #0047779 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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			25,316	25,316		25,316	7,915	33,231			30
31	Amortization of Pre-Op. & Org.			1,774	1,774		1,774		1,774			31
32	Interest			15,720	15,720		15,720	798	16,518			32
33	Real Estate Taxes					110,001	110,001	1,466	111,467			33
34	Rent-Facility & Grounds			623,368	623,368	(110,001)	513,367		513,367			34
35	Rent-Equipment & Vehicles			8,517	8,517		8,517	16	8,533			35
36	Other (specify):*											36
37	**TOTAL Ownership**			674,695	674,695		674,695	10,195	684,890			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		99,357	299,347	398,704		398,704		398,704			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			256,324	256,324		256,324		256,324			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		99,357	555,671	655,028		655,028		655,028			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,352,740	438,674	3,114,759	5,906,173		5,906,173	(646,566)	5,259,607			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 NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VI. ADJUSTMENT DETAIL

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

	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	5,091	30		9
10	Interest and Other Investment Income	(227)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(824)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(36)	21		18
19	Entertainment		20		19
20	Contributions	(102,185)	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	(64,777)	27		24
25	Fund Raising, Advertising and Promotional	(4,693)	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	(122,703)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (290,354)		$	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)	(356,212)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (356,212)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (646,566)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

LAKEFRONT NRSING & REHAB CTR

ID# 0047779

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	BANK CHARGE	$ (244)	21	1
2	DISALLOWED AUTO LEASING	(1,284)	14	2
3	DISALLOWED ENTERTAINMENT	(770)	24	3
4	MANAGEMENT FEES- CHAIM RAJCHENBACH	(54,000)	17	4
5	MANAGEMENT FEES- JACK RAJCHENBACH	(27,000)	17	5
6	MANAGEMENT FEES- RONALD SHABAT	(27,000)	17	6
7	RELATED PARTY- ML GROUP	(12,000)	6	7
8	RELATED PARTY- LIFELINE AMBULANCE	(405)	14	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**	(122,703)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LAKEFRONT NRSING & REHAB CTR # 0047779 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(824)	0	(1)	0	6	0	0	0	0	0	0	(819)	2
3	Housekeeping	0	0	458	0	0	0	0	0	0	0	0	458	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	913	0	0	0	0	0	0	0	0	913	5
6	Maintenance	(12,000)	0	1,063	0	36	0	0	0	0	0	0	(10,901)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(12,824)	0	2,433	0	42	0	0	0	0	0	0	(10,349)	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	(21,890)	0	0	0	0	0	0	(21,890)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	187	0	0	0	0	0	0	0	0	187	11
12	Social Services	0	0	0	0	2,152	0	0	0	0	0	0	2,152	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(1,689)	0	0	0	0	0	0	0	0	0	0	(1,689)	14
15	Other (specify):*	0	0	0	0	85	0	0	0	0	0	0	85	15
16	**TOTAL Health Care and Programs**	(1,689)	0	187	0	(19,653)	0	0	0	0	0	0	(21,155)	16
	C. General Administration													
17	Administrative	(108,000)	0	(274,746)	0	3,587	0	0	0	0	0	0	(379,159)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	3,071	51	248	0	0	0	0	0	0	3,370	19
20	Fees, Subscriptions & Promotions	(106,878)	0	252	0	9	0	0	0	0	0	0	(106,617)	20
21	Clerical & General Office Expenses	(280)	0	(96,983)	0	938	0	0	0	0	0	0	(96,325)	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	(770)	0	260	0	8	0	0	0	0	0	0	(502)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	436	0	0	0	0	0	0	0	0	436	26
27	Other (specify):*	(64,777)	0	18,046	0	271	0	0	0	0	0	0	(46,460)	27
28	**TOTAL General Administration**	(280,705)	0	(349,664)	51	5,061	0	0	0	0	0	0	(625,257)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(295,218)	0	(347,044)	51	(14,550)	0	0	0	0	0	0	(656,761)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKEFRONT NRSING & REHAB CTR # 0047779 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

	Capital Expense 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	5,091	0	1,161	1,663	0	0	0	0	0	0	0	7,915	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(227)	0	7	1,018	0	0	0	0	0	0	0	798	32
33	Real Estate Taxes	0	0	1,466	0	0	0	0	0	0	0	0	1,466	33
34	Rent-Facility & Grounds	0	0	5,250	(5,250)	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	16	0	0	0	0	0	0	16	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	4,864	0	7,884	(2,569)	16	0	0	0	0	0	0	10,195	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)**	(290,354)	0	(339,160)	(2,518)	(14,534)	0	0	0	0	0	0	(646,566)	45

Facility Name & ID Number LAKEFRONT NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

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 NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	MENACHEM SHABAT	99.00	ASTORIA PLACE	CHICAGO	buffalo property holdings		BUILDING CO	1
2	AHUVA SHABAT	1.00	BETHANY TERRACE	MORTON GROVE	legacy real properties		BUILDING CO	2
3			CHALET LIVING & REHAB	CHICAGO	legacy healthcare fin services		home office/bookeep	3
4			ELMBROOK	ELMHURST	ml group design and dev		asset management	4
5			THE GROVE OF EVANSTON,LLC	EVANSTON				5
6			THE VILLA AT EVERGREEN	EVERGREEN PARK				6
7			THE GROVE OF FOX VALLEY	AURORA				7
8			THE GROVE OF LAGRANGE PARK	LAGRANGE PARK				8
9			THE GROVE AT THE LAKE	ZION				9
10			LAKEFRONT NURSING & REHAB CENTER	CHICAGO				10
11			the grove at lincoln park living and rehab	CHICAGO				11
12			AVANTARA LONG GROVE	LONG GROVE				12
13			THE GROVE NORTH LIVING AND REHAB	SKOKIE				13
14			THE GROVE OF NORTHBROOK	NORTHBROOK				14
15			WARREN BARR NORTH SHORE	HIGHLAND PARK				15
16			AVANTAR PARK RIDGE	PARK RIDGE				16
17			WARREN BARR SOUTH LOOP	CHICAGO				17
18			WARREN BARR	CHICAGO				18
19			AURORA SUPPORTIVE LIVING	AURORA				19
20			peterson park associates limited ptnship	CHICAGO				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 NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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		(1)	(1)	17
18	V	3	HOUSEKEEPING SALARIES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		409	409	18
19	V	3	HOUSEKEEPING		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		49	49	19
20	V	5	UTILITIES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		913	913	20
21	V	6	GROUNDS & MAINTENANCE		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		1,063	1,063	21
22	V	11	ACTIVITIES PROGRAM		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		187	187	22
23	V	17	MANAGEMENT FEES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		13,254	13,254	23
24	V	19	PROFESSIONAL FEES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		3,071	3,071	24
25	V	20	FEES,SUBSCRIPTIONS		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		252	252	25
26	V	21	CLERICAL & GENERAL WAGES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		63,804	63,804	26
27	V	21	CLERICAL & GENERAL		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		4,213	4,213	27
28	V	24	SEMINARS		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		260	260	28
29	V	26	INSURANCE		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		436	436	29
30	V	27	EMPL BENEFITS-GEN ADMIN		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		13,039	13,039	30
31	V	27	EMPL BENEFITS-OWNERS		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		5,007	5,007	31
32	V	30	DEPRECIATION		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		1,161	1,161	32
33	V	32	INTEREST		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		7	7	33
34	V	33	REAL ESTATE TAXES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		1,466	1,466	34
35	V	34	RENT		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		5,250	5,250	35
36	V								36
37	V								37
38	V								38
39	Total			$ 453,000			$ 113,840	$ * (339,160)	39

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

Facility Name & ID Number LAKEFRONT NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 5,250	LEGACY REAL PROPERTIES LLC		$	$ (5,250)	15
16	V	19	PROFESSIONAL FEES		LEGACY REAL PROPERTIES LLC		51	51	16
17	V	30	DEPRECIATION		LEGACY REAL PROPERTIES LLC		1,663	1,663	17
18	V	32	INTEREST EXPENSE		LEGACY REAL PROPERTIES LLC		1,018	1,018	18
19	V								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			$ 5,250			$ 2,732	$ * (2,518)	39

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

Facility Name & ID Number LAKEFRONT NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	2	FOOD		PROGRESSIVE HEALTHCARE CONSULTING		6	6	16
17	V	6	BUILDING MAINT & SUPPLIES		PROGRESSIVE HEALTHCARE CONSULTING		36	36	17
18	V	10	NURSING SUPPLIES		PROGRESSIVE HEALTHCARE CONSULTING		3	3	18
19	V	10	NURSING SALARIES		PROGRESSIVE HEALTHCARE CONSULTING		2,107	2,107	19
20	V	12	CLERGY SALARY		PROGRESSIVE HEALTHCARE CONSULTING		88	88	20
21	V	12	ADMISSIONS SALARY		PROGRESSIVE HEALTHCARE CONSULTING		2,064	2,064	21
22	V	15	EMPL BENEFIT- NURSING		PROGRESSIVE HEALTHCARE CONSULTING		85	85	22
23	V	17	ADMIN SAL-NON OWNERS		PROGRESSIVE HEALTHCARE CONSULTING		3,587	3,587	23
24	V	19	PROFESSIONAL FEES		PROGRESSIVE HEALTHCARE CONSULTING		248	248	24
25	V	20	FEES, SUBSCRIPTIONS		PROGRESSIVE HEALTHCARE CONSULTING		9	9	25
26	V	21	CLERICAL & GEN OFFICE		PROGRESSIVE HEALTHCARE CONSULTING		938	938	26
27	V	24	SEMINARS		PROGRESSIVE HEALTHCARE CONSULTING		8	8	27
28	V	27	AUTO AND TRAVEL		PROGRESSIVE HEALTHCARE CONSULTING		271	271	28
29	V	35	EQUIPMENT RENTAL		PROGRESSIVE HEALTHCARE CONSULTING		16	16	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			$ 9,466	$ * (14,534)	39

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

Facility Name & ID Number LAKEFRONT NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	DIRECTOR OF NURSING	$ 9,612	PROGRESSIVE HEALTHCARE CONSULTING		$ 9,612	$	15
16	V	10	CLINICAL NURSE	12,715	PROGRESSIVE HEALTHCARE CONSULTING		12,715		16
17	V	10	MDS COORDINATOR	5,708	PROGRESSIVE HEALTHCARE CONSULTING		5,708		17
18	V	10	E.H.R. IMPLEMENTATION	7,236	PROGRESSIVE HEALTHCARE CONSULTING		7,236		18
19	V	17	ADMINISTRATOR	24,100	PROGRESSIVE HEALTHCARE CONSULTING		24,100		19
20	V	17	ASST ADMINISTRATOR	5,280	PROGRESSIVE HEALTHCARE CONSULTING		5,280		20
21	V	21	CLERICAL	367	PROGRESSIVE HEALTHCARE CONSULTING		367		21
22	V	21	ADMITTING	13,995	PROGRESSIVE HEALTHCARE CONSULTING		13,995		22
23	V	21	PERSONNEL	3,753	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		3,753		23
24	V	21	AR FIELD COORDINATOR	7,714	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		7,714		24
25	V	21	MANAGED CARE	2,627	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		2,627		25
26	V	21	IN-HOUSE COUNSEL	4,792	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		4,792		26
27	V	21	PURCHASING DIRECTOR	2,594	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		2,594		27
28	V	22	PAYROLL TAXES	1,954	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		1,954		28
29	V	22	PAYROLL TAXES	8,993	PROGRESSIVE HEALTHCARE CONSULTING		8,993		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			$ 111,440			$ 111,440	$ *	39

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

Facility Name & ID Number LAKEFRONT NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	1.66	3.32	MGMT FEE	$ 6,627	17-7	1
2								PR TAXES	2,503	27-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 9,130		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 NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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 NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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	1,090,513	21	$ (38)	$	36,135	$ (1)	1
2	3	HOUSEKEEPING SALARIES	Bed Days Available	1,090,513	21	12,349	12,349	36,135	409	2
3	3	HOUSEKEEPING	Bed Days Available	1,090,513	21	1,477		36,135	49	3
4	5	UTILITIES	Bed Days Available	1,090,513	21	27,544		36,135	913	4
5	6	GROUNDS & MAINTENANCE	Bed Days Available	1,090,513	21	32,093		36,135	1,063	5
6	11	ACTIVITIES PROGRAM	Bed Days Available	1,090,513	21	5,642		36,135	187	6
7	17	MANAGEMENT FEES	Bed Days Available	1,090,513	21	400,000	400,000	36,135	13,254	7
8	19	PROFESSIONAL FEES	Bed Days Available	1,090,513	21	92,690		36,135	3,071	8
9	20	FEES,SUBSCRIPTIONS	Bed Days Available	1,090,513	21	7,596		36,135	252	9
10	21	CLERICAL & GENERAL WAGES	Bed Days Available	1,090,513	21	1,925,545	1,925,545	36,135	63,804	10
11	21	CLERICAL & GENERAL	Bed Days Available	1,090,513	21	127,135		36,135	4,213	11
12	24	SEMINARS	Bed Days Available	1,090,513	21	7,856		36,135	260	12
13	26	INSURANCE	Bed Days Available	1,090,513	21	13,167		36,135	436	13
14	27	EMPL BENEFITS-GEN ADMIN	Bed Days Available	1,090,513	21	393,489		36,135	13,039	14
15	27	EMPL BENEFITS-OWNERS	Bed Days Available	1,090,513	21	151,094		36,135	5,007	15
16	30	DEPRECIATION	Bed Days Available	1,090,513	21	35,040		36,135	1,161	16
17	32	INTEREST	Bed Days Available	1,090,513	21	199		36,135	7	17
18	33	REAL ESTATE TAXES	Bed Days Available	1,090,513	21	44,250		36,135	1,466	18
19	34	RENT	Bed Days Available	1,090,513	21	158,445		36,135	5,250	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,435,573	$ 2,337,894		$ 113,840	25

Facility Name & ID Number LAKEFRONT NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: LEGACY REAL PROPERTIES
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	19	PROFESSIONAL FEES	Bed Days Available	1,090,513	21	$ 1,550	$	36,135	$ 51	1
2	30	DEPRECIATION	Bed Days Available	1,090,513	21	50,196		36,135	1,663	2
3	32	INTEREST EXPENSE	Bed Days Available	1,090,513	21	30,719		36,135	1,018	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					$ 82,465	$		$ 2,732	25

Facility Name & ID Number LAKEFRONT NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	2	FOOD	Bed Days Available	951,147	21	$ 149	$	36,135	$ 6	1
2	6	BUILDING MAINT & SUPPLIES	Bed Days Available	951,147	21	943		36,135	36	2
3	10	NURSING SUPPLIES	Bed Days Available	951,147	21	68		36,135	3	3
4	10	NURSING SALARIES	Bed Days Available	951,147	21	55,460	55,460	36,135	2,107	4
5	12	CLERGY SALARY	Bed Days Available	951,147	21	2,320	2,320	36,135	88	5
6	12	ADMISSIONS SALARY	Bed Days Available	951,147	21	54,336	54,336	36,135	2,064	6
7	15	EMPL BENEFIT- NURSING	Bed Days Available	951,147	21	2,247		36,135	85	7
8	17	ADMIN SAL-NON OWNERS	Bed Days Available	951,147	21	94,409	94,409	36,135	3,587	8
9	19	PROFESSIONAL FEES	Bed Days Available	951,147	21	6,532		36,135	248	9
10	20	FEES, SUBSCRIPTIONS	Bed Days Available	951,147	21	250		36,135	9	10
11	21	CLERICAL & GEN OFFICE	Bed Days Available	951,147	21	24,680		36,135	938	11
12	24	SEMINARS	Bed Days Available	951,147	21	199		36,135	8	12
13	27	AUTO AND TRAVEL	Bed Days Available	951,147	21	7,129		36,135	271	13
14	35	EQUIPMENT RENTAL	Bed Days Available	951,147	21	413		36,135	16	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 249,135	$ 206,525		$ 9,466	25

Facility Name & ID Number LAKEFRONT NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BANK FINANCIAL		X	WORKING CAPITAL	INTEREST			433,898	REVOLV	PRIME+	14,054	6
7				INSURANCE							1,666	7
8												8
9	TOTAL Facility Related						$	$ 433,898			$ 15,720	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 433,898			$ 15,720	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 NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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.)		$ 111,467	2
3. Under or (over) accrual (line 2 minus line 1).		$ 111,467	3
4. Real Estate Tax accrual used for 2014 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.		$ 111,467	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	96,716	8
	2010	103,431	9
	2011	102,640	10
	2012	110,507	11
	2013	111,467	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 2013 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LAKEFRONT NRSING & 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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-29-108-011-0000	NURSING HOME	$ 55,000.54	$ 55,000.54
2.	11-29-108-012-0000	NURSING HOME	$ 55,000.54	$ 55,000.54
3.			$	$
4.			$	$
5.	10-35-104-076-0000	HOME OFFICE ALLOCATION	$ 38,392.00	$ 1,466.00
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 148,393.08	$ 111,467.08

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

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

Facility Name & ID Number LAKEFRONT NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 2,711	1
2					2
3	TOTALS			$ 2,711	3

Facility Name & ID Number LAKEFRONT NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 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		386	9
10	EXHAUST FAN			2006	2,400	87	27.5	87		602	10
11	SECURITY SYSTEM			2006	27,540	1,001	27.5	1,001		6,926	11
12	ELEVATOR REHAB			2006	17,126	623	27.5	623		4,308	12
13	WATER PUMP			2006	4,500	164	27.5	164		1,134	13
14	ELECTRICAL WORK			2006	2,175	79	27.5	79		546	14
15	NURSE CALL SYSTEM			2007	9,378	341	27.5	341		2,401	15
16	DOOR			2007	5,365	195	27.5	195		1,194	16
17	WIRING FOR CABLE			2007	6,200	225	27.5	225		1,863	17
18	PAINTING & WALLPAPER			2007	25,660		5			25,660	18
19	LIGHT FIXTURES			2007	6,431	234	27.5	234		1,511	19
20	CUSTOM NURSE STATION			2007	11,517	419	27.5	419		2,706	20
21	COVE BASE, VCT, VINYL SHEET			2007	22,486	818	27.5	818		5,283	21
22	HAND RAILS & BUMPERS			2007	6,434	234	27.5	234		1,511	22
23	DRAPERIES			2007	3,063	111	27.5	111		717	23
24	WALLCOVERINGS			2007	4,121	150	27.5	150		969	24
25	SHOWER REHAB			2008	4,600	167	27.5	167		912	25
26	BOILER			2008	10,700	389	27.5	389		2,123	26
27	FIRE DOORS			2009	47,687	1,734	27.5	1,734		8,814	27
28	handrails, flooring, wallpaper,drywall,wallguards less 65,529 ins			2009	10,326	375	27.5	375		1,906	28
29	FIRE ALARM SYSTEM			2009	54,000	1,964	27.5	1,964		9,984	29
30	SIGN			2009	4,558	166	27.5	166		844	30
31	PUMP,CONDENSOR,COIL FOR CHILLER			2010	4,600	167	27.5	167		898	31
32	KITCHEN CABINETS,FLOORING,COUNTER TOPS AND PLUMBIN			2011	10,290	374	27.5	374		1,263	32
33	FIRE DAMPERS			2011	6,700	244	27.5	244		823	33
34	FIRE SPRINKLER			2011	4,250	154	27.5	154		520	34
35	BURGLAR/FIRE ARARM SYSTEM			2012	5,966	217	27.5	217		497	35
36	PED DR,FRAME,SIDELIGHT, & TRANSOM- PATIO NORTH			2012	9,060	329	27.5	329		754	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 NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 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	$	$ 582	37
38	EXHAUST FAN	2012	5,550	202	27.5	202		463	38
39	new walls,fire preventive work & plumbing-various locations	2012	7,675	279	27.5	279		639	39
40	CHILLER 15 TON COMPRESSOR	2012	18,402	669	27.5	669		1,533	40
41	EXHAUST FAN	2012	8,287	301	27.5	301		690	41
42	CHIMNEY WITH STAINLESS STEEL LINER AND TOP	2012	2,998	109	27.5	109		250	42
43	NEW RAMP	2012	1,245	83	15	83		176	43
44	CONCRETE	2012	34,100	2,273	15	2,273		4,831	44
45	ADA ENTRY RAMP WITH 42" GUARD RAIL WITH 34" HANI	2013	16,000	582	27.5	582		897	45
46	RAIL IN FRONT OF BUILDING								46
47	CABINETS AND WORKSTATION IN THERAPY/SOCIAL	2013	3,750	136	27.5	136		210	47
48	SERVICE OFFICE								48
49	1 ST AND 2ND FLOOR FIRE RATED CORRIDOR DOORS	2013	13,107	477	27.5	477		735	49
50	KITCHEN GARBAGE DISPOSAL	2013	7,977	290	27.5	290		447	50
51	NEW PATIO IN FRONT OF WALK	2013	4,975	332	15	332		498	51
52	DOORS	2014	6,450	69	27.5	69		69	52
53	ROOFING SYSTEM	2014	6,197	47	27.5	47		47	53
54	CHAIN LINK FENCE	2014	4,299	144	15	144		144	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)		$ 476,648	$ 17,264		$ 17,264	$	$ 99,266	70

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

Facility Name & ID Number LAKEFRONT NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 476,648	$ 17,264		$ 17,264	$	$ 99,266	1
2									2
3									3
4	RELATED PARTY INFORMATION								4
5	BUILDINGS:								5
6	ALLOCATED FROM LEGACY RP	2009	21,004	700	30	700		4,243	6
7									7
8									8
9									9
10	LEASEDHOLD IMPROVEMENTS:								10
11	ALLOCATED FROM LEGACY RP (SEE ATTACHED)	2009	11,928	298	20	596	298		11
12	ALLOCATED FROM LEGACY RP (SEE ATTACHED)	2010	3,627	118	20	145	27		12
13	ALLOCATED FROM LEGACY RP (SEE ATTACHED)	2011	5,155		20	258	258		13
14									14
15									15
16									16
17									17
18									18
19	ALLOCATED FROM LEGACY HEALTHCARE FINANCIAL-	2012	945	66	20	47	(19)		19
20	CARPETING INSTALLATION AND FLOOR PREP, CUBICLES								20
21	WITH OVERHEAD STORAGE CABINETS AND FILE								21
22	CABINETS, CARPETIN INSTALLATION, OFFICE BUILD-								22
23	OUT-WALLS, INSULATION, ELECTRICAL, DOORS,								23
24	BASEBOARDS, LIGHTS, WINDOWS, PAINT, SECURITY								24
25	SYSTEM								25
26	ALLOCATED FROM LEGACY HEALTHCARE FINANCIAL-	2013	3,022	210	20	151	(59)		26
27	BUILDING SUPPLIES FOR 2013 IMPROVEMENTS, PHONE								27
28	SYSTEM & WIRING, BUILT IN SHELVING & DROP								28
29	CEILINGS								29
30									30
31	ALLOCATE FROM LEGACY HEALTHCARE FINANCIAL-								31
32	LIGHT FIXTURES AND ELECTRICAL WIRING,								32
33	PRINTER RECEPTACLES	2014	295	20	20	15	(5)		33
34	TOTAL (lines 1 thru 33)		$ 522,624	$ 18,676		$ 19,176	$ 500	$ 103,509	34

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

Facility Name & ID Number LAKEFRONT NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 124,339	$ 2,667	$ 12,435	$ 9,768		$ 92,368	71
72	Current Year Purchases	8,975	5,385	449	(4,936)		449	72
73	Fully Depreciated Assets							73
74	REL PARTY		1,412	1,171	(241)			74
75	TOTALS	$ 133,314	$ 9,464	$ 14,055	$ 4,591		$ 92,817	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)	$ 658,649	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 28,140	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 33,231	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,091	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 196,326	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 NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: LAKEFRONT PROPERTIES
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		$ 623,368			3
4	Additions							4
5								5
6								6
7	TOTAL		99		$ 623,368 **			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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 7,233 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				1,284	18
19					19
20					20
21	TOTAL		$	$ 1,284	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 NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

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

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

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

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number LAKEFRONT NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$		$ 128,480	$		$ 128,480	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			36,095			36,095	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			134,772			134,772	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				99,357		99,357	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			$		$ 299,347	$ 99,357		$ 398,704	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 NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 72,330	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (400,000))	798,707		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	97,464		6
7	Other Prepaid Expenses	17,475		7
8	Accounts Receivable (owners or related parties)	11,967		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 997,943	$	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	476,648		15
16	Equipment, at Historical Cost	133,314		16
17	Accumulated Depreciation (book methods)	(232,256)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	26,610		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(15,523)		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)**	$ 388,793	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,386,736	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 412,721	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	433,898		29
30	Accrued Salaries Payable	78,121		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,679		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,102		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	due to north main	65,214		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,006,735	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,006,735	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 380,001	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,386,736	$	48

***(See instructions.)**

Facility Name & ID Number LAKEFRONT NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 414,642	1	
2	Restatements (describe):		2	
3	**POST CLOSING ADJUSTMENTS**	(22,495)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 392,147	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	59,854	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	(72,000)	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)**	$ (12,146)	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)**	$ 380,001	24	*

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

Facility Name & ID Number LAKEFRONT NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 5,968,928	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,968,928	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***	227	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 227	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)**	$ 5,969,155	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	942,022	31
32	Health Care	1,875,473	32
33	General Administration	1,758,955	33
	B. Capital Expense		
34	Ownership	674,695	34
	C. Ancillary Expense		
35	Special Cost Centers	398,704	35
36	Provider Participation Fee	256,324	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,906,173	40
41	**Income before Income Taxes (line 30 minus line 40)****	62,982	41
42	**Income Taxes**	(3,128)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 59,854	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,366,534	44
45	Private Pay - Net Inpatient Revenue	44,081	45
46	Medicare - Net Inpatient Revenue	1,332,662	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	43,415	47
48	Other-(specify) VETERAN	182,236	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,968,928	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 LAKEFRONT NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,038	2,457	$ 114,504	$ 46.60	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,121	7,147	196,762	27.53	3
4	Licensed Practical Nurses	20,350	22,329	496,242	22.22	4
5	CNAs & Orderlies	49,845	54,644	560,468	10.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,377	2,591	46,285	17.86	8
9	Activity Director	1,964	2,134	39,474	18.50	9
10	Activity Assistants	1,763	1,833	21,050	11.48	10
11	Social Service Workers	3,481	3,794	67,777	17.86	11
12	Dietician					12
13	Food Service Supervisor	2,018	2,189	39,394	18.00	13
14	Head Cook	3,457	3,730	38,680	10.37	14
15	Cook Helpers/Assistants	12,302	13,477	122,491	9.09	15
16	Dishwashers					16
17	Maintenance Workers	11,686	12,726	150,619	11.84	17
18	Housekeepers	11,393	12,604	129,563	10.28	18
19	Laundry	3,529	3,928	36,270	9.23	19
20	Administrator	2,004	2,528	125,415	49.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,857	4,311	47,127	10.93	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)	2,004	2,255	27,852	12.35	30
31	Medical Records	2,120	2,262	61,820	27.33	31
32	Other Health Care(specify)	2,592	2,695	30,947	11.48	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	144,901	159,634	$ 2,352,740 *	$ 14.74	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	$ 17,578	1-3	35
36	Medical Director	MONTHLY	21,600	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		1,685	10-3	38
39	Pharmacist Consultant	MONTHLY	7,722	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	51	2,448	11-3	44
45	Social Service Consultant	51	3,111	12-3	45
46	Other(specify) NURSING	MONTHLY	12,000	10-3	46
47	NURSING PROGRAM CONSULTAN	MONTHLY	52,181	10-3	47
48					48
49	TOTAL (lines 35 - 48)	102	$ 118,325		49

C. CONTRACT NURSES

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

Facility Name & ID Number LAKEFRONT NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ADLER,AHARON	ADMINISTRATOR		$ 125,415
	ASST ADMIN		0
	OTHER ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 125,415

B. Administrative - Other

Description	Amount
MANAGEMENT FEES- LEGACY HEALTHCARE	$ 288,000
MANAGEMENT FEES- CHAIM, JACK AND RON	108,000
PROGRESSIVE HEALTHCARE- ADMIN & ASSIST ADMIN	29,380
TOTAL (agree to Schedule V, line 17, col. 3)	$ 425,380
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		131,687
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 131,687

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,697
Unemployment Compensation Insurance	50,544
FICA Taxes	175,325
Employee Health Insurance	170,761
Employee Meals	21,900
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	328
EMPLOYEE PHYSICAL EXAMS	1,578
PENSION/PROFIT SHARING PLANS	17,671
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
PAYROLL TAX - LEGACY & PROGRESSIVE	10,947
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 504,751

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	3,615
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	102,185
MARKETING/ADV/PROMO	4,693
LICENSES/DUES/SUBSCRIPTIONS	13,104
MGMT CO ALLOC	261
TRUST/FRANCHISE/CONTRIB/ETC	(102,185)
Less: Public Relations Expense	(0)
Non-allowable advertising	(4,693)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,005

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	1,260
RELATED PARTY	268
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,528

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number LAKEFRONT NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 NRSING & REHAB CTR # 0047779 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ICLTC $6,687**

(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. $ **7,282** 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. $ **256,324**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **21,900** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees.