

		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: <u>0050237</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Grove North Living and Rehab Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2011</u> to <u>12/31/2011</u> 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.																																															
Address: <u>9000 North Lavergne Avenue</u> <u>Skokie</u> <u>60077</u> Number City Zip Code																																																	
County: <u>Cook</u>																																																	
Telephone Number: <u>(773) 248-6000</u> Fax # <u>(773) 248-9703</u>																																																	
HFS ID Number: _____																																																	
Date of Initial License for Current Owners: <u>9/1/08</u>		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) <u>SEE ACCOUNTANTS' PREPARATION REPORT</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u></td></tr><tr><td>(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) <u>SEE ACCOUNTANTS' PREPARATION REPORT</u>	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u>	(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u>																																				
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Type of Ownership:																																																	
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		☐	Limited Liability Co.																																														
		☐	Trust																																														
		☐	Other _____																																														
In the event there are further questions about this report, please contact:		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																																															
Name: <u>Michael W. Martin</u> Telephone Number: <u>(217) 258-8888</u>																																																	
Email Address: _____																																																	

Facility Name & ID Number Grove North Living and Rehab Center

0050237 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>51</u>	Intermediate (ICF)	<u>51</u>	<u>18,615</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>149</u>	TOTALS	<u>149</u>	<u>54,385</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>24,826</u>	<u>1,890</u>	<u>9,751</u>	<u>36,467</u>	8
9	SNF/PED					9
10	ICF	<u>12,789</u>	<u>772</u>	<u>480</u>	<u>14,041</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>37,615</u>	<u>2,662</u>	<u>10,231</u>	<u>50,508</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.87%

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) N/A

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 9/01/2008

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 09/01/2008 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 98 and days of care provided 9,751

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: 12/31/2011 Fiscal Year: 12/31/2011
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Grove North Living and Rehab Center # 0050237 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	270,541	24,923	39,185	334,649		334,649		334,649			1
2	Food Purchase		306,931		306,931		306,931	82	307,013			2
3	Housekeeping	133,761	25,061	305	159,127		159,127	863	159,990			3
4	Laundry	60,915	10,004	8,071	78,990		78,990		78,990			4
5	Heat and Other Utilities			151,140	151,140		151,140	1,784	152,924			5
6	Maintenance	60,984		86,805	147,789		147,789	(5,743)	142,046			6
7	Other (specify):*											7
8	TOTAL General Services	526,201	366,919	285,506	1,178,626		1,178,626	(3,014)	1,175,612			8
	B. Health Care and Programs											
9	Medical Director			60,700	60,700		60,700		60,700			9
10	Nursing and Medical Records	2,301,986	140,726	97,314	2,540,026		2,540,026	31,022	2,571,048			10
10a	Therapy			859,709	859,709		859,709		859,709			10a
11	Activities	154,252	13,881	2,276	170,409		170,409		170,409			11
12	Social Services	131,909		4,661	136,570		136,570		136,570			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,588,147	154,607	1,024,660	3,767,414		3,767,414	31,022	3,798,436			16
	C. General Administration											
17	Administrative	295,743		676,225	971,968		971,968	(620,225)	351,743			17
18	Directors Fees											18
19	Professional Services			102,399	102,399		102,399	6,568	108,967			19
20	Dues, Fees, Subscriptions & Promotions			13,464	13,464		13,464	(1,102)	12,362			20
21	Clerical & General Office Expenses	105,365	36,294	255,260	396,919		396,919	(105,822)	291,097			21
22	Employee Benefits & Payroll Taxes			647,171	647,171		647,171	2,542	649,713			22
23	Inservice Training & Education							560	560			23
24	Travel and Seminar			3,711	3,711		3,711	(233)	3,478			24
25	Other Admin. Staff Transportation			17,220	17,220		17,220		17,220			25
26	Insurance-Prop.Liab.Malpractice			75,109	75,109		75,109	326	75,435			26
27	Other (specify):* Home Ofc- EE Benefi							19,652	19,652			27
28	TOTAL General Administration	401,108	36,294	1,790,559	2,227,961		2,227,961	(697,734)	1,530,227			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,515,456	557,820	3,100,725	7,174,001		7,174,001	(669,726)	6,504,275			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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			57,891	57,891		57,891	493	58,384			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,703	13,703		13,703	13,000	26,703			32
33	Real Estate Taxes			504,211	504,211		504,211		504,211			33
34	Rent-Facility & Grounds			734,196	734,196		734,196	12,702	746,898			34
35	Rent-Equipment & Vehicles			67,430	67,430		67,430		67,430			35
36	Other (specify):*											36
37	TOTAL Ownership			1,377,431	1,377,431		1,377,431	26,195	1,403,626			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		367,654		367,654		367,654		367,654			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			81,578	81,578		81,578		81,578			42
43	Other (specify):* Non-Allow Costs			412,638	412,638		412,638	(412,638)				43
44	TOTAL Special Cost Centers		367,654	494,216	861,870		861,870	(412,638)	449,232			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,515,456	925,474	4,972,372	9,413,302		9,413,302	(1,056,169)	8,357,133			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				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,351)	30		9
10	Interest and Other Investment Income	(4,717)	32		10
11	Discounts, Allowances, Rebates & Refunds				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	(2,658)	43		18
19	Entertainment				19
20	Contributions	(101,014)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(172,623)	43		24
25	Fund Raising, Advertising and Promotional	(85,143)	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 See Pg 5A	(62,659)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (434,165)		\$	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)	(622,004)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (622,004)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,056,169)		37

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

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

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

Report Period Beginning:

Ending:

ID#0050237

01/01/2011

12/31/2011

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	X-Rays - Part A	\$ (20,293)	43	1
2	Patient Personal Items	(1,813)	43	2
3	Cable TV	(7,058)	43	3
4	Cost of prescription	(19,701)	43	4
5	Admitting non Certified	(4,909)	43	5
6	Capitalization of repairs more than \$2500	(9,897)	6	6
7	Non Allowable dues, subscription etc.	(1,320)	20	7
8	Discount	2,574	43	8
9	Accounting Fees	(242)	19	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
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43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(62,659)		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	See Pg 6-Supp		See Pg 6-Supp		
Menachem Shabat	29					
Jack Rajchenbach	6.1					
The Rajchenbach Family Trust	15.5					
Ronald Shabat	15.5					
The Robert Hartman Family Trust	4.9					

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%	\$ 82	\$ 82	1
2	V	3	Housekeeping Salaries		Legacy Healthcare Financial Services, LLC	100.00%	853	853	2
3	V	3	Housekeeping Supplies		Legacy Healthcare Financial Services, LLC	100.00%	10	10	3
4	V	5	Utilities		Legacy Healthcare Financial Services, LLC	100.00%	1,784	1,784	4
5	V	6	Repairs & Maintenance		Legacy Healthcare Financial Services, LLC	100.00%	4,154	4,154	5
6	V	10	RN Salaries		Legacy Healthcare Financial Services, LLC	100.00%			6
7	V	17	Administrative Salary - Mgmt. Alloc.	676,225	Legacy Healthcare Financial Services, LLC	100.00%	56,000	(620,225)	7
8	V	19	Other Professional Fees		Legacy Healthcare Financial Services, LLC	100.00%	3,801	3,802	8
9	V	19	Accounting		Legacy Healthcare Financial Services, LLC	100.00%	242	242	9
10	V	19	Legal Fees		Legacy Healthcare Financial Services, LLC	100.00%	(1,137)	(1,137)	10
11	V	19	Data Processing		Legacy Healthcare Financial Services, LLC	100.00%	286	286	11
12	V	20	Dues, Licenses & Fees		Legacy Healthcare Financial Services, LLC	100.00%	45	45	12
13	V	21	Office Supplies		Legacy Healthcare Financial Services, LLC	100.00%	7,213	7,213	13
14	Total			\$ 676,225			\$ 73,333	\$ * (602,891)	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.

☒ 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%	\$ 76,687	\$ (123,313)	15
16	V	24	Travel and Seminar		Legacy Healthcare Financial Services LLC	100.00%	327	327	16
17	V	26	Insurance Expense		Legacy Healthcare Financial Services LLC	100.00%	326	326	17
18	V	22	Employee Benefits		Legacy Healthcare Financial Services LLC	100.00%	19,652	19,652	18
19	V	30	Depreciation		Legacy Healthcare Financial Services LLC	100.00%	532	532	19
20	V	32	Amortization		Legacy Healthcare Financial Services LLC	100.00%	6	6	20
21	V	34	Rent Expense		Legacy Healthcare Financial Services LLC	100.00%	12,702	12,702	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			\$ 200,000			\$ 110,232	\$ * (89,768)	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	20	Dues, Licenses & Fees	\$	Legacy Real Properties, LLC	100.00%	\$ 24	\$	24
16	V	30	Depreciation Expense		Legacy Real Properties, LLC	100.00%	4,823		4,823
17	V	32	Interest Expense		Legacy Real Properties, LLC	100.00%	4,711		4,711
18	V	33	Taxes - Property	4,365	Legacy Real Properties, LLC	100.00%	4,365		
19	V								
20	V								
21	V								
22	V								
23	V								
24	V								
25	V								
26	V								
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ 4,365			\$ 13,923	\$ *	9,558

* 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		\$ 6,729	\$ 6,729	15
16	V	20	License & Fees		Grove Healthcare Properties, LLC		144	144	16
17	V	21	Bank Service Charges		Grove Healthcare Properties, LLC		10,223	10,223	17
18	V	30	Depreciation		Grove Healthcare Properties, LLC		1,552	1,552	18
19	V	32	Interest Expense		Grove Healthcare Properties, LLC		8,605	8,605	19
20	V	34	Rent	734,196	Grove Healthcare Properties, LLC		734,196		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			\$ 734,196			\$ 761,449	\$ * 27,253	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	10	RN Salary	\$	Progressive Healthcare Consulting		\$ 31,022	\$ 31,022	15
16	V	19	Professional Fees		Progressive Healthcare Consulting		196	196	16
17	V	20	Dues and Subscriptions		Progressive Healthcare Consulting		29	29	17
18	V	21	Clerical & General		Progressive Healthcare Consulting		55	55	18
19	V	22	Employee Benefits - Nursing		Progressive Healthcare Consulting		2,542	2,542	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			\$			\$ 33,844	\$ * 33,844	39

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

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			Grove Lincoln Park Living & Rehab Ctr.	Chicago	Legacy Healthcare	Skokie	Management Co.	1
2			Pine Acres Rehab & Living Center	Dekalb	Financial Srvcs, LLC			2
3			Astoria Place Living & Rehab	Chicago				3
4			The Grove of Evanston	Evanston	Legacy Real	Skokie	Real Estate	4
5			Grove North Living & Rehab Center	Chicago	Properties, LLC			5
6			Elmbrook Nursing	Elmbrook				6
7			The Grove of LaGrange Park	LaGrange Park	Grove Healthcare	Skokie	Real Estate	7
8			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

Facility Name & ID Number Grove North Living and Rehab Center # 0050237 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	172,000	7	14.00	Mgmt. Salary	\$ 28,000	17(7)	1
2	Menachem Shabat	Owner	Administrative	29.00	172,000	7	14.00	Mgmt. Salary	28,000	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	\$ 56,000		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 North Living and Rehab Center # 0050237 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Legacy Healthcare 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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	2	Food	Patient Days	590,233	12	\$ 890	\$	54,385	\$ 82	1
2	3	Housekeeping Salaries	Patient Days	590,233	12	9,260	9,260	54,385	853	2
3	3	Housekeeping Supplies	Patient Days	590,233	12	110		54,385	10	3
4	5	Utilities	Patient Days	590,233	12	19,366		54,385	1,784	4
5	6	Repairs & Maintenance	Patient Days	590,233	12	45,083		54,385	4,154	5
6	10	RN Salaries	Patient Days	590,233	12			54,385	0	6
7	17	Administrative Salary - Mgmt. All	Hours	50	12	400,000		7	56,000	7
8	19	Other Professional Fees	Patient Days	590,233	12	41,252		54,385	3,801	8
9	19	Accounting	Patient Days	590,233	12	2,627		54,385	242	9
10	19	Legal Fees	Patient Days	590,233	12	(12,339)		54,385	(1,137)	10
11	19	Data Processing	Patient Days	590,233	12	3,108		54,385	286	11
12	20	Dues, Licenses & Fees	Patient Days	590,233	12	493		54,385	45	12
13	21	Office Supplies	Patient Days	590,233	12	78,277		54,385	7,213	13
14	21	Clerical Salaries	Patient Days	590,233	12	832,276	832,276	54,385	76,687	14
15	24	Travel and Seminar	Patient Days	590,233	12	3,552		54,385	327	15
16	25	Travel	Patient Days	590,233	12			54,385	0	16
17	26	Insurance Expense	Patient Days	590,233	12	3,535		54,385	326	17
18	22	Employee Benefits	Patient Days	590,233	12	213,280		54,385	19,652	18
19	30	Depreciation	Bed Days Available	590,233	12	5,774		54,385	532	19
20	32	Amortization	Patient Days	590,233	12	62		54,385	6	20
21	33	Real Estate Taxes	Patient Days	590,233	12			54,385	0	21
22	34	Rent Expense	Patient Days	590,233	12	137,855		54,385	12,702	22
23	35	Equipment Rental	Patient Days	590,233	12			54,385	0	23
24										24
25	TOTALS					\$ 1,784,461	\$ 841,536		\$ 183,565	25

Facility Name & ID Number Grove North Living and Rehab Center # 0050237 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 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

	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	54,385	\$ 31,022	1
2	19	Professional Fees	Patient Days	465,768	10	1,681		54,385	196	2
3	20	Dues and Subscriptions	Patient Days	465,768	10	250		54,385	29	3
4	21	Clerical & General	Patient Days	465,768	10	472	472	54,385	55	4
5	22	Employee Benefits - Nursing	Patient Days	465,768	10	21,767		54,385	2,542	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	\$ 266,153		\$ 33,844	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	Private Bank		X	Capital Expenditures	\$10,186.00	10/23/08	\$ 671,440	\$ 213,456	10/1/13	3.7606	\$ 11,942	1	
2	Private Bank		X	Line of Credit		10/31/11	790,000	790,000	10/30/12	Varies	308	2	
3								Interest on Insurance Financing			1,453	3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$10,186.00		\$ 1,461,440	\$ 1,003,456			\$ 13,703	9	
	B. Non-Facility Related*												
10								Offset Interest Income			(322)	10	
11								Allocated from Management Company				6	11
12								Allocated from Legacy Real Properties, LI				4,711	12
13								Allocated from Grove Healthcare Properti				8,605	13
14	TOTAL Non-Facility Related						\$	\$			\$ 13,000	14	
15	TOTALS (line 9+line14)						\$ 1,461,440	\$ 1,003,456			\$ 26,703	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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.			\$	186,000	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.)		2010	\$	336,689	2
3. Under or (over) accrual (line 2 minus line 1).			\$	150,689	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	353,522	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.					
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	504,211	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	_____	8	
		2007	_____	9	
		2008	83,959	10	
		2009	183,952	11	
		2010	336,689	12	
Estimated accrual based on PY tax plus a 5% increase.					

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 North Living and Rehab Center</u>	COUNTY	<u>Cook</u>
FACILITY IDPH LICENSE NUMBER	<u>0050237</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Chaim Rajchenbach</u>		
TELEPHONE	<u>(773) 248-6000</u>	FAX #:	<u>(773) 248-9703</u>

Enter the tax index number and real estate tax assessed for 2010 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 2010.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,350

B. General Construction Type: Exterior Brick Frame Number of Stories 2

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).
N/A

E. Does this cost report reflect any organization or pre-operating costs which are being amortized?
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			\$ 7,538	1
2					2
3	TOTALS			\$ 7,538	3

Facility Name & ID Number Grove North Living and Rehab Center

0050237

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	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	Allocated from Legacy Real Properties				\$ 58,405	\$		\$ 1,909	\$ 1,909	\$ 4,867	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Landscaping			2009	10,000	666	15	666		1,665	9
10	Landscaping			2009	32,000	2,134	15	2,134		5,335	10
11	Built-in Cabinets			2009	66,890	1,672	40	1,672		4,180	11
12	Satellite System Installation			2009	11,305	283	40	283		707	12
13	Exterior Painting			2009	44,020	1,101	40	1,101		2,752	13
14	1st Floor remodel			2009	18,589	465	40	465		1,162	14
15	Electrical Work			2009	11,488	287	40	287		718	15
16	Painting & Décor			2009	107,803	2,695	40	2,695		6,738	16
17	Rehab Bathrooms			2009	25,000	625	40	625		1,563	17
18	2nd Floor & Nurses Station Remodel			2009	131,292	3,282	40	3,282		8,205	18
19	Install Locks			2009	8,500	213	40	213		532	19
20	New Roof			2009	39,725	993	40	993		2,483	20
21	Call Light System			2009	15,988	400	40	400		1,000	21
22	Kitchen Remodel			2009	46,284	1,157	40	1,157		2,893	22
23	Vent System Installation			2009	15,466	387	40	387		967	23
24	Therapy Room Remodel			2009	29,544	739	40	739		1,847	24
25	Elevator Repairs			2009	16,128	403	40	403		1,008	25
26	Rehab DON Office			2009	5,767	144	40	144		360	26
27	Rehab 34 Resident Bathrooms			2009	14,593	365	40	365		912	27
28	Building Improvement			2009	5,767	144	40	144		360	28
29	Electrical & Lighting			2009	4,025	101	40	101		252	29
30	Fire Sprinkler System			2009	7,952	199	40	199		497	30
31	Ventilation System Installation			2009	15,466	387	40	387		967	31
32	Window Coverings & Installation			2009	29,706	743	40	743		1,857	32
33	Ceiling Fixtures			2009	4,530	113	40	113		283	33
34	Flooring			2009	51,071	1,277	40	1,277		3,192	34
35	Smoke Detectors			2009	6,174	154	40	154		385	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

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 Irrigation System	2009	\$ 21,000	\$ 525	40	\$ 525	\$	\$ 1,313	37
38 Patch & Paint Conference Room	2009	1,860	47	40	47		117	38
39 Fire Sprinkler System	2009	2,100	53	40	53		132	39
40 Nurse Call System	2009	15,556	389	40	389		973	40
41 Tile Installation on 2nd Floor	2009	2,700	68	40	68		170	41
42 Rewire for Cable	2009	2,703	68	40	68		170	42
43 MDS Office Cabinetry	2009	7,400	185	40	185		463	43
44 Tile installation	2010	3,908	49	40	98	49	147	44
45 Electrical for new sign	2010	14,447	181	40	361	180	542	45
46								46
47 Shower Room renovation	2011	21,977	733	15	733	(0)	733	47
48 Doors	2011	3,228	231	7	231	(0)	231	48
49 Storm Sewer	2011	3,500	88	20	88		88	49
50 Landscaping	2011	3,020	101	15	101		101	50
51 Replacement of Water Heating Pipe	2011	3,377	42	40	42		42	51
52 Storm Sewer Repair	2011	3,500	44	40	44		44	52
53								53
54 Allocated from Legacy Real Properties		57,588			1,318	1,318	2,955	54
55								55
56 Reconcile to Book Depreciation			(870)			870		56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 1,001,342	\$ 23,063		\$ 27,388	\$ 4,325	\$ 65,908	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	\$ 204,289	\$ 34,333	\$ 28,371	\$ (5,962)	10	\$ 73,034	71
72	Current Year Purchases	6,939	496	498	2	7	496	72
73	Fully Depreciated Assets							73
74	See Schedule 13A	17,458		2,128	2,128	7	3,254	74
75	TOTALS	\$ 228,686	\$ 34,829	\$ 30,997	\$ (3,832)		\$ 76,784	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	N/A			\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

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)			\$ 1,237,566
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 57,891
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 58,384
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ 493
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 142,692

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	N/A	\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$ N/A
93		
94		
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 North Living and Rehab Center

0050237

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	2,249		532	532	7	562
2 Allocated from Legacy Real Properties	15,209		1,596	1,596	7	2,692
Totals	17,458	-	2,128	2,128		3,254

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Chicago Title Land Trust Company (Master Lessor); Grove HC Properties (Sub-Lessor--Related Party)

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:	1983	149	9/1/08	\$ 734,196	3	7	3
4	Additions							4
5								5
6	Home Office Allocation				12,702			6
7	TOTAL		149		\$ 746,898			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 N/A.

N/A

N/A

9. Option to Buy: YES X NO Terms: N/A *

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: \$ 36,140 Description: Nursing Rental \$35,810; Postage Machine \$330;

(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	See schedule 14A	See schedule 14A	\$ 4,043.00	\$ 31,290	17
18					18
19					19
20					20
21	TOTAL		\$ 4,043.00	\$ 31,290	21

10. Effective dates of current rental agreement:

Beginning 9/1/08

Ending 8/31/11

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

Fiscal Year Ending Annual Rent

12. /2012 \$

13. /2013 \$

14. /2014 \$

* 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.

Grove North Living and Rehab Center

0050237

12/31/2011

Schedule 14A

Use	Model Year and Make	Monthly Lease Payment	Rental Expense for this Period
Facility Related	Lexus, GX 470	915.00	10,065
Facility Related	Lexus, RX 350	670.87	4,025
Facility Related	Lexus, RX 350	704.41	2,293
Facility Related	Toyota Camry	600.06	7,201
Facility Related	2011 Nissan Maxima	428.08	2,981
Facility Related	2011 Acura MDX	725.00	4,725
		4,043.42	31,290

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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		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)	\$			

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				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	4,714	\$ 395,999	\$	4,714	\$ 395,999	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		841	70,681		841	70,681	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		4,679	393,029		4,679	393,029	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				355,361		355,361	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	39(2)					12,293		12,293	12
13	Other (specify): <u></u>									13
14	TOTAL			\$	10,234	\$ 859,709	\$ 367,654	10,234	\$ 1,227,363	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.

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 (209,689))	3,545,322	3,545,322	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,775	190,486	6
7	Other Prepaid Expenses	1,925	1,925	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Sch 17A	2,058,545	2,058,545	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,624,567	\$ 5,796,278	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	(7,000)	7,538	13
14	Buildings, at Historical Cost		58,405	14
15	Leasehold Improvements, at Historical Cost	867,730	942,937	15
16	Equipment, at Historical Cost	239,839	228,686	16
17	Accumulated Depreciation (book methods)	(130,179)	(142,692)	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)	\$ 970,390	\$ 1,094,874	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,594,957	\$ 6,891,152	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 502,160	\$ 502,160	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	315,617	315,617	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	181,811	353,522	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch 17A	1,172,234	1,172,234	36
37	Federal Unemployment Tax	377	377	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,172,199	\$ 2,343,910	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,003,456	1,003,456	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)	\$ 1,003,456	\$ 1,003,456	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,175,655	\$ 3,347,366	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,419,302	\$ 3,543,786	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,594,957	\$ 6,891,152	48

*(See instructions.)

Provider Name: Grove North Living and Rehab Center
Provider #: 0050237
Year End 12/31/2011
Schedule 17A

XV. BALANCE SHEET

Line 9: Other Current Assets (specify):

	Operating	After Consolidation
Due From Med Inter	421,571	421,571
Security Deposit	521,500	521,500
Due to Others	-	-
Accrued Illinois Bed Tax	20,340	20,340
Leg. Charity	1,966	1,966
Lagrange	134	134
Due T/F Legacy Charity	-	-
Due to 1st Health	927,660	927,660
Income Trust	20,872	20,872
Due To/From Legacy	144,502	144,502
	<u>2,058,545</u>	<u>2,058,545</u>

Line 36: Other Current Liabilities (specify):

Emp Loan, Adv, W/A	140	140
Due to Medicare	43,197	43,197
Due to Lessor/Prior Owner	24,979	24,979
Admin Bonus	15,000	15,000
Accrued Management Fees	109,025	109,025
Accrued FICA	9,870	9,870
GHCP	797,723	797,723
Members	172,300	172,300
	<u>1,172,234</u>	<u>1,172,234</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,585,706	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(300,000)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,285,706	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,158,595	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) Rounding	1	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,133,596	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)	\$ 3,419,302	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Grove North Living and Rehab Center# 0050237Report Period Beginning: 01/01/2011Ending: 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.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,821,955	1
2	Discounts and Allowances for all Levels	2,672,421	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,494,376	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	73,154	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 73,154	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	2,585	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	951	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,536	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	322	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 322	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Miscellaneous Income</u>	509	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 509	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,571,897	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,178,626	31
32	Health Care	3,767,414	32
33	General Administration	2,227,961	33
	B. Capital Expense		
34	Ownership	1,377,431	34
	C. Ancillary Expense		
35	Special Cost Centers	780,292	35
36	Provider Participation Fee	81,578	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,413,302	40
41	Income before Income Taxes (line 30 minus line 40)**	2,158,595	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,158,595	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
**LLC members are cash basis tax payers

*** 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	1,968	2,160	\$ 112,072	\$ 51.89	1
2	Assistant Director of Nursing	880	976	33,157	33.97	2
3	Registered Nurses	20,546	22,758	656,363	28.84	3
4	Licensed Practical Nurses	14,315	15,315	359,900	23.50	4
5	CNAs & Orderlies	80,822	87,155	963,065	11.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,574	7,362	99,259	13.48	8
9	Activity Director	1,960	2,116	37,762	17.85	9
10	Activity Assistants	10,446	11,189	116,490	10.41	10
11	Social Service Workers	7,001	7,258	131,909	18.17	11
12	Dietician					12
13	Food Service Supervisor	1,872	2,160	31,646	14.65	13
14	Head Cook	1,802	2,193	35,261	16.08	14
15	Cook Helpers/Assistants	17,668	19,169	203,634	10.62	15
16	Dishwashers					16
17	Maintenance Workers	4,129	4,625	60,984	13.19	17
18	Housekeepers	13,903	14,972	133,761	8.93	18
19	Laundry	5,212	5,700	60,915	10.69	19
20	Administrator	3,324	3,440	204,064	59.32	20
21	Assistant Administrator	2,544	2,680	91,679	34.21	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,950	8,233	105,365	12.80	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)	1,344	1,400	38,942	27.82	30
31	Medical Records	3,043	3,181	39,228	12.33	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	207,303	224,042	\$ 3,515,456 *	\$ 15.69	34

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	364	\$ 37,308	1(3)	35
36	Medical Director	Monthly	60,700	9(3)	36
37	Medical Records Consultant	33	4,512	10(3)	37
38	Nurse Consultant	628	27,000	10(3)	38
39	Pharmacist Consultant	Monthly	5,802	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	46	2,276	11(3)	44
45	Social Service Consultant	58	4,661	12(3)	45
46	Other(specify) <u>MDS Consultant</u>	Monthly	48,000	10(3)	46
47	<u>Psyco-Social</u>	Monthly	9,000	10(3)	47
48	<u>Miscellaneous nursing consultant</u>	Monthly	3,000	10(3)	48
49	TOTAL (lines 35 - 48)	1,129	\$ 202,259		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		N/A		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Grove North Living and Rehab Center

0050237Report Period Beginning: 01/01/2011Page 21Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jamie Dlatt	Administrator	0%	\$ 76,747
Mark Dubovick	Administrator	0%	127,317
Igor Rebel	Asst. Administrator	0%	91,679
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 295,743

B. Administrative - Other

Description	Amount
Management Fees "Eliminated in Col. 7"	\$ 676,225
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Schedule 21A		\$ 102,399
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 102,399

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 123,912
Unemployment Compensation Insurance	69,111
FICA Taxes	258,403
Employee Health Insurance	131,252
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	
Employee Benefits Other	51,009
State Income Tax	12,000
Unreimbursed Payroll Taxes	1,484
Progressive Healthcare Allocation	2,542
TOTAL (agree to Schedule V, line 22, col.8)	

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	\$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed 14)	1,031
Patient Background Checks 71	1,994
IL Council on Long Term Care	5,574
Miscellaneous Licenses & Fees	1,555
Legacy Healthcare Allocation	45
Grove Healthcare Properties Allocation	144
Progressive Healthcare Allocation	29
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	3,151
Home Office Allocation	327
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 3,478

* Attach copy of IMRF notifications

**See instructions.

Provider Name: Grove North Living and Rehab Center
Provider #: 0050237
Year End 12/31/2011
Schedule 21A

XIX.C. Professional Services

<u>Vendor/Payee</u>	Type	Amount
RSM McGladrey	Accounting	3,225
McGladrey & Pullen	Accounting	27,859
FR&R	Accounting	1,288
Scott and Kraus	Legal	(1,511)
Meyer Magence	Legal	5,128
Damon W. Douchet	Legal	1,030
Sheryl E. Fuhr & Associates	Legal	3,297
Skidelsky & Associates	Legal	185
Stone, McGuire & Siegal	Legal	2,205
Much Shelist	Legal	5,936
Ashman & Stein	Legal	666
Ogletree	Legal	790
Law Offices of Thomas E. Brewer	Legal	675
Citibusiness Card	Computer	756
Personnel Planners	Workers Comp Consultant	694
IIT/Sourcetek	Purchasing Consultant	895
ML Enterprises	Purchasing Consultant	3,500
Singer Networks	Computer	6,350
Prospect Resources	Risk Management	800
HDSI	Computer	13,728
E-Health Data	Computer	6,953
Singer Networks	Computer	12,904
National Datacare	Computer	580
American Data	Computer	4,468
	Schedule V, Line 19, Column	102,399

Legacy HC Finance Svcs, LLC Allocation	3,192
Grove Healthcare Properties, LLC Allocation	6,729
Progressive Healthcare Consulting Allocation	196
Out of Period Legal	(1,438)
Corporate Matters - Legal	(2,112)

Schedule V, Line 19, Column	<u>108,967</u>
-----------------------------	----------------

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.

ILCLTC \$5574
- (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?

7 Yrs.
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

33,080

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?

X

YES

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.

\$

81,578

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.

\$

0

Has any meal income been offset against related costs?

N/A

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?

N/A

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 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.