

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

I.

IDPH License ID Number: 0050245

Facility Name: Grove at Lincoln Park Living and Rehabilitation Center, LLC

Address: 2732 North Hampden Court Chicago 60614

County: Cook

Telephone Number: (773) 248-6000 Fax #: (773) 248-9703

HFS ID Number:

Date of Initial License for Current Owners: 09/01/2008

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

X

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:

Name: Michael W. Martin

Telephone Number: (217) 258-8888

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 01/01/2011 to 12/31/2011 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)

(Type or Print Name)

(Title)

Paid Preparer

(Signed) SEE ACCOUNTANTS' PREPARATION REPORT

(Print Name and Title)

(Firm Name & Address) McGladrey & Pullen, LLP 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173

(Telephone) (847) 517-7070 Fax #: (847) 517-7067

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 Grove at Lincoln Park Living and Rehabilitation Center, LLC

0050245 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>98</u>	Skilled (SNF)	<u>98</u>	<u>35,770</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>11</u>	Intermediate (ICF)	<u>11</u>	<u>4,015</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>109</u>	TOTALS	<u>109</u>	<u>39,785</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>10,938</u>	<u>3,170</u>	<u>15,712</u>	<u>29,820</u>	8
9	SNF/PED					9
10	ICF			<u>889</u>	<u>889</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>10,938</u>	<u>3,170</u>	<u>16,601</u>	<u>30,709</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.19%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒ Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 09/01/08

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 09/01/08 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 109 and days of care provided 15,712

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/11 Fiscal Year: 12/31/11
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Grove at Lincoln Park Living and Rehabilitat # 0050245 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	229,137	23,909	8,377	261,423		261,423		261,423			1
2	Food Purchase		205,008		205,008		205,008	60	205,068			2
3	Housekeeping	151,014	26,960		177,974		177,974	631	178,605			3
4	Laundry	13,617	(317)	83,135	96,435		96,435		96,435			4
5	Heat and Other Utilities			94,339	94,339		94,339	1,305	95,644			5
6	Maintenance	32,872		102,324	135,196		135,196	(4,361)	130,835			6
7	Other (specify):*											7
8	TOTAL General Services	426,640	255,560	288,175	970,375		970,375	(2,365)	968,010			8
	B. Health Care and Programs											
9	Medical Director			14,000	14,000		14,000		14,000			9
10	Nursing and Medical Records	2,136,117	158,320	89,700	2,384,137		2,384,137	22,694	2,406,831			10
10a	Therapy			1,503,748	1,503,748		1,503,748		1,503,748			10a
11	Activities	184,509	19,631	755	204,895		204,895		204,895			11
12	Social Services	57,097		13,250	70,347		70,347		70,347			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,377,723	177,951	1,621,453	4,177,127		4,177,127	22,694	4,199,821			16
	C. General Administration											
17	Administrative	361,007		780,532	1,141,539		1,141,539	(740,532)	401,007			17
18	Directors Fees											18
19	Professional Services			120,122	120,122		120,122	7,402	127,524			19
20	Dues, Fees, Subscriptions & Promotions			10,590	10,590		10,590	177	10,767			20
21	Clerical & General Office Expenses	66,162	33,050	252,060	351,272		351,272	(132,207)	219,065			21
22	Employee Benefits & Payroll Taxes			552,078	552,078		552,078	1,859	553,937			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,936	1,936		1,936	239	2,175			24
25	Other Admin. Staff Transportation			44,652	44,652		44,652		44,652			25
26	Insurance-Prop.Liab.Malpractice			63,019	63,019		63,019	238	63,257			26
27	Other (specify):* Mgmt Alloc of Benefit							14,376	14,376			27
28	TOTAL General Administration	427,169	33,050	1,824,989	2,285,208		2,285,208	(848,448)	1,436,760			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,231,532	466,561	3,734,617	7,432,710		7,432,710	(828,119)	6,604,591			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

Grove at Lincoln Park Living and Rehabilitation Center, LLC #0050245

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			35,739	35,739		35,739	6,919	42,658			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,945	10,945		10,945	8,255	19,200			32
33	Real Estate Taxes			113,987	113,987		113,987		113,987			33
34	Rent-Facility & Grounds			537,118	537,118		537,118	9,292	546,410			34
35	Rent-Equipment & Vehicles			82,537	82,537		82,537		82,537			35
36	Other (specify):*											36
37	TOTAL Ownership			780,326	780,326		780,326	24,466	804,792			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		740,994	1,350	742,344		742,344		742,344			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,678	59,678		59,678		59,678			42
43	Other (specify):* Non-Allow Costs			749,321	749,321		749,321	(749,321)				43
44	TOTAL Special Cost Centers		740,994	810,349	1,551,343		1,551,343	(749,321)	802,022			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,231,532	1,207,555	5,325,292	9,764,379		9,764,379	(1,552,974)	8,211,405			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(33,430)	43		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,120)	30		9
10	Interest and Other Investment Income	(1,491)	32		10
11	Discounts, Allowances, Rebates & Refunds	5,248	43		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(1,864)	43		18
19	Entertainment				19
20	Contributions	(90,903)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(242,049)	43		24
25	Fund Raising, Advertising and Promotional	(154,007)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See Pg 5A</u>	(240,818)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (760,434)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(792,540)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (792,540)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,552,974)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs - Part A	\$ (54,503)	43	1
2	Misc. Income	(1,102)	21	2
3	Offset Cable TV Revenue	(7,704)	43	3
4				4
5				5
6				6
7	Personal Items	(6,857)	43	7
8	Admitting Non-Certified	(163,252)	43	8
9				9
10				10
11				11
12	Capitalisation of Repair and Maintenance expenses above \$ 2500 into fixed assets.	(7,400)	MCD # 16	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(240,818)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Chaim Rajchenbach	29.00	See Schedule 6A		See Schedule 6A		
Menachem Shabat	29.00					
Ronald Shabat	15.50					
Jack Rajchenbach	6.10					
The Rajchenbach Family Trust	15.50					
The Robert Hartman Family Trust	4.90					

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	\$	Legacy Healthcare Financial Services, LLC	100.00%	\$ 60	\$ 60	1
2	V	3	Housekeeping Salaries		Legacy Healthcare Financial Services, LLC	100.00%	624	624	2
3	V	3	Housekeeping Supplies		Legacy Healthcare Financial Services, LLC	100.00%	7	7	3
4	V	5	Utilities		Legacy Healthcare Financial Services, LLC	100.00%	1,305	1,305	4
5	V	6	Repairs & Maintenance		Legacy Healthcare Financial Services, LLC	100.00%	3,039	3,039	5
6	V								6
7	V	17	Administrative Salary - Mgmt. Alloc.	780,532	Legacy Healthcare Financial Services, LLC	100.00%	40,000	(740,532)	7
8	V	19	Other Professional Fees		Legacy Healthcare Financial Services, LLC	100.00%	2,781	2,781	8
9	V	19	Accounting		Legacy Healthcare Financial Services, LLC	100.00%	177	177	9
10	V	19	Legal Fees		Legacy Healthcare Financial Services, LLC	100.00%	(832)	(832)	10
11	V	19	Data Processing		Legacy Healthcare Financial Services, LLC	100.00%	209	209	11
12	V	20	License Fee		Legacy Healthcare Financial Services, LLC	100.00%	33	33	12
13	V	21	Office Supplies		Legacy Healthcare Financial Services, LLC	100.00%	5,276	5,276	13
14	Total			\$ 780,532			\$ 52,679	\$ * (727,853)	14

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

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Clerical Salaries	\$ 200,000	Legacy Healthcare Financial Services, LLC	100.00%	\$ 56,100	\$ (143,900)	15
16	V	24	Travel and Seminar		Legacy Healthcare Financial Services, LLC	100.00%	239	239	16
17	V	26	Insurance Expense		Legacy Healthcare Financial Services, LLC	100.00%	238	238	17
18	V	27	Employee Benefits		Legacy Healthcare Financial Services, LLC	100.00%	14,376	14,376	18
19	V	30	Depreciation		Legacy Healthcare Financial Services, LLC	100.00%	389	389	19
20	V	32	Amortization		Legacy Healthcare Financial Services, LLC	100.00%	4	4	20
21	V	34	Rent Expense		Legacy Healthcare Financial Services, LLC	100.00%			21
22	V	6	R & M Salary		Legacy Healthcare Financial Services, LLC	100.00%	9,292	9,292	22
23	V	34	Rent Expense		Legacy Healthcare Financial Services, LLC	100.00%			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			\$ 200,000			\$ 80,638	\$ * (119,362)	39

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

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V	30	Depreciation Expense		Legacy Real Properties, LLC	100.00%	3,528	3,528	17
18	V	32	Interest Expense		Legacy Real Properties, LLC	100.00%	3,447	3,447	18
19	V	33	Taxes - Property	3,193	Legacy Real Properties, LLC	100.00%	3,193		19
20	V								20
21	V	20	Dues & Subscriptions		Legacy Real Properties, LLC	100.00%	17	17	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			\$ 3,193			\$ 10,185	\$ * 6,992	39

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

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Computer Services	\$	Grove Healthcare Properties, LLC		\$ 4,923	\$ 4,923	15
16	V	20	License & Fees		Grove Healthcare Properties, LLC		106	106	16
17	V	21	Bank Service Charges		Grove Healthcare Properties, LLC		7,479	7,479	17
18	V	30	Depreciation		Grove Healthcare Properties, LLC		4,122	4,122	18
19	V	32	Interest Expense		Grove Healthcare Properties, LLC		6,295	6,295	19
20	V	34	Rent	537,118	Grove Healthcare Properties, LLC		537,118		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			\$ 537,118			\$ 560,043	\$ * 22,925	39

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

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	RN Salary	\$	Progressive Healthcare Consulting	100.00%	\$ 22,694	\$ 22,694	15
16	V	19	Professional Fees		Progressive Healthcare Consulting	100.00%	144	144	16
17	V	20	Fees and Subscriptions		Progressive Healthcare Consulting	100.00%	21	21	17
18	V	21	Clerical & General Office		Progressive Healthcare Consulting	100.00%	40	40	18
19	V	22	Emp Ben - Nursing		Progressive Healthcare Consulting	100.00%	1,859	1,859	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			\$			\$ 24,758	\$ * 24,758	39

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

Facility Name & ID Number Grove at Lincoln Park Living and Rehabilitation Center, LLC # 0050245 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	Chaim Rajchenbach		Grove Lincoln Park Living & Rehab Ctr.	Chicago	Legacy Healthcare	Skokie	Management Co.	1
2	Menachem Shabat		Pine Acres Rehab & Living Center	Dekalb	Financial Srvcs, LLC			2
3	Jack Rajchenback		Astoria Place Living & Rehab	Chicago				3
4	Ronald Shabat		The Grove of Evanston	Evanston	Legacy Real	Skokie	Real Estate	4
5	Menachem Berger		Grove North Living & Rehab Center	Chicago	Properties, LLC			5
6	Jake Weiss		Elmbrook Nursing	Elmbrook				6
7	The Rajchenbach Family Trust		The Grove of LaGrange Park	LaGrange Park	Grove Healthcare	Skokie	Real Estate	7
8	The Robert Hartman Family Trust		Lakefront Nursing & Rehab Center	Chicago	Properties, LLC			8
9			Bridgeview Health Care Center	Bridgeview				9
10			The Carlton at the Lake	Chicago	Shabat &	Chicago	Management Co.	10
11			Clark Manor Convalescent Center	Chicago	Associates, LLC			11
12			Springfield Terrace	Springfield				12
13			Tower Hill Healthcare Center	South Elgin	JLR Management	Chicago	Management Co.	13
14			Glenview Terrace Nursing Center	Glenview				14
15			The Imperial Grove Pavilion	Chicago				15
16			The Arc of Jacksonville, Ltd.	Jacksonville				16
17			Peterson Park Health Care Center	Chicago				17
18			Embassy Health Care Center	Wilmington				18
19			Whitehall North	Deerfield				19
20			Harmony Nursing & Rehab Center	Chicago				20
21			Florence Nursing Home	Marengo				21
22			The Fountain's	Marion				22
23			Friendship Care Center - Herrin	Herrin				23
24			City Care Center of Cobden	Combden				24
25			Ridgeway Manor	Ridgeway				25
26			Sheridan Health Care Center	Zion				26
27			Oak Grove Rehab & Skilled Care	Carbondale				27
28								28
29								29
30								30

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Chaim Rajchenbach	Owner	Administrative	29.00	180,000	5	10.00	Mgmt. Salary	\$ 20,000	17(7)	1
2	Menachem Shabat	Owner	Administrative	29.00	180,000	5	10.00	Mgmt. Salary	20,000	17(7)	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 40,000		13

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

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

Facility Name & ID Number Grove at Lincoln Park Living and Rehabilitation Center, I # 0050245 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Legacy Healthcare Financial Services, LLC
Street Address 7040 North Ridgeway Avenue
City / State / Zip Code Lincolnwood, IL 60712
Phone Number (847) 679-9797
Fax Number (847) 679-3676

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.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Patient Days	590,233	12	\$ 890	\$	39,785	\$ 60	1
2	3	Housekeeping Salaries	Patient Days	590,233	12	9,260	9,260	39,785	624	2
3	3	Housekeeping Supplies	Patient Days	590,233	12	110		39,785	7	3
4	5	Utilities	Patient Days	590,233	12	19,366		39,785	1,305	4
5	6	Repairs & Maintenance	Patient Days	590,233	12	45,083		39,785	3,039	5
6	10	RN Salaries	Patient Days	590,233	12			39,785	0	6
7	17	Administrative Salary - Mgmt. Al	Hours	50	12	400,000		5	40,000	7
8	19	Other Professional Fees	Patient Days	590,233	12	41,252		39,785	2,781	8
9	19	Accounting	Patient Days	590,233	12	2,627		39,785	177	9
10	19	Legal Fees	Patient Days	590,233	12	(12,339)		39,785	(832)	10
11	19	Data Processing	Patient Days	590,233	12	3,108		39,785	209	11
12	20	Dues, Licenses & Fees	Patient Days	590,233	12	493		39,785	33	12
13	21	Office Supplies	Patient Days	590,233	12	78,277		39,785	5,276	13
14	21	Clerical Salaries	Patient Days	590,233	12	832,276	832,276	39,785	56,100	14
15	24	Travel and Seminar	Patient Days	590,233	12	3,552		39,785	239	15
16	25	Travel	Patient Days	590,233	12			39,785	0	16
17	26	Insurance Expense	Patient Days	590,233	12	3,535		39,785	238	17
18	27	Employee Benefits	Patient Days	590,233	12	213,280		39,785	14,376	18
19	30	Depreciation	Bed Days Available	590,233	12	5,774		39,785	389	19
20	32	Amortization	Patient Days	590,233	12	62		39,785	4	20
21	33	Real Estate Taxes	Patient Days	590,233	12			39,785	0	21
22	34	Rent Expense	Patient Days	590,233	12	137,855		39,785	9,292	22
23	35	Equipment Rental	Patient Days	590,233	12			39,785	0	23
24										24
25	TOTALS					\$ 1,784,461	\$ 841,536		\$ 133,317	25

Facility Name & ID Number Grove at Lincoln Park Living and Rehabilitation Center, I # 0050245 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Progressive Healthcare Consulting
Street Address 7040 North Ridgeway Avenue
City / State / Zip Code Lincolnwood, IL 60712
Phone Number (847) 679-9797
Fax Number (847) 679-3676

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.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	RN Salary	Patient Days	465,768	10	\$ 265,681	\$ 265,681	39,785	\$ 22,694	1
2	19	Professional Fees	Patient Days	465,768	10	1,681		39,785	144	2
3	20	Fees and Subscriptions	Patient Days	465,768	10	250		39,785	21	3
4	21	Clerical & General Office	Patient Days	465,768	10	472		39,785	40	4
5	22	Emp Ben - Nursing	Patient Days	465,768	10	21,767		39,785	1,859	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					\$ 289,851	\$ 265,681		\$ 24,758	25

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	CAPEX #3001		X	Capital Expenditures	\$10,186.00	10/23/08	\$ 482,205	\$ 169,547	10/01/13	0.0373	\$ 10,945	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$10,186.00		\$ 482,205	\$ 169,547			\$ 10,945	9
	B. Non-Facility Related*											
10							Interest Income Offset				(1,491)	10
11							Allocated from Management Company				3,447	11
12							Allocated from Real Estate Entity				4	12
13							Allocated from Real Estate Entity				6,295	13
14	TOTAL Non-Facility Related						\$	\$			\$ 8,255	14
15	TOTALS (line 9+line14)						\$ 482,205	\$ 169,547			\$ 19,200	15

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

* 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.)

HFS 3745 (N-4-99)

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

B. Real Estate Taxes

[illegible]

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.

FACILITY NAME	<u>Grove at Lincoln Park Living and Rehabilitation Center, LLC</u>	COUNTY	<u>Cook</u>
---------------	--	--------	-------------

CONTACT PERSON REGARDING THIS REPORT Chaim Rajchenbach

A. Summary of Real Estate Tax Cost

[illegible]

B. Real Estate Tax Cost Allocations

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.)

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,325

B. General Construction Type: Exterior Brick Frame Number of Stories 4

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (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?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (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

☒ NO

If so, please complete the following:

1. Total Amount Incurred: N/A

2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Allocated from Legacy Real Properties			\$ 5,515	1
2					2
3	TOTALS			\$ 5,515	3

XI. OWNERSHIP COSTS (continued) B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	Allocated from Legacy Real Properties				\$ 42,726	\$		\$ 1,397	\$ 1,397	\$ 3,560	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Office Remodel - carpeting & built in cabinets			2009	54,635	1,366	40	1,366		3,415	9
10	Satellite system purchase & installation			2009	11,600	290	40	290		725	10
11	New Roof			2009	34,325	858	40	858		2,145	11
12	1st Floor Remodel										12
13	- Flooring, wallpaper & paint, carpeting, permits, update			2009	32,473	812	40	812		2,030	13
14	survey & architectural drawings										14
15	Electrical work			2009	8,645	216	40	216		540	15
16	Painting, Decor & Wallcoverings			2009	104,931	2,623	40	2,623		6,558	16
17	2nd Floor Remodel			2009	108,080	2,702	40	2,722	20	6,893	17
18	- Built in resident room furniture, handrails & baseboards										18
19	Outdoor Improvements - Awnings, Red Stucco			2009	42,033	1,051	40	1,051		2,627	19
20	Landscaping			2009	36,271	907	40	907		2,267	20
21	- install new flower bed, remove existing cement sidewalk,										21
22	remove gravel base, install new gravel base, brick pavers,										22
23	tuckpointing, remove/repair and transplant existing										23
24	landscaping, install new landscaping and plants										24
25	Install new phone system			2009	21,675	542	40	542		1,355	25
26	Sprinkler system			2009	3,047	76	40	76		190	26
27	Lock installation			2009	10,773	269	40	269		673	27
28	Patient Room Update - built in resident room furniture			2009	65,040	1,626	40	1,626		4,063	28
29	Chandeliers			2009	2,542	64	40	64		160	29
30											30
31	Landscaping			2009	26,271	1,751	15	1,751		4,378	31
32	- install new flower bed, remove existing cement sidewalk,										32
33	remove gravel base, install new gravel base, brick pavers,										33
34	tuckpointing, remove/repair and transplant existing										34
35	landscaping, install new landscaping and plants										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 Grove at Lincoln Park Living and Rehabilitation Center, LLC # 0050245 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 <u>Install 2 cab systems in elevators</u>	2009	\$ 16,042	\$ 401	40	\$ 401	\$	\$ 1,003	37
38 <u>Window treatments, cubicle curtains</u>	2009	2,564	64	40	64		160	38
39 <u>Flooring</u>	2009	15,995	400	40	400		1,000	39
40 <u>Window treatments, cubicle curtains</u>	2009	18,149	454	40	454		1,135	40
41 <u>Installed new air cooled condensing unit</u>	2009	3,500	88	40	88		220	41
42 <u>Sidewalk extension</u>	2009	3,985	100	40	100		250	42
43 <u>4 Floors hand railings, baseboards, lights above beds</u>	2009	10,120	253	40	253		633	43
44 <u>Install new 30HO motor on fire pump</u>	2009	3,844	96	40	96		240	44
45 <u>Plumbing work</u>	2009	7,751	194	40	194		485	45
46 <u>Project design fee</u>	2009	10,000	250	40	250		625	46
47								47
48 <u>Installation of 19 jacks on 3rd floor</u>	2010	2,578	64	40	64		96	48
49 <u>New doors and trims, and window trims</u>	2010	28,831	721	40	721		1,081	49
50 <u>Doors and trims</u>	2010	4,800	120	40	120		180	50
51 <u>Resident room furniture</u>	2010	14,135	353	40	353		530	51
52 <u>Door frames, built in cabinets</u>	2011	2,671	89	15	89		89	52
53 <u>Floor tiles, kitchen cabinets, baseboards</u>	2011	2,640	88	15	88		88	53
54 <u>Outlets, switches</u>	2011	2,860	143	10	143		143	54
55 <u>Cabinets, counters, back splash, etc.</u>	2011	9,535	318	15	318		318	55
56 <u>Partitions w/ granite tops</u>	2011	3,200	107	15	107		107	56
57 <u>paint rooms, prime woodwork, various other</u>	2011	2,765	138	10	138		138	57
58 <u>Construction of New Metal wall and kitchen cabinets</u>	2011	5,000	167	15	167		167	58
59 <u>Construction of first floor halfway and Dumpster for therapy room</u>	2011	2,690	90	15	90		90	59
60 <u>Flooring</u>	2011	42,763	3,054	7	3,054		3,054	60
61 <u>Flooring for 3rd and 4th floor</u>	2011	45,095	3,221	7	3,221		3,221	61
62 <u>Landscaping</u>	2011	7,400	247	15	247		247	62
63								63
64								64
65								65
66 <u>Allocated from Legacy Real Properties</u>		42,128			964	964	2,162	66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 916,105	\$ 26,371		\$ 28,752	\$ 2,381	\$ 59,039	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 124,732	\$ 6,461	\$ 9,443	\$ 2,982	3 to 10	\$ 27,075	71
72	Current Year Purchases	50,635	2,907	2,907		7 to 10	2,907	72
73	Fully Depreciated Assets							73
74	See Schedule 13A	12,771		1,556	1,556	10	2,380	74
75	TOTALS	\$ 188,138	\$ 9,368	\$ 13,906	\$ 4,538		\$ 32,362	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	N/A									77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,109,758	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 35,739	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 42,658	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,919	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 91,401	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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.

Grove at Lincoln Park Living and Rehabilitation Center, LLC
0050245
12/31/2011

Schedule 13A

Category of Equipment	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Component Life	Accumulated Depreciation
1 Allocation from LHFS, Inc	1,645		389	389	10	411
2 Allocated from Legacy Real Properties	11,126		1,167	1,167	10	1,969
Totals	12,771	-	1,556	1,556		2,380

Facility Name & ID Number	Grove at Lincoln Park Living and Rehabilitation Center, LLC #	0050245	Report Period Beginning:	01/01/2011	Ending: 12/31/2011
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XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **Park Terrace Partnership**

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:		109	Sep-08	\$ 537,118			3
4	Additions							4
5								5
6	Home Office Allocation				9,292			6
7	TOTAL		109		\$ 546,410			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:

X

YES

10

NO

Terms:

✦

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

16. Rental Amount for movable equipment: \$ **63,842**

☐ YES ☐ NO

Description: **Nursing Equip:60,648; Dietary Equip.:3,194;**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1	2	3	4	
	Use	Model Year and Make	Monthly Lease Payment	Rental Expense for this Period	
17	Business	Toyota Land Cruiser	\$ 1,199.99	\$ 15,135	17
18	Business	Nissan Altima	415.89	416	18
19	Business	Lexus RX 350	700.00	7,700	19
20	Reimbursement			(4,556)	20
21	TOTAL		\$ 2,315.88	\$ 18,695	21

10. Effective dates of current rental agreement:

Beginning 09/01/2008

Ending **08/31/2018**

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

Fiscal Year Ending

Annual Rent

12. 12/2012

\$ 543,728

13. 12/2013

\$ 563,621

14. 12/2014

\$ 583,513

*** 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.**

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

☒ NO

It is the policy of this facility to only hire certified nurses aides.
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.

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				
					Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	10,519	\$ 652,174	\$	10,519	\$ 652,174	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,737	169,672		2,737	169,672	2
3	Licensed Recreational Therapist	10A(3)	hrs							3
4	Licensed Physical Therapist		hrs		10,998	681,902		10,998	681,902	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				729,330		729,330	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	39(2)					11,664		11,664	12
13	Other (specify): <u></u>									13
14	TOTAL			\$	24,254	\$ 1,503,748	\$ 740,994	24,254	\$ 2,244,742	14

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

Facility Name & ID Number Grove at Lincoln Park Living and Rehabilitation Center, LI # 0050245 Report Period Beginning: 01/01/2011 Ending: 12/31/2011
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2011 (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	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>254,078</u>)	3,101,824	3,101,824	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	26,091	26,091	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Sch17A</u>	2,340,523	2,340,523	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,468,438	\$ 5,468,438	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		5,515	13
14	Buildings, at Historical Cost		42,726	14
15	Leasehold Improvements, at Historical Cost	831,643	873,379	15
16	Equipment, at Historical Cost	167,574	188,138	16
17	Accumulated Depreciation (book methods)	(80,296)	(91,401)	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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 918,921	\$ 1,018,357	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,387,359	\$ 6,486,795	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 586,686	\$ 586,686	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	268,045	268,045	30
31	Accrued Taxes Payable (excluding real estate taxes)	26,331	26,331	31
32	Accrued Real Estate Taxes(Sch.IX-B)	110,000	110,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Sch17A</u>	1,330,425	1,330,425	36
37	<u>Federal Unemployment Tax</u>	298	298	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,321,785	\$ 2,321,785	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	169,547	169,547	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 169,547	\$ 169,547	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,491,332	\$ 2,491,332	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,896,027	\$ 3,995,463	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,387,359	\$ 6,486,795	48

*(See instructions.)

Schedule 17A

XV: Special Services

Line 9 - Other Current Assets

	Operating	After Consolidation
GLP INCOME-TRUST	6,072	6,072
GLP EMP LOAN, ADV, W/A	10,000	10,000
GLP LEASE DEPOSIT	481,500	481,500
GLP DUE TO MEDICARE	296,222	296,222
GLP ACCRUED ILLINOIS BED TAX	14,880	14,880
GLP LEG CHARITY	2,428	2,428
GLP LEGACY	134,884	134,884
GLP GHCP	1,145,772	1,145,772
GLP AP	995	995
GLP DUE LESSOR/PRIOR OWNER	(2,230)	(2,230)
GLP DUE T/F LAKEFRONT	150,000	150,000
GLP T/F CHALET REALTY	100,000	100,000
	2,340,523	2,340,523
	-	-

Line 36 - Other Current Liabilities

	Operating	After Consolidation
GLP PREPAID INS - LIAB	1,722	1,722
GLP ADMIN BONUS	30,000	30,000
GLP ACC MGMT FEE	139,729	139,729
GLP ACCRUED F I C A	14,014	14,014
GLP HEALTH INSURANCE PAY	-	-
GLP GN	927,660	927,660
GLP DUE TO MEMBERS	117,300	117,300
GLP RELATED LESSOR	100,000	100,000
	1,330,425	1,330,425
	-	-

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,608,590	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(346,002)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,262,588	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,658,439	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	(1,025,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,633,439	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,896,027	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Grove at Lincoln Park Living and Rehabilitation Center # 0050245 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,087,198	1
2	Discounts and Allowances for all Levels	5,105,804	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,193,002	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	217,978	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 217,978	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	6,556	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,689	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 9,245	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,491	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,491	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Misc. Income</u>	1,102	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,102	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,422,818	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	970,375	31
32	Health Care	4,177,127	32
33	General Administration	2,285,208	33
	B. Capital Expense		
34	Ownership	780,326	34
	C. Ancillary Expense		
35	Special Cost Centers	1,491,665	35
36	Provider Participation Fee	59,678	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,764,379	40
41	Income before Income Taxes (line 30 minus line 40)**	2,658,439	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,658,439	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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.

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

(This schedule must cover the entire reporting period.)

		1	2**	3		4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages		Average Hourly Wage	
1	Director of Nursing	2,104	2,360	\$	110,392	\$ 46.78	1
2	Assistant Director of Nursing	2,097	2,281		72,192	31.65	2
3	Registered Nurses	31,228	33,895		913,572	26.95	3
4	Licensed Practical Nurses	6,195	6,738		164,516	24.42	4
5	CNAs & Orderlies	54,323	60,095		699,153	11.63	5
6	CNA Trainees						6
7	Licensed Therapist						7
8	Rehab/Therapy Aides	6,169	6,726		142,436	21.18	8
9	Activity Director	1,999	2,191		32,417	14.80	9
10	Activity Assistants	5,864	6,329		152,092	24.03	10
11	Social Service Workers	2,301	2,549		57,097	22.40	11
12	Dietician						12
13	Food Service Supervisor	2,526	2,799		62,965	22.50	13
14	Head Cook	844	860		9,260	10.77	14
15	Cook Helpers/Assistants	13,964	15,289		156,912	10.26	15
16	Dishwashers						16
17	Maintenance Workers	2,042	2,244		32,872	14.65	17
18	Housekeepers	12,719	14,004		151,014	10.78	18
19	Laundry	589	957		13,617	14.23	19
20	Administrator	2,104	2,160		293,427	135.85	20
21	Assistant Administrator	1,888	1,992		67,580	33.93	21
22	Other Administrative						22
23	Office Manager						23
24	Clerical	5,747	6,032		66,162	10.97	24
25	Vocational Instruction						25
26	Academic Instruction						26
27	Medical Director						27
28	Qualified MR Prof. (QMRP)						28
29	Resident Services Coordinator						29
30	Habilitation Aides (DD Homes)						30
31	Medical Records	2,392	2,480		33,856	13.65	31
32	Other Health Care(specify)						32
33	Other(specify)						33
34	TOTAL (lines 1 - 33)	157,095	171,981	\$	3,231,532 *	\$ 18.79	34

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

**** See instructions.**

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	85	\$ 8,377	1(3)	35
36	Medical Director	Monthly	14,000	9(3)	36
37	Medical Records Consultant	Monthly	4,888	10(3)	37
38	Nurse Consultant	Monthly	23,000	10(3)	38
39	Pharmacist Consultant	Monthly	4,572	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	13,250	12(3)	45
46	Other(specify) <u>MDS Consulting</u>	Monthly	44,000	10(3)	46
47	<u>Physician</u>	Monthly	1,000	10(3)	47
48					48
49	TOTAL (lines 35 - 48)	85	\$ 113,087		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	490	12,240	10(3)	52
53	TOTAL (lines 50 - 52)	490	\$ 12,240		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Jamie Dlatt	Administrator	0	\$ 16,862
Yair Zuckerman	Administrator	0	276,565
Mordechai Polstein	Assit. Administrator	0	19,780
Karen Glaza	Asst. Administrator	0	17,205
Josh Baumol	Asst. Administrator	0	30,595
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 361,007
B. Administrative - Other			
Description	Amount		
Management Fees (eliminated in Col. 7)	\$ 780,532		
(Eliminated in Col. 7)			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 780,532
C. Professional Services			
Vendor/Payee	Type	Amount	
		\$	
See Schedule 21A		120,122	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 120,122
D. Employee Benefits and Payroll Taxes			
Description	Amount		
Workers' Compensation Insurance	\$ 77,970		
Unemployment Compensation Insurance	10,797		
FICA Taxes	232,253		
Employee Health Insurance	180,508		
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Union Pension	21,935		
Other Employee Benefits	6,976		
Chicago Head Tax	16,850		
Unreimbursed Payroll Taxes	1,085		
Employee Physical Exam	204		
State Income Tax	3,500		
Allocation from Progressive Healthcare	1,859		
TOTAL (agree to Schedule V, line 22, col.8)			\$ 553,937
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #	Amount	
N/A		\$	
TOTAL		\$	
F. Dues, Fees, Subscriptions and Promotions			
Description	Amount		
IDPH License Fee	\$ 3,980		
Advertising: Employee Recruitment	744		
Health Care Worker Background Check (Indicate # of checks performed 38)	1,140		
Patient Background Checks 100	1,000		
Miscellaneous Licenses & fees	106		
Miscellaneous Dues & Subscriptions	3,025		
IL Council on LTC	701		
Allocated from Management Co.	71		
Less: Public Relations Expense	()		
Non-allowable advertising	()		
Yellow page advertising	()		
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 10,767
G. Schedule of Travel and Seminar**			
Description	Amount		
Out-of-State Travel	\$		
In-State Travel			
Seminar Expense	1,936		
Allocated from Management Co.	239		
Entertainment Expense	()		
(agree to Sch. V, line 24, col. 8)			\$ 2,175

*** Attach copy of IMRF notifications**

****See instructions.**

Schedule 21A

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor/Payee	Type	Amount
RSM McGladrey	Accounting	3,325.00
McGladrey & Pullen	Accounting	23,938.00
HDSI	Data Processing	13,770.00
E-Health Data Solutions	Data Processing	5,502.00
Singer Networks	Data Processing	17,671.00
Accu-Med Services	Data Processing	3,660.00
Professional search network	Recruitment	4,688.00
Prospect resources	Energy Procurement services	750.00
lit Sourcetech	Data Processing	985.00
ML Enterprizes	Purchasing Consultant	3,850.00
Personnel Planners	Unemployment Tax Consultant	1,060.00
Commitment Consulting	Data Processing	735.00
Mayer Magence	Legal	1,063.00
Elderlife Development LTD	Legal	2,154.00
MTS Consulting	Legal	1,667.00
MUCH SHELIST	Legal Fees	17,767.00
ASHMAN & STEIN	Legal Fees	1,424.00
FR&R	Legal Fees	1,287.00
MEYER MAGENCE	Legal Fees	5,711.00
OGLETREE DEAKINS NASH SMOAK &	Legal Fees	632.00
SKIDELSKY & ASSOCIATES	Legal Fees	185.00
STONE MCGUIRE & SIEGEL	Legal Fees	5,123.00
Collaborative Health care	LTC Consulting	3,175.00
TOTAL (agree to Schedule V, line 19, column 3)		120,122
Plus: Allocation from Management Company	MCD 4	2,479
Plus: Allocation from Real Estate Entity	MCD 13	4,923
TOTAL (agree to Schedule V, line 19, column 8)		127,524

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2007	6 FY2008	7 FY2009	8 FY2010	9 FY2011	10 FY2012	11 FY2013	12 FY2014	13 FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3									N/A				
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC: \$701
- (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? 6.5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 24,186 Line 10 (2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. 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. \$ 59,678
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 benefit: on Schedule V. \$ 0 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? 0
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
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? Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees