FOR BHF USE

LL1

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

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0053868

Facility Name: Lakefront Skilled Nursing Facility

Address: 7618 North 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: 4/1/2006

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: Steven N. Lavenda **Telephone Number:** (847) 282-6300
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 01/01/17 to 12/31/17 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)
(Title)

Paid Preparer
(Signed) (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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 Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 N/A

	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			1,469	1,469	8
9	SNF/PED					9
10	ICF	32,064		885	32,949	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,064		2,354	34,418	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.25%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 4/1/2006

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/1/2006 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 1,469

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	271,621	15,311	8,460	295,392		295,392		295,392			1
2	Food Purchase		169,699		169,699	(1,774)	167,925	40	167,965			2
3	Housekeeping	169,097	27,824		196,921		196,921	132	197,053			3
4	Laundry	25,928	8,064		33,992		33,992	3	33,995			4
5	Heat and Other Utilities			124,591	124,591		124,591	(4,312)	120,279			5
6	Maintenance	185,816	13,023	91,506	290,345		290,345	30,238	320,583			6
7	Other (specify):*											7
8	**TOTAL General Services**	652,462	233,921	224,557	1,110,940	(1,774)	1,109,166	26,102	1,135,268			8
	B. Health Care and Programs											
9	Medical Director			14,413	14,413		14,413	404	14,817			9
10	Nursing and Medical Records	1,586,227	25,082	28,524	1,639,833		1,639,833	63,163	1,702,996			10
10a	Therapy	53,672			53,672		53,672	(216)	53,456			10a
11	Activities	78,139	8,720	2,580	89,439		89,439	3,069	92,508			11
12	Social Services	141,594		9,360	150,954		150,954	1,102	152,056			12
13	CNA Training											13
14	Program Transportation			937	937		937		937			14
15	Other (specify):*							10,534	10,534			15
16	**TOTAL Health Care and Programs**	1,859,632	33,802	55,814	1,949,248		1,949,248	78,056	2,027,304			16
	C. General Administration											
17	Administrative	145,117			145,117		145,117	105,546	250,663			17
18	Directors Fees											18
19	Professional Services			77,365	77,365	(141)	77,224	5,109	82,333			19
20	Dues, Fees, Subscriptions & Promotions			22,755	22,755		22,755	(2,869)	19,886			20
21	Clerical & General Office Expenses	84,979	1,971	186,407	273,357		273,357	11,767	285,124			21
22	Employee Benefits & Payroll Taxes			453,601	453,601	1,774	455,375		455,375			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,653	2,653		2,653	1,218	3,871			24
25	Other Admin. Staff Transportation			1,900	1,900		1,900		1,900			25
26	Insurance-Prop.Liab.Malpractice			94,730	94,730		94,730	2,244	96,974			26
27	Other (specify):*							44,175	44,175			27
28	**TOTAL General Administration**	230,096	1,971	839,411	1,071,478	1,633	1,073,111	167,189	1,240,300			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,742,190	269,694	1,119,782	4,131,666	(141)	4,131,525	271,347	4,402,872			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 Number Lakefront Skilled Nursing Facility #0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			14,668	14,668		14,668	34,115	48,783			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			36,805	36,805		36,805	343,351	380,156			32
33	Real Estate Taxes			123,600	123,600	141	123,741	2,842	126,583			33
34	Rent-Facility & Grounds			705,479	705,479		705,479	(703,170)	2,309			34
35	Rent-Equipment & Vehicles			16,160	16,160		16,160	2,795	18,955			35
36	Other (specify):*											36
37	TOTAL Ownership			896,712	896,712	141	896,853	(320,068)	576,785			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		86,230	245,507	331,737		331,737		331,737			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			257,906	257,906		257,906		257,906			42
43	Other (specify):*			293,014	293,014		293,014	(293,014)				43
44	TOTAL Special Cost Centers		86,230	796,427	882,657		882,657	(293,014)	589,643			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,742,190	355,924	2,812,921	5,911,035	0	5,911,035	(341,735)	5,569,300			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 Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	(5,079)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	33,605	30		9
10	Interest and Other Investment Income	(8,827)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,020)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(211)	21		18
19	Entertainment	(1,512)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(75,239)	21		24
25	Fund Raising, Advertising and Promotional	(902)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,636)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(563,458)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (627,279)		$	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)	285,544		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 285,544		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (341,735)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Lakefront Skilled Nursing Facility

ID# 0053868

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Personal Items	$ (4,580)	10	1
2	Bank Charges	(17,797)	21	2
3	Sequestration	(16,603)	21	3
4	Therapy Discounts	(216)	10a	4
5	Non-Allowable Legal	(2,229)	19	5
6	Capitalized R&M	(6,554)	06	6
7	Additional R&M	6,373	06	7
8	Non-Allowable Expense	(293,014)	43	8
9	Bldg Co - Tax extension fee	(1,500)	21	9
10	Bldg Co. - Filing Fees	(250)	21	10
11	Bldg Co - Title Fees	(8,203)	21	11
12	bldg Co - Professional Fees - Accounting	(3,854)	19	12
13	Bldg Co - Professional Fees - Legal	(3,871)	19	13
14	Bldg Co - Professional Fees - Loan	(20,674)	19	14
15	Bldg Co - Property Management Fees	(186,747)	17	15
16	Misc. Income	(1,120)	21	16
17	PAC Dues	(2,619)	20	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**	(563,458)		49

Lakefront Skilled Nursing Facility

ID# 0053868

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase			29	11								40	2
3	Housekeeping			132									132	3
4	Laundry			3									3	4
5	Heat and Other Utilities	(5,079)				767							(4,312)	5
6	Maintenance	(181)		1,777	27,672	970							30,238	6
7	Other (specify):*													7
8	**TOTAL General Services**	(5,260)		1,941	27,683	1,738							26,102	8
	B. Health Care and Programs													
9	Medical Director			404									404	9
10	Nursing and Medical Records	(4,580)		25	67,782		(64)						63,163	10
10a	Therapy	(216)											(216)	10a
11	Activities			3,058	12								3,069	11
12	Social Services			48	1,054								1,102	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				10,534								10,534	15
16	**TOTAL Health Care and Programs**	(4,796)		3,535	79,381		(64)						78,056	16
	C. General Administration													
17	Administrative	(186,747)	186,747	13,900	91,646								105,546	17
18	Directors Fees													18
19	Professional Services	(30,628)	28,399	9,443	231	193			(2,529)				5,109	19
20	Fees, Subscriptions & Promotions	(3,521)		537	113	2							(2,869)	20
21	Clerical & General Office Expenses	(128,091)	9,953	110,273	19,631	1							11,767	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			710	508								1,218	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			595	1,450	199							2,244	26
27	Other (specify):*			22,627	21,548								44,175	27
28	**TOTAL General Administration**	(348,987)	225,099	158,085	135,128	394			(2,529)				167,189	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(359,043)	225,099	163,561	242,192	2,131	(64)		(2,529)				271,347	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Lakefront Skilled Nursing Facility** **#** **0053868** **Report Period Beginning:** **01/01/17** **Ending:** **12/31/17**

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	33,605			510								34,115	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(8,827)	348,699	11		3,467							343,351	32
33	Real Estate Taxes					2,842							2,842	33
34	Rent-Facility & Grounds		(703,267)	27,515	39	(27,458)							(703,170)	34
35	Rent-Equipment & Vehicles			2,015	780								2,795	35
36	Other (specify):*													36
37	**TOTAL Ownership**	24,778	(354,568)	29,541	1,329	(21,149)							(320,068)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(293,014)											(293,014)	43
44	**TOTAL Special Cost Centers**	(293,014)											(293,014)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(627,279)	(129,469)	193,102	243,522	(19,018)	(64)		(2,529)				(341,735)	45

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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. [ ] YES [X] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 703,267	Lakefront Realty	100.00%	$	$ (703,267)	1
2	V	21	Tax extension fee		Lakefront Realty	100.00%	1,500	1,500	2
3	V	21	Filing Fees		Lakefront Realty	100.00%	250	250	3
4	V	21	Title Fees		Lakefront Realty	100.00%	8,203	8,203	4
5	V	19	Professional Fees - Accounting		Lakefront Realty	100.00%	3,854	3,854	5
6	V	19	Professional Fees - Legal		Lakefront Realty	100.00%	3,871	3,871	6
7	V	19	Professional Fees - Loan		Lakefront Realty	100.00%	20,674	20,674	7
8	V	17	Property Management Fees		Lakefront Realty	100.00%	186,747	186,747	8
9	V	32	Interest Expense - Mortgage		Lakefront Realty	100.00%	348,699	348,699	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 703,267			$ 573,798	$ * (129,469)	14

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

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	2	FOOD	$	Legacy Healthcare Financial Services	100.00%	$ 29	$ 29	15
16	V	3	HOUSEKEEPING SUPPLIES		Legacy Healthcare Financial Services	100.00%	132	132	16
17	V	4	LINEN REPLACEMENT		Legacy Healthcare Financial Services	100.00%	3	3	17
18	V	6	UTILITIES		Legacy Healthcare Financial Services	100.00%	8	8	18
19	V	6	GROUNDS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	1,769	1,769	19
20	V	9	MEDICAL DIRECTOR CONSULTANT		Legacy Healthcare Financial Services	100.00%	404	404	20
21	V	10	MEDICAL SUPPLIES		Legacy Healthcare Financial Services	100.00%	25	25	21
22	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services	100.00%	3,058	3,058	22
23	V	12	SOCIAL SERVICE CONSULTANT		Legacy Healthcare Financial Services	100.00%	48	48	23
24	V	17	ADMINISTRATIVE SALARY		Legacy Healthcare Financial Services	100.00%	13,900	13,900	24
25	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	9,443	9,443	25
26	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	537	537	26
27	V	21	CLERICAL & GENERAL WAGES		Legacy Healthcare Financial Services	100.00%	107,307	107,307	27
28	V	21	CLERICAL & GENERAL OTHER COSTS		Legacy Healthcare Financial Services	100.00%	2,965	2,965	28
29	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	710	710	29
30	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	595	595	30
31	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	22,627	22,627	31
32	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	11	11	32
33	V	34	RENT		Legacy Healthcare Financial Services	100.00%	27,458	27,458	33
34	V	34	STORAGE		Legacy Healthcare Financial Services	100.00%	57	57	34
35	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services	100.00%	14	14	35
36	V	35	AUTO RENTAL		Legacy Healthcare Financial Services	100.00%	2,001	2,001	36
37	V								37
38	V								38
39	Total			$			$ 193,102	$ * 193,102	39

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

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	2	FOOD	$	Progressive Healthcare Consulting	100.00%	$ 11	$ 11	15
16	V	6	MAINTENANCE SALARY		Progressive Healthcare Consulting	100.00%	27,590	27,590	16
17	V	6	BUILDING MAINTENANCE AND R&M		Progressive Healthcare Consulting	100.00%	82	82	17
18	V	10	NURSING SALARIES		Progressive Healthcare Consulting	100.00%	67,782	67,782	18
19	V	11	ACTIVITIES PROGRAM		Progressive Healthcare Consulting	100.00%	12	12	19
20	V	12	CLERGY CONSULTANT		Progressive Healthcare Consulting	100.00%	1,051	1,051	20
21	V	12	SOCIAL SERVICE		Progressive Healthcare Consulting	100.00%	2	2	21
22	V	15	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	10,534	10,534	22
23	V	17	ADMIN SALARY- NON OWNER		Progressive Healthcare Consulting	100.00%	91,646	91,646	23
24	V	19	PROFESSIONAL FEES		Progressive Healthcare Consulting	100.00%	231	231	24
25	V	20	DUES, SUBSCRIPTIONS, LICENSES		Progressive Healthcare Consulting	100.00%	113	113	25
26	V	21	CLERICAL WAGES		Progressive Healthcare Consulting	100.00%	19,424	19,424	26
27	V	21	CLERICAL & GENERAL - OTHER		Progressive Healthcare Consulting	100.00%	207	207	27
28	V	24	SEMINARS		Progressive Healthcare Consulting	100.00%	508	508	28
29	V	27	EMP. BEN.-NON-NURSING		Progressive Healthcare Consulting	100.00%	21,548	21,548	29
30	V	26	INSURANCE		Progressive Healthcare Consulting	100.00%	1,450	1,450	30
31	V	30	DEPRECIATION		Progressive Healthcare Consulting	100.00%	510	510	31
32	V	34	STORAGE RENTAL		Progressive Healthcare Consulting	100.00%	39	39	32
33	V	35	AUTO RENTAL		Progressive Healthcare Consulting	100.00%	780	780	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 243,522	$ * 243,522	39

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

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	5	UTILITIES	$	CF ST. LOUIS, LLC	100.00%	$ 767	$ 767	15
16	V	6	REPAIRS & MAINTENANCE		CF ST. LOUIS, LLC	100.00%	970	970	16
17	V	19	PROFESSIONAL FEES		CF ST. LOUIS, LLC	100.00%	193	193	17
18	V	20	DUES & SUBSCRIPTIONS		CF ST. LOUIS, LLC	100.00%	2	2	18
19	V	21	OFFICE EXPENSE		CF ST. LOUIS, LLC	100.00%	1	1	19
20	V	26	INSURANCE		CF ST. LOUIS, LLC	100.00%	199	199	20
21	V	32	INTEREST EXPENSE		CF ST. LOUIS, LLC	100.00%	3,467	3,467	21
22	V	33	REAL ESTATE TAXES		CF ST. LOUIS, LLC	100.00%	2,842	2,842	22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	27,458	CF ST. LOUIS, LLC	100.00%		(27,458)	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			$ 27,458			$ 8,440	$ * (19,018)	39

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

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Medical Supplies	$ 1,554	ReMed Services		$ 1,490	$ (64)	15
16	V								16
17	V								17
18	V								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			$ 1,554			$ 1,490	$ * (64)	39

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

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	06	Maintenance	$ 9,600	ML Group Design and Development		$ 9,600	$	15
16	V								16
17	V								17
18	V								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			$ 9,600			$ 9,600	$ *	39

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

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	19	Payroll Services	$ 10,538	ProPay	24.00%	$ 8,009	$ (2,529)	15
16	V								16
17	V								17
18	V								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			$ 10,538			$ 8,009	$ * (2,529)	39

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

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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. ☐ 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			$			$	$	15
16	V								16
17	V								17
18	V								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			$			$	$ *	39

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

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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. ☐ 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			$			$	$	15
16	V								16
17	V								17
18	V								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			$			$	$ *	39

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

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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. ☐ 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			$			$	$	15
16	V								16
17	V								17
18	V								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			$			$	$ *	39

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

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	GPN Family Trust	50.00%	ASTORIA PLACE SKILLED NURSING FACILITY LLC	CHICAGO	LAKEFRONT REALTY	CHICAGO	BUILDING CO	1
2	Doros Generation Trust	50.00%	AVANTARA LONG GROVE	LONG GROVE	LEGACY HC & FINANCIAL SER	LINCOLNWOOD	HOME OFFICE/BOOKKEEPI	2
3			AVANTARA PARK RIDGE	PARK RIDGE	PROGRESSIVE HC	LINCOLNWOOD	NURSE CONSULTANT	3
4			AZRIA MIDTOWN	OMAHA, NE	ML GROUP DESIGN & DEV	SKOKIE	ASSET MANAGEMENT	4
5			AZRIA MONTCLAIR	OMAHA, NE	REMED SERVICES LLC	LINCOLNWOOD	NURSING EQUIPMENT	5
6			AZRIA OLATHE	OLATHE, KS	AURORA SUPPORTIVE LIVING	AURORA	SUPPORTIVE LIVING	6
7			BETHANY TERRACE	MORTON GROVE	TERRACE GARDENS	MORTON GROVE	ASSISTED LIVING	7
8			CARLTON SKILLED NURSING FACILITY LLC	CHICAGO	LINCOLNSHIRE ASSISTED LIVI	LINCOLNSHIRE	ASSISTED LIVING	8
9			CEDAR SKILLED NURSING FACILITY	CEDAR CITY, UT	PROPAY HR LLC	EVANSTON	PAYROLL PROCESSING	9
10			CHALET SKILLED NURSING FACILITY LLC	CHICAGO	CF ST. LOUIS LLC	SKOKIE	BUILDING CO	10
11			CLARK SKILLED NURSING FACILITY	CHICAGO				11
12			ELMBROOK SKILLED NURSING FACILITY LLC	ELMHURST				12
13			EVANSTON SKILLED NURSING FACILITY LLC	EVANSTON				13
14			GROVE AT THE LAKE SKILLED NURSING FACILITY LLC	ZION				14
15			GROVE OF FOX VALLEY	AURORA				15
16			LAGRANGE SKILLED NURSING FACILITY LLC	LAGRANGE PARK				16
17			LINCOLN PARK SKILLED NURSING FACILITY LLC	CHICAGO				17
18			LINCOLNSHIRE LIVING & REHAB CENTER LLC	LINCOLNSHIRE				18
19			NORTHBROOK SKILLED NURSING FACILITY LLC	NORTHBROOK				19
20			PARKER SKILLED NURSING FACILITY LLC	PARKER, CO				20
21			PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO				21
22			SKOKIE SKILLED NURSING FACILITY LLC	SKOKIE				22
23			ST. GEORGE SKILLED NURSING FACILITY	ST. GEORGE, UT				23
24			WARREN BARR NORTH SHORE	HIGHLAND PARK				24
25			WARREN BARR SOUTH LOOP	CHICAGO				25
26			WARREN BARR LIVING AND REHAB	CHICAGO				26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	N/A								$		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 Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 [X]

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 Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Financial Services
Street Address: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 679-9797
Fax Number: (847) 683-2900

	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	AVAIL. BED DAYS	1,789,215	30	$ 1,460	$	36,135	$ 29	1
2	3	HOUSEKEEPING SUPPLIES	AVAIL. BED DAYS	1,789,215	30	6,519		36,135	132	2
3	4	LINEN REPLACEMENT	AVAIL. BED DAYS	1,789,215	30	171		36,135	3	3
4	6	UTILITIES	AVAIL. BED DAYS	1,789,215	30	372		36,135	8	4
5	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	1,789,215	30	87,596		36,135	1,769	5
6	9	MEDICAL DIRECTOR CONSU	AVAIL. BED DAYS	1,789,215	30	20,000		36,135	404	6
7	10	MEDICAL SUPPLIES	AVAIL. BED DAYS	1,789,215	30	1,237		36,135	25	7
8	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,789,215	30	151,405		36,135	3,058	8
9	12	SOCIAL SERVICE CONSULTA	AVAIL. BED DAYS	1,789,215	30	2,392		36,135	48	9
10	17	ADMINISTRATIVE SALARY	AVAIL. BED DAYS	1,789,215	30	688,242	688,242	36,135	13,900	10
11	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,789,215	30	467,580		36,135	9,443	11
12	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,789,215	30	26,590		36,135	537	12
13	21	CLERICAL & GENERAL WAG	AVAIL. BED DAYS	1,789,215	30	5,313,296	5,313,296	36,135	107,307	13
14	21	CLERICAL & GENERAL OTH	AVAIL. BED DAYS	1,789,215	30	146,833		36,135	2,965	14
15	24	SEMINARS	AVAIL. BED DAYS	1,789,215	30	35,138		36,135	710	15
16	26	INSURANCE	AVAIL. BED DAYS	1,789,215	30	29,475		36,135	595	16
17	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	1,789,215	30	1,120,380		36,135	22,627	17
18	32	INTEREST	AVAIL. BED DAYS	1,789,215	30	561		36,135	11	18
19	34	RENT	AVAIL. BED DAYS	1,789,215	30	1,359,562		36,135	27,458	19
20	34	STORAGE	AVAIL. BED DAYS	1,789,215	30	2,842		36,135	57	20
21	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,789,215	30	694		36,135	14	21
22	35	AUTO RENTAL	AVAIL. BED DAYS	1,789,215	30	99,069		36,135	2,001	22
23										23
24										24
25	TOTALS					$ 9,561,416	$ 6,001,539		$ 193,102	25

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Consulting
Street Address: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 679-9797
Fax Number: (847) 683-2900

	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	AVAIL. BED DAYS	1,374,590	21	$ 432	$	36,135	$ 11	1
2	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,374,590	21	1,049,531	1,049,531	36,135	27,590	2
3	6	BUILDING MAINTENANCE AI	AVAIL. BED DAYS	1,374,590	21	3,133		36,135	82	3
4	10	NURSING SALARIES	AVAIL. BED DAYS	1,374,590	21	2,578,462	2,578,462	36,135	67,782	4
5	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,374,590	21	443		36,135	12	5
6	12	CLERGY CONSULTANT	AVAIL. BED DAYS	1,374,590	21	39,998		36,135	1,051	6
7	12	SOCIAL SERVICE	AVAIL. BED DAYS	1,374,590	21	95		36,135	2	7
8	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,374,590	21	400,703		36,135	10,534	8
9	17	ADMIN SALARY- NON OWNE	AVAIL. BED DAYS	1,374,590	21	3,486,246	3,486,246	36,135	91,646	9
10	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,374,590	21	8,800		36,135	231	10
11	20	DUES, SUBSCRIPTIONS, LICE	AVAIL. BED DAYS	1,374,590	21	4,293		36,135	113	11
12	21	CLERICAL WAGES	AVAIL. BED DAYS	1,374,590	21	738,904	738,904	36,135	19,424	12
13	21	CLERICAL & GENERAL - OTI	AVAIL. BED DAYS	1,374,590	21	7,880		36,135	207	13
14	24	SEMINARS	AVAIL. BED DAYS	1,374,590	21	19,314		36,135	508	14
15	27	EMP. BEN.-NON-NURSING	AVAIL. BED DAYS	1,374,590	21	819,705		36,135	21,548	15
16	26	INSURANCE	AVAIL. BED DAYS	1,374,590	21	55,168		36,135	1,450	16
17	30	DEPRECIATION	AVAIL. BED DAYS	1,374,590	21	19,384		36,135	510	17
18	34	STORAGE RENTAL	AVAIL. BED DAYS	1,374,590	21	1,500		36,135	39	18
19	35	AUTO RENTAL	AVAIL. BED DAYS	1,374,590	21	29,674		36,135	780	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 9,263,664	$ 7,853,142		$ 243,522	25

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: CF St. Louis LLC
Street Address: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 676-5300
Fax Number: (847) 676-5348

	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	5	UTILITIES	AVAIL. BED DAYS	1,789,215	30	$ 37,998	$	36,135	$ 767	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,789,215	30	48,042		36,135	970	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,789,215	30	9,551		36,135	193	3
4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,789,215	30	76		36,135	2	4
5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,789,215	30	32		36,135	1	5
6	26	INSURANCE	AVAIL. BED DAYS	1,789,215	30	9,839		36,135	199	6
7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,789,215	30	171,679		36,135	3,467	7
8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,789,215	30	140,710		36,135	2,842	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					$ 417,927	$		$ 8,440	25

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: Remed Services LLC
Street Address: 3424 Oakton Street, Suite 102
City / State / Zip Code: Skokie, IL
Phone Number: (847) 440-2600
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	10	Medical Supplies	Direct			$	$		$ 1,490	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					$	$		$ 1,490	25

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: ML Group Desing and Development
Street Address: 3424 Oakton Street
City / State / Zip Code: Skokie, IL
Phone Number: (847) 676-5300
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	6	Maintenance	Direct			$	$		$ 9,600	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					$	$		$ 9,600	25

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: ProPay HR LLC
Street Address: 2201 W. Main St
City / State / Zip Code: Evanston, IL 60202
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	19	Payroll Services	Direct			$	$		$ 8,009	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					$	$		$ 8,009	25

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	The Private Bank		X	Mortgage			$	$ 6,314,467			$ 348,699	1
2	The Private Bank		X	Note Payable				611,776			36,805	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 6,926,243			$ 385,504	9
	B. Non-Facility Related*											
10	Interest Income		X								(8,827)	10
11	Allocated from Legacy HC Financial		X								11	11
12	Allocated from CF St. Louis, LLC		X								3,467	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (5,349)	14
15	TOTALS (line 9+line14)						$	$ 6,926,243			$ 380,155	15

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

*** 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 Skilled Nursing Facility **#** 0053868 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 124,557	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.)		$ 129,961	2
3. Under or (over) accrual (line 2 minus line 1).		$ 5,404	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 121,038	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.)**		$ 141	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.		$ 126,583	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	110,507	8
	2013	111,467	9
	2014	112,217	10
	2015	116,302	11
	2016	127,119	12

2017 Accrual = $127,119 x 0.95 = $121,038

Allocated from CF St. Louis LLC $2,842

Beginning accrual adjusted

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lakefront Skilled Nursing Facility COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053868

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-29-108-011-0000	Long Term Care Property	$ 63,559.42	$ 63,559.42
2.	11-29-108-012-0000	Long Term Care Property	$ 63,559.42	$ 63,559.42
3.	Allocated from CF. St. Louis, LLC	Home Office	$ 463,439.48	$ 2,841.78
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 590,558.32	$ 129,960.62

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? X YES _____ 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2016 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2016 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2016.

Please complete the Real Estate Tax Statement below and include it in the 2017 cost report along with a copy of your 2016 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lakefront Skilled Nursing Facility COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053868

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 _____ 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

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

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (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).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Allocated from CF. St. Louis, LLC			$ 13,127	1
2					2
3	TOTALS			$ 13,127	3

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Various			2006	55,269		20	2,763	2,763	33,161	9
10	Various			2007	100,655		20	5,033	5,033	55,360	10
11	Various			2008	15,300		20	765	765	7,650	11
12	Various			2009	116,571		20	5,829	5,829	52,457	12
13	Various			2010	4,600		20	230	230	1,840	13
14	Various			2011	21,240		20	1,062	1,062	7,434	14
15	Various			2012	100,258		20	5,013	5,013	30,077	15
16	Various			2013	45,809		20	2,290	2,290	11,452	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

*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 Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		157,803			7,430	7,430	14,706	68
69	Financial Statement Depreciation			14,668			(14,668)		69
70	TOTAL (lines 4 thru 69)		$ 617,505	$ 14,668		$ 30,415	$ 15,747	$ 214,138	70

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

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 617,505	$ 14,668		$ 30,415	$ 15,747	$ 214,138	1
2	Doors	2014	6,450		20	323	323	1,290	2
3	Roofing System	2014	6,197		20	310	310	1,239	3
4	Chain Link Fence	2014	4,299		20	215	215	860	4
5	Electrical Work For Transfer Switch Replacement	2017	3,475		20	87	87	87	5
6	Replacement Of Actuator, And Installation Of Additional Damper	2017	4,500		20	900	900	900	6
7	Furnish And Installation Of New Door Operator	2017	5,200		20	347	347	347	7
8	Tested Connectivity To New Lines For Computers	2017	2,615		20	218	218	218	8
9	Install Temp Chiller	2017	3,128		20	156	156	156	9
10	Install. Of New Magn Lock & Alarm In Dining Room 1St Fl	2017	3,304		20	165	165	165	10
11	Elevator Repair	2017	3,250		20	163	163	163	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	TOTAL (lines 1 thru 33)		$ 659,923	$ 14,668		$ 33,298	$ 18,630	$ 219,564	34

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

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 659,923	$ 14,668		$ 33,298	$ 18,630	$ 219,564	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
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 659,923	$ 14,668		$ 33,298	$ 18,630	$ 219,564	34

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

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 659,923	$ 14,668		$ 33,298	$ 18,630	$ 219,564	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 659,923	$ 14,668		$ 33,298	$ 18,630	$ 219,564	34

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

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 659,923	$ 14,668		$ 33,298	$ 18,630	$ 219,564	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
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 659,923	$ 14,668		$ 33,298	$ 18,630	$ 219,564	34

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

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 12F, Carried Forward		$	$		$	$	$	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
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from CF. St. Louis, LLC	2016	21,462		35	613	613	1,226	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF. St. Louis, LLC	2016	133,248		20	6,662	6,662	13,325	9
10	Allocated from CF. St. Louis, LLC	2017	3,093		20	155	155	155	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	TOTAL (lines 1 thru 33)		$ 157,803	$		$ 7,430	$ 7,430	$ 14,706	34

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

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 12H, Carried Forward		$ 157,803	$		$ 7,430	$ 7,430	$ 14,706	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
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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)		$ 157,803	$		$ 7,430	$ 7,430	$ 14,706	34

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

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 147,421	$ 510	$ 14,742	$ 14,232	10	$ 122,339	71
72	Current Year Purchases	6,729		742	742	10	742	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 154,150	$ 510	$ 15,484	$ 14,974		$ 123,081	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)	$ 827,200	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 15,178	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 48,783	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 33,605	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 342,645	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 Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Storage/Parking				2,212			5
6	Allocated from Legacy HC Financial/Progressive				96			6
7	TOTAL				$ 2,308 **			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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 16,174 Description: See Attached Schedule
(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	Allocated from Legacy HC Financial		$	$ 2,001	17
18	Allocated from Progressive HC Consulting			780	18
19					19
20					20
21	TOTAL		$	$ 2,781	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 Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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.

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 Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 94,031	$		$ 94,031	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			24,653			24,653	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			113,114			113,114	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				64,798		64,798	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					13,709	21,432		35,141	13
14	TOTAL			$		$ 245,507	$ 86,230		$ 331,737	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/17 (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	$ 300	$ 300	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	844,593	820,687	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	114,446	114,446	6
7	Other Prepaid Expenses	12,859	105,643	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	18,598	18,598	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 990,796	$ 1,059,674	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		471,695	13
14	Buildings, at Historical Cost		4,245,251	14
15	Leasehold Improvements, at Historical Cost	194,897	194,897	15
16	Equipment, at Historical Cost	39,461	569,515	16
17	Accumulated Depreciation (book methods)	(15,908)	(262,046)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	638,919	2,003,223	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 857,369	$ 7,222,535	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,848,165	$ 8,282,209	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 487,005	$ 487,005	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		151,425	29
30	Accrued Salaries Payable	205,260	205,260	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,356	8,356	31
32	Accrued Real Estate Taxes(Sch.IX-B)		121,038	32
33	Accrued Interest Payable		31,898	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	10,688	10,688	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 711,309	$ 1,015,670	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	611,776	611,776	39
40	Mortgage Payable		6,163,042	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	442,540	442,540	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,054,316	$ 7,217,358	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,765,625	$ 8,233,028	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 82,540	$ 49,181	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,848,165	$ 8,282,209	48

***(See instructions.)**

Facility Name & ID Number Lakefront Skilled Nursing Facility **#** 0053868 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 121,106	1
2	Restatements (describe):		2
3	**Rounding**	(1)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 121,105	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(38,565)	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	( )	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)**	$ (38,565)	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)**	$ 82,540	24 *

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

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 10,453,059	1
2	Discounts and Allowances for all Levels	(5,763,050)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,690,009	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,095,350	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,095,350	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	62,094	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,777	19
20	Radiology and X-Ray		20
21	Other Medical Services	8,056	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 74,927	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,827	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,827	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	3,357	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,357	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,872,470	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,110,940	31
32	Health Care	1,949,248	32
33	General Administration	1,071,478	33
	B. Capital Expense		
34	Ownership	896,712	34
	C. Ancillary Expense		
35	Special Cost Centers	624,751	35
36	Provider Participation Fee	257,906	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,911,035	40
41	**Income before Income Taxes (line 30 minus line 40)****	(38,565)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (38,565)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,323,264	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue	286,905	46
47	Other-(specify) Insurance	79,840	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,690,009	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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 Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,904	2,112	$ 97,263	$ 46.05	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,169	6,891	238,185	34.56	3
4	Licensed Practical Nurses	21,935	24,509	554,929	22.64	4
5	CNAs & Orderlies	50,245	55,698	695,347	12.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,799	4,225	53,672	12.70	8
9	Activity Director	984	992	20,253	20.42	9
10	Activity Assistants	5,009	5,243	57,886	11.04	10
11	Social Service Workers	6,064	6,771	141,594	20.91	11
12	Dietician					12
13	Food Service Supervisor	1,920	2,072	47,340	22.85	13
14	Head Cook	6,863	7,927	94,378	11.91	14
15	Cook Helpers/Assistants	10,849	11,603	129,903	11.20	15
16	Dishwashers					16
17	Maintenance Workers	12,669	14,260	185,816	13.03	17
18	Housekeepers	13,006	14,509	169,097	11.65	18
19	Laundry	1,835	2,270	25,928	11.42	19
20	Administrator	2,008	2,258	115,154	51.00	20
21	Assistant Administrator	1,016	1,168	29,963	25.65	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,067	7,531	84,979	11.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	15	23	503	21.87	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	153,357	170,062	$ 2,742,190 *	$ 16.12	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	$ 8,460	01-03	35
36	Medical Director	Monthly	14,413	09-03	36
37	Medical Records Consultant	Monthly			37
38	Nurse Consultant	Monthly	20,841	10-03	38
39	Pharmacist Consultant	Monthly	7,683	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	54	2,580	11-03	44
45	Social Service Consultant	153	9,360	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	207	$ 63,337		49

C. CONTRACT NURSES

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

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Barnett, Eliyahu	Administrator	0	$ 68,085
De Anda, Magdalena	Assistant Administrator	0	32,234
Seifer, Gianni V.	Administrator	0	44,798
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 145,117

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 25,764
See Attached	Legal	22,620
Documentation Solutions Inc	Compliance Audit	2,734
Compliance Resources Inc.	Compliance Audit	1,586
ProPay HR	Payroll Processing	10,538
PSD Solutions	Data Processing	365
2401 Incorporated	Architectural Services	2,040
BlueOrange Compliance	Professional Servoces	815
IIT/Sourcetech	Data Processing	1,870
Lexis Nexis Risk Solutions	Data Processing	31
Madison Specs LLC	Cost Segregation Study	4,225
See Supplemental Schedule		4,778
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 77,365

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 44,898
Unemployment Compensation Insurance	12,828
FICA Taxes	204,233
Employee Health Insurance	142,518
Employee Meals	1,774
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	21,569
401K Expense	3,915
Employee Physical Exams	6,722
Holiday Expense	
Other Employee Benefits	16,917
TOTAL (agree to Schedule V, line 22, col.8)	$ 455,375

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	232
Health Care Worker Background Check	3,922
(Indicate # of checks performed 392.2)	
Patient Background Checks 345	3,450
Dues and Subscriptions	6,284
License and Permits	5,346
Allocated from Legacy HC Financial	537
Allocated from Progressive HC Consulting	113
See Supplemental Schedule	2
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,886

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,653
Allocated from Legacy HC Financial	710
Allocated from Progressive HC Consulting	508
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,871

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lakefront Skilled Nursing Facility # 0053868 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 $5,237**

(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? **N/A**

(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 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,681** Line **10**

(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. **N/A**

(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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **257,906**
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. $ **1,774** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(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. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **Yes**
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: **N/A**

(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