

		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>0050948</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Grove Of Evanston</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/11</u> to <u>12/31/11</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>500 Asbury Street</u> <u>Evanston</u> <u>60202</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(847)316-3320</u> Fax # <u>(847)316-3320</u>																									
HFS ID Number: _____		<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) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Cary C. Buxbaum, C.P.A.</u></td></tr><tr><td>(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Print Name and Title) <u>Cary C. Buxbaum, C.P.A.</u>	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	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												
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	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																								
Date of Initial License for Current Owners: <u>07/01/10</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236-1111</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove Of Evanston

0050948 Report Period Beginning: 01/01/11 Ending: 12/31/11

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>124</u>	Skilled (SNF)	<u>124</u>	<u>45,260</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>124</u>	TOTALS	<u>124</u>	<u>45,260</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>2,621</u>	<u>550</u>	<u>14,954</u>	<u>18,125</u>	8
9	SNF/PED					9
10	ICF	<u>14,287</u>	<u>1,949</u>		<u>16,236</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,908</u>	<u>2,499</u>	<u>14,954</u>	<u>34,361</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.92%

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 ☒

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 07/01/2010

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 07/01/2010 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 124 and days of care provided 14,079

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.

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	315,604	22,205	186	337,995		337,995		337,995			1
2	Food Purchase		232,947		232,947	(36,252)	196,695	(101)	196,594			2
3	Housekeeping	153,140	28,517	2,572	184,229		184,229	718	184,947			3
4	Laundry		340	83,205	83,545		83,545		83,545			4
5	Heat and Other Utilities			131,908	131,908		131,908	(22,756)	109,152			5
6	Maintenance	43,533		120,389	163,922		163,922	8,118	172,040			6
7	Other (specify):*											7
8	TOTAL General Services	512,277	284,009	338,260	1,134,546	(36,252)	1,098,294	(14,021)	1,084,273			8
	B. Health Care and Programs											
9	Medical Director			78,400	78,400		78,400		78,400			9
10	Nursing and Medical Records	2,013,434	158,516	84,892	2,256,842		2,256,842	(55,916)	2,200,926			10
10a	Therapy	158,977			158,977		158,977		158,977			10a
11	Activities	120,294	6,685		126,979		126,979		126,979			11
12	Social Services	146,510		6,558	153,068		153,068		153,068			12
13	CNA Training											13
14	Program Transportation			52,861	52,861		52,861		52,861			14
15	Other (specify):*							2,115	2,115			15
16	TOTAL Health Care and Programs	2,439,215	165,201	222,711	2,827,127		2,827,127	(53,801)	2,773,326			16
	C. General Administration											
17	Administrative	200,583		696,675	897,258		897,258	(612,676)	284,582			17
18	Directors Fees											18
19	Professional Services			364,149	364,149	(2,750)	361,399	(241,700)	119,699			19
20	Dues, Fees, Subscriptions & Promotions			315,848	315,848		315,848	(246,310)	69,538			20
21	Clerical & General Office Expenses	81,011	3,810	337,278	422,099		422,099	(178,834)	243,265			21
22	Employee Benefits & Payroll Taxes			564,960	564,960	36,252	601,212		601,212			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,706	1,706		1,706	272	1,978			24
25	Other Admin. Staff Transportation			1,973	1,973		1,973		1,973			25
26	Insurance-Prop.Liab.Malpractice			69,119	69,119		69,119	271	69,390			26
27	Other (specify):*							16,355	16,355			27
28	TOTAL General Administration	281,594	3,810	2,351,708	2,637,112	33,502	2,670,614	(1,262,623)	1,407,991			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,233,086	453,020	2,912,679	6,598,785	(2,750)	6,596,035	(1,330,444)	5,265,591			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' COMPILATION REPORT
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			247,973	247,973		247,973	(33,939)	214,034			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			26,844	26,844		26,844	454,287	481,131			32
33	Real Estate Taxes			360,911	360,911	2,750	363,661	3,633	367,294			33
34	Rent-Facility & Grounds			767,195	767,195		767,195	(760,000)	7,195			34
35	Rent-Equipment & Vehicles			11,623	11,623		11,623		11,623			35
36	Other (specify):*			13,540	13,540		13,540		13,540			36
37	TOTAL Ownership			1,428,086	1,428,086	2,750	1,430,836	(336,019)	1,094,817			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		656,441	1,426,141	2,082,582		2,082,582		2,082,582			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,890	67,890		67,890		67,890			42
43	Other (specify):*	30,468		95,206	125,674		125,674	(125,674)	0			43
44	TOTAL Special Cost Centers	30,468	656,441	1,589,237	2,276,146		2,276,146	(125,674)	2,150,472			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,263,554	1,109,461	5,930,002	10,303,017		10,303,017	(1,792,137)	8,510,880			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	(11,055)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(166,663)	30		9
10	Interest and Other Investment Income	(540)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(169)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,190)	21		18
19	Entertainment				19
20	Contributions	(89,387)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(213,615)	21		24
25	Fund Raising, Advertising and Promotional	(156,754)	20		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	(248,335)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (888,708)		\$	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)	(903,429)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (903,429)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,792,137)		37

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

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

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

Grove Of Evanston

	ID#	0050948
Report Period Beginning:		01/01/11
Ending:		12/31/11

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Patient Personal Items	\$ (6,733)	10	1
2	Guest Services	(1,928)	21	2
3	Bank Charges	(5,915)	21	3
4	Discounts Earned	(17,958)	21	4
5	State Income Tax	(1,300)	21	5
6	Annual Report	(250)	20	6
7	Marketing Wages	(30,468)	43	7
8	Building Co. - Accounting Fees	(4,000)	19	8
9	Building Co. - Loan Fees	(32,666)	21	9
10	Building Co. - Legal Fees	(14,386)	19	10
11	Building Co. - Other Professional Fees	(17,750)	19	11
12	Building Co. - Dues & Subscriptions	(250)	20	12
13	Building Co. - Equipment Rental Fee	(516)	35	13
14	Building Co. - Bank Fees	(167)	21	14
15	Non-Allowable Legal	(4,520)	19	15
16	Additional R&M	7,546	06	16
17	Capitalized R&M	(2,885)	06	17
18	Non-Allowable Fees	(95,206)	43	18
19	Miscellaneous Income	(5,797)	21	19
20	Income From Insurance	(13,186)	05	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	(248,335)		49

Grove Of Evanston

	ID#	0050948
Report Period Beginning:		01/01/11
Ending:		12/31/11

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

Summary A

12/31/11

[illegible]

Summary B

12/31/11

[illegible]

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page -Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ 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	34	Rental Income	\$ 760,000	Evanston Healthcare Realty, LLC		\$	(760,000)	1
2	V	32	Interest	54,981	Evanston Healthcare Realty, LLC		505,882	450,901	2
3	V	19	Accounting Fees		Evanston Healthcare Realty, LLC		4,000	4,000	3
4	V	21	Loan Fees		Evanston Healthcare Realty, LLC		32,666	32,666	4
5	V	19	Legal Fees		Evanston Healthcare Realty, LLC		14,386	14,386	5
6	V	19	Other Professional Fees		Evanston Healthcare Realty, LLC		17,750	17,750	6
7	V	20	Dues & Subscriptions		Evanston Healthcare Realty, LLC		250	250	7
8	V	35	Equipment Rental Fee		Evanston Healthcare Realty, LLC		516	516	8
9	V	21	Bank Fees		Evanston Healthcare Realty, LLC		167	167	9
10	V	30	Depreciation		Evanston Healthcare Realty, LLC		128,268	128,268	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 814,981			\$ 703,885	\$ * (111,096)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	2	FOOD	\$	Legacy Healthcare Financial Services	100.00%	\$ 68	\$ 68	15
16	V	3	HOUSEKEEPING		Legacy Healthcare Financial Services	100.00%	718	718	16
17	V	5	UTILITIES		Legacy Healthcare Financial Services	100.00%	1,485	1,485	17
18	V	6	GROUNDS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	3,457	3,457	18
19	V								19
20	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	2,657	2,657	20
21	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	38	38	21
22	V	21	CLERICAL & GENERAL		Legacy Healthcare Financial Services	100.00%	69,823	69,823	22
23	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	272	272	23
24	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	271	271	24
25	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	16,355	16,355	25
26	V	30	DEPRECIATION		Legacy Healthcare Financial Services	100.00%	443	443	26
27	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	5	5	27
28	V	34	RENT		Legacy Healthcare Financial Services	100.00%	10,571	10,571	28
29	V								29
30	V								30
31	V	17	MANAGEMENT FEES	636,676	Legacy Healthcare Financial Services	100.00%		(636,676)	31
32	V	19	BOOKKEEPING FEES	240,000	Legacy Healthcare Financial Services	100.00%		(240,000)	32
33	V				Legacy Healthcare Financial Services	100.00%			33
34	V								34
35	V	17	MANAGEMENT FEES- C. RAJCHENBACH		Legacy Healthcare Financial Services	100.00%	12,000	12,000	35
36	V	17	MANAGEMENT FEES- M. SHABAT		Legacy Healthcare Financial Services	100.00%	12,000	12,000	36
37	V								37
38	V								38
39	Total			\$ 876,676			\$ 130,163	\$ * (746,513)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 & SUBSCRIPTIONS		Legacy Real Properties	100.00%	19	\$	19
16	V	30	DEPRECIATION		Legacy Real Properties	100.00%	4,014		4,014
17	V	32	INTEREST EXPENSE		Legacy Real Properties	100.00%	3,921		3,921
18	V	33	REAL ESTATE TAXES		Legacy Real Properties		3,633		3,633
19	V								
20	V								
21	V								
22	V								
23	V	34	RENT	10,571	Legacy Real Properties	100.00%			(10,571)
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			\$ 10,571			\$ 11,587	\$ *	1,016

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	100.00%	25,817	\$	25,817
16	V	15	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	2,115		2,115
17	V	19	PROFESSIONAL FEES		Progressive Healthcare Consulting	100.00%	163		163
18	V	20	FEES, SUBSCRIPTIONS		Progressive Healthcare Consulting	100.00%	24		24
19	V	21	CLERICAL & GENERAL		Progressive Healthcare Consulting	100.00%	46		46
20	V								20
21	V								21
22	V	10	NURSING	75,000	Progressive Healthcare Consulting	100.00%			(75,000)
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			\$ 75,000			\$ 28,165	\$ *	(46,835)

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								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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	AVROHOM RAJCHENBACH	2.505%	ASTORIA PLACE LIVING AND REHABILITATION CENTER,LLC	CHICAGO	EVANSTON HC REALTY	EVANSTON	BUILDING CO	1
2	CHAIM RAJCHENBACH	30.000%	ELMBROOK NURSING,LLC	ELMHURST	LEGACY REAL PROPERTIES , L	LINCOLNWOOD	BUILDING CO	2
3	CHAVA BUSEL	2.505%	THE GROVE NORTH LIVING AND REHAB CENTER,LLC	SKOKIE	LEGACY HEALTHCARE & FINA	LINCOLNWOOD	HOME OFFICE / BOOKK	3
4	MENACHEM BERGER	9.950%	THE GROVE OF LAGRANGE PARK,LLC	LAGRANGE PARK	PROGRESSIVE HEALTHCARE CL	LINCOLNWOOD	NURSE CONSULTING	4
5	MENACHEM SHABAT	30.000%	THE GROVE AT LINCOLN PARK LIVING AND REHAB CENTER,LLC	CHICAGO				5
6	NAHAM SCHWARTZ	2.505%	LAKEFRONT NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO				6
7	RONALD SHABAT	12.525%	PARK VILLA NURSING AND REHABILITATION CENTER,LLC	MELROSE PARK				7
8	THE RAJCHENBACH FAMILY TRUST	2.505%	PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO				8
9	YAIR ZUCKERMAN	5.000%	WINDSOR PARK	CHICAGO				9
10	YOSEF RAJCHENBACH	2.505%	CHALET LIVING	CHICAGO				10
11			GROVE AT THE LAKE	ZION				11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES

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

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

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	30.00%	See Attached	3	6.00%	Al Mgmt Fee	\$ 12,000	17-7	1
2	Menachem Shabat	Owner	Administrative	30.00%	See Attached	3	6.00%	Al Mgmt Fee	12,000	17-7	2
3	Yair Zuckerman	Owner	Administrative	5.00%	None	40	100.00%	Salary	100,862	17-1	3
4	Menachem Berger	Owner	Administrative	9.95%	See Attached			Mgmt. Fees	60,000	17-3	4
5											5
6											6
7											7
8											8
9											9
10	Where applicable, the amounts on this page have been adjusted from the actual costs to reflect										10
11	only those amounts anticipated to be considered allowable by the IL Dept. of HFS.										11
12											12
13								TOTAL	\$ 184,862		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 Of Evanston # 0050948 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	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						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Grove Of Evanston # 0050948 Report Period Beginning: 01/01/11 Ending: 12/31/11

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
Street Address 7040 N. Ridgeway
City / State / Zip Code Lincolnwood, IL 60712
Phone Number (847) 679-9797
Fax Number (847) 679-1126

	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	AVAIL. BED DAYS	590,233	12	\$ 890	\$	45,260	\$ 68	1
2	3	HOUSEKEEPING	AVAIL. BED DAYS	590,233	12	9,370	9,260	45,260	718	2
3	5	UTILITIES	AVAIL. BED DAYS	590,233	12	19,367		45,260	1,485	3
4	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	590,233	12	45,083	9,228	45,260	3,457	4
5										5
6	19	PROFESSIONAL FEES	AVAIL. BED DAYS	590,233	12	34,648		45,260	2,657	6
7	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	590,233	12	493		45,260	38	7
8	21	CLERICAL & GENERAL	AVAIL. BED DAYS	590,233	12	910,553	832,276	45,260	69,823	8
9	24	SEMINARS	AVAIL. BED DAYS	590,233	12	3,552		45,260	272	9
10	26	INSURANCE	AVAIL. BED DAYS	590,233	12	3,535		45,260	271	10
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	590,233	12	213,280		45,260	16,355	11
12	30	DEPRECIATION	AVAIL. BED DAYS	590,233	12	5,774		45,260	443	12
13	32	INTEREST	AVAIL. BED DAYS	590,233	12	62		45,260	5	13
14	34	RENT	AVAIL. BED DAYS	590,233	12	137,855		45,260	10,571	14
15										15
16	17	MANAGEMENT FEES- C. RAJ	AVG HOURS WKD	50	11	200,000		3	12,000	16
17	17	MANAGEMENT FEES- M. SHA	AVG HOURS WKD	50	11	200,000		3	12,000	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,784,461	\$ 850,764		\$ 130,163	25

Facility Name & ID Number Grove Of Evanston # 0050948 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Real Properties
Street Address 7040 N. Ridgeway
City / State / Zip Code Lincolnwood, IL 60712
Phone Number (847) 679-9797
Fax Number (847) 679-1126

	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	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	590,233	12	250		45,260	19	1
2	30	DEPRECIATION	AVAIL. BED DAYS	590,233	12	52,340		45,260	4,014	2
3	32	INTEREST EXPENSE	AVAIL. BED DAYS	590,233	12	51,132		45,260	3,921	3
4	33	REAL ESTATE TAXES	AVAIL. BED DAYS	590,233	12	47,377		45,260	3,633	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 151,099	\$		\$ 11,587	25

Facility Name & ID Number Grove Of Evanston # 0050948 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 N. Ridgeway
City / State / Zip Code Lincolnwood, IL 60712
Phone Number (847) 679-9797
Fax Number (847) 679-1126

	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	10	RN SALARY	AVAIL. BED DAYS	465,768	10	265,681	265,681	45,260	25,817	1
2	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	465,768	10	21,767		45,260	2,115	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	465,768	10	1,681		45,260	163	3
4	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	465,768	10	250		45,260	24	4
5	21	CLERICAL & GENERAL	AVAIL. BED DAYS	465,768	10	472		45,260	46	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		\$ 28,165	25

Facility Name & ID Number Grove Of Evanston # 0050948 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	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						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Grove Of Evanston # 0050948 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	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						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Grove Of Evanston # 0050948 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	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						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
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14										14
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Grove Of Evanston # 0050948 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	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						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Grove Of Evanston # 0050948 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	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						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Grove Of Evanston # 0050948 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	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						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	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	Loan A			\$	5,310,000			\$	354,051	1
2	Private Bank		X	Loan B				2,700,000				96,601	2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	Private Bank		X	Line of Credit		09/23/10	2,000,000	1,410,000	07/03/12	5.5000		25,311	6
7	Insurance Financing		X			09/01/11						1,533	7
8	See Supplemental Schedule							928,119				55,230	8
9	TOTAL Facility Related						\$	2,000,000	\$	10,348,119			
	B. Non-Facility Related*												
10	Interest Income		X									(540)	10
11	Interest Income - Bldg. Co.		X									(54,981)	11
12	Allocated from Legacy Healthcare		X									5	12
13	See Supplemental Schedule											3,921	13
14	TOTAL Non-Facility Related						\$					\$	(51,595)
15	TOTALS (line 9+line14)						\$	2,000,000	\$	10,348,119			\$
												481,131	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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.) SEE ACCOUNTANTS' COMPILATION REPORT

** 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 - SUPPLEMENTAL SCHEDULE

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

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1							\$				\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	TOTAL Long-Term											7							
	Working Capital																		
8	Private Bank		X	Capex Loan			\$	928,119			\$ 55,230	8							
9												9							
10												10							
11												11							
12												12							
13												13							
14	TOTAL Working Capital							928,119			55,230	14							
	B. Non-Facility Related*																		
15	Allocated from Legacy Real Properties						\$				\$ 3,921	15							
16												16							
17												17							
18												18							
19												19							
20	TOTAL Non-Facility Related										3,921	20							

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** 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.		\$	56,769	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.)		\$	3,633	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(53,136)	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	417,680	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.)		\$	2,750	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.		\$	367,294	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006		8	
		2007		9	
		2008		10	
		2009		11	
		2010		12	
Beginning Accrual Adjusted / Allocated from Legacy Real Properties = \$3,633					
Grove of Evanston was previously a not-for-profit and did not pay real estate tax.					
The facility has recently filed for R/E taxes with the county and is currently waiting for the R/E Tax Bills.					
See Attached					
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2010 \$		13
		14	PLUS APPEAL COST FROM LINE 5 \$		14
		15	LESS REFUND FROM LINE 6 \$		15
		16	AMOUNT TO USE FOR RATE CALCULATION \$		16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

FACILITY NAME	<u>Grove Of Evanston</u>	COUNTY	<u>Cook</u>
FACILITY IDPH LICENSE NUMBER	<u>0050948</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Steve Lavenda</u>		
TELEPHONE	<u>(847) 236-1111</u>	FAX #:	<u>(847) 236-1155</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.

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

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.

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.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Grove Of Evanston

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0050948

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()

FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

51,712

B. General Construction Type:

Exterior

Brick

Frame

Number of Stories

3

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:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	51,712		\$ 824,151	1
2	Allocated from Legacy Real Properties			6,273	2
3	TOTALS	51,712		\$ 830,424	3

SEE ACCOUNTANTS' COMPILATION REPORT

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	124		2010	1961	\$ 3,299,125	\$ 107,399	39	\$ 84,593	\$ (22,806)	\$ 109,971	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

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			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		22,435	2,102		1,122	(980)	1,122	67
68	Related Party Allocations (Pages 12H & 12I)		96,532	2,685		3,932	1,247	7,105	68
69	Financial Statement Depreciation			265,099			(265,099)		69
70	TOTAL (lines 4 thru 69)		\$ 3,418,092	\$ 377,285		\$ 89,647	\$ (287,638)	\$ 118,198	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grove Of Evanston

0050948

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,418,092	\$ 377,285		\$ 89,647	\$ (287,638)	\$ 118,198	1
2	New Telephone System-Installation & Training	2010	41,002		20	2,050	2,050	26,651	2
3	Security Cameras	2010	7,410		20	371	371	4,755	3
4	Wall Outlet Installation	2010	7,680		20	384	384	1,024	4
5	Repair Walls & Ceiling- Drywall/ Plaster From Electrical Work	2010	3,000		20				5
6	Cable System & Outlet Installation	2010	17,720		20				6
7	Exterior Sign Installation	2010	5,413		20				7
8	Landscaping-Peking Cotoneaster & Planting	2010	5,425		20				8
9	Glass & Glazing 3Rd Floor Stairwell Window	2011	3,305		20	165	165	248	9
10	Glass & Glazing Stairwell Window	2011	3,305		20	165	165	193	10
11	1St Flr Day Rm - Installation Of Stocked Cabinets With Granite T	2011	4,771		20	119	119	119	11
12	2Nd Floor New Flooring - Resilient & Milwork Base	2011	27,350		20	228	228	228	12
13	Installation Of Tv Cable Outlets & Drywall/Plaster 44 Resident R	2011	10,490		20				13
14	Installation Of Blinds/Ceiling System/Cove Base/Lighting/Storage	2011	20,365		20				14
15	Custom Room Signs	2011	7,674		20				15
16	Canopy With Signage	2011	3,240		20				16
17	Building Exterior Painting	2011	7,500		20				17
18	Installation Of Railing Bars For Stairways	2011	6,950		20				18
19	Lobby-Wallpaper,Tile,Flooring,Ceiling,Doors,Electrical	2011	47,946		20				19
20	Basement Corridor-Tile,Ceiling,Wall Covering,Sinage,Door Fram	2011	45,716		20				20
21	Therapy Rm-Electrical,Built In Cabinets/Workstations, Drywall,F	2011	76,067		20				21
22	Nurses Station-Reception Area Repair	2011	4,631		20				22
23	Offices-Tiling,Walls & Flooring	2011	6,862		20				23
24	1St Floor-Wall Covering	2011	30,879		20				24
25	Corridor Renovation-Wallpaper,Tile,Flooring,Woodlock Protectio	2011	124,666		20				25
26	Conference Rooms-Tiling,Wallpaper,Plumbing,Light Fixtures,Ele	2011	23,364		20				26
27	1St Floor Day Rm-Wallpaper,Tiling,Lights	2011	9,703		20				27
28	1St Floor Resident Rms-Flooring,Window Coverings,Cubicle Curt	2011	39,319		20				28
29	Tiling-1St Flr Resident Bathrms	2011	6,827		20				29
30	Second Flr-Wallpaper	2011	30,879		20				30
31	2Nd Flr Day Rm-Wallpaper,Window Covering, Chair Rail & Inst	2011	5,278		20				31
32	2Nd Flr Resident Rms-Window Covering, Cubicle Curtains,Floori	2011	62,378		20				32
33	Tiling-2Nd Flr Resident Bathrms	2011	16,166		20				33
34	TOTAL (lines 1 thru 33)		\$ 4,131,373	\$ 377,285		\$ 93,129	\$ (284,156)	\$ 151,416	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	
1	Totals from Page 12B, Carried Forward	\$ 4,131,373	\$ 377,285		\$ 93,129	\$ (284,156)	\$ 151,416	1
2	3Rd Flr-Wall Covering	2011	30,879	20				2
3	3Rd Flr Day Rm-Wall Covering, Window Covering, Chair Rail &	2011	6,652	20				3
4	3Rd Flr Resident Rms-Cubicle Curtains,Flooring,Closets,Window	2011	74,768	20				4
5	Elevator-Tiling & Wallpaper Removal & Replacement	2011	21,383	20				5
6	Guest Bathroom Renovation	2011	4,704	20				6
7	New Lounge/Spa/Beauty Salon-Renovation,Flooring,Wallcovering	2011	42,156	20				7
8	Electrical-Resident Rooms	2011	5,886	20				8
9	Private Bathroom Renovation	2011	26,994	20				9
10	Relocate 10 Tv'S & Brackets/Cable Tv Outlets	2011	2,885	20				10
11								11
12								12
13								13
14								14
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29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,347,681	\$ 377,285		\$ 93,129	\$ (284,156)	\$ 151,416	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	
1	Totals from Page 12C, Carried Forward		\$ 4,347,681	\$ 377,285		\$ 93,129	\$ (284,156)	\$ 151,416	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,347,681	\$ 377,285		\$ 93,129	\$ (284,156)	\$ 151,416	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	
1	Totals from Page 12D, Carried Forward		\$ 4,347,681	\$ 377,285		\$ 93,129	\$ (284,156)	\$ 151,416	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,347,681	\$ 377,285		\$ 93,129	\$ (284,156)	\$ 151,416	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grove Of Evanston

0050948

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Installed Duplex Outlets, Disconnected & Capped off Scones	2010	2,825	141	20	141	0	141	9
10	Landscape Restoration	2010	12,110	1,211	20	606	(606)	606	10
11	Landscape Irrigation System - Installation	2010	7,500	750	20	375	(375)	375	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	
1	Building Company Information Continued		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		\$ 22,435	\$ 2,102		\$ 1,122	\$ (980)	\$ 1,122	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grove Of Evanston

0050948

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Legacy Real Properties	2009	48,606	1,589	30	1,620	31	4,050	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Legacy Real Properties	2009	27,603	636	20	1,380	744	1,955	9
10	Allocated from Legacy Real Properties	2010	8,393	197	20	336	139	504	10
11	Allocated from Legacy Real Properties	2011	11,930	263	20	596	333	596	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		\$ 96,532	\$ 2,685		\$ 3,932	\$ 1,247	\$ 7,105	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$1,195,641	\$3,412	\$117,818	\$114,406	10	\$354,259	71
72	Current Year Purchases	270,379		3,087	3,087	10	3,392	72
73	Fully Depreciated Assets	37,654				10	37,654	73
74								74
75	TOTALS	\$1,503,673	\$3,412	\$120,905	\$117,493		\$395,305	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	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)	\$6,681,779	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$380,697	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$214,034	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(166,663)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$546,720	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

YESNO
- If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Public Storage Rental				2,195			5
6	Parking Lot Rental				5,000			6
7	TOTAL				\$7,195			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:

YESNO

Terms: *

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

15. Is Movable equipment rental included in building rental?

YES

X

NO
16. Rental Amount for movable equipment: \$Description: (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	Facility	2010 Toyota Rav4	\$395.00	\$4,799	17
18	Facility	2011 Lexus IS350	804.95	6,823	18
19					19
20					20
21	TOTAL		\$1,199.95	\$11,622	21

10. Effective dates of current rental agreement:

Beginning

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

Fiscal Year Ending

Annual Rent

12. /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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

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)	
		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)	\$			

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 493,822	\$		\$ 493,822	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			198,356			198,356	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			639,887			639,887	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				605,311		605,311	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					94,076	51,130		145,206	13
14	TOTAL			\$		\$ 1,426,141	\$ 656,441		\$ 2,082,582	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 750	\$ 3,041,958	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,041,010	4,041,010	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,073	19,073	6
7	Other Prepaid Expenses		33,861	7
8	Accounts Receivable (owners or related parties)	117,168	117,168	8
9	Other(specify): <u>See Attached Schedule</u>	324,701	324,701	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,502,702	\$ 7,577,771	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		824,151	13
14	Buildings, at Historical Cost		3,299,125	14
15	Leasehold Improvements, at Historical Cost	238,856	1,325,221	15
16	Equipment, at Historical Cost	1,284,588	1,306,093	16
17	Accumulated Depreciation (book methods)	(300,181)	(461,546)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		48,999	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	1,220,450	1,220,450	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,443,713	\$ 7,562,493	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,946,415	\$ 15,140,264	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 619,189	\$ 619,189	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	264,461	264,461	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,109	10,109	31
32	Accrued Real Estate Taxes(Sch.IX-B)	417,680	417,680	32
33	Accrued Interest Payable		29,791	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	150,905	1,075,049	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,462,344	\$ 2,416,279	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,410,000	10,348,119	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,410,000	\$ 10,348,119	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,872,344	\$ 12,764,398	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,074,071	\$ 2,375,866	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,946,415	\$ 15,140,264	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,746,398	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,746,398	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,677,673	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	(350,000)	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)	\$ 1,327,673	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)	\$ 4,074,071	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 7,236,263	1
2	Discounts and Allowances for all Levels	1,818,257	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,054,520	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,253,060	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,253,060	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	582,926	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	52,703	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 635,629	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	540	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 540	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	36,941	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 36,941	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,980,690	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,134,546	31
32	Health Care	2,827,127	32
33	General Administration	2,637,112	33
	B. Capital Expense		
34	Ownership	1,428,086	34
	C. Ancillary Expense		
35	Special Cost Centers	2,208,256	35
36	Provider Participation Fee	67,890	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,303,017	40
41	Income before Income Taxes (line 30 minus line 40)**	1,677,673	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,677,673	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****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	1,522	1,546	\$ 66,867	\$ 43.25	1
2	Assistant Director of Nursing	770	858	32,501	37.88	2
3	Registered Nurses	19,912	21,148	682,999	32.30	3
4	Licensed Practical Nurses	15,561	16,175	407,822	25.21	4
5	CNAs & Orderlies	62,479	66,270	809,638	12.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,754	9,515	158,977	16.71	8
9	Activity Director	2,229	2,261	39,644	17.53	9
10	Activity Assistants	4,580	4,722	80,650	17.08	10
11	Social Service Workers	7,034	7,327	146,510	20.00	11
12	Dietician					12
13	Food Service Supervisor	2,048	2,080	54,452	26.18	13
14	Head Cook	3,352	3,396	39,332	11.58	14
15	Cook Helpers/Assistants	16,237	17,832	221,820	12.44	15
16	Dishwashers					16
17	Maintenance Workers	2,126	2,186	43,533	19.91	17
18	Housekeepers	15,223	15,962	153,140	9.59	18
19	Laundry					19
20	Administrator	2,000	2,120	99,721	47.04	20
21	Assistant Administrator	2,032	2,080	100,862	48.49	21
22	Other Administrative					22
23	Office Manager	240	240	3,366	14.03	23
24	Clerical	6,099	6,451	77,645	12.04	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	801	801	13,607	16.99	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,040	1,040	30,469	29.30	33
34	TOTAL (lines 1 - 33)	174,039	184,010	\$ 3,263,555 *	\$ 17.74	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	Monthly	\$ 186	01-03	35
36	Medical Director	Monthly	78,400	09-03	36
37	Medical Records Consultant	96	4,932	10-03	37
38	Nurse Consultant	Monthly	75,000	10-03	38
39	Pharmacist Consultant	Monthly	4,960	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	3,033	12-03	45
46	Other(specify)				46
47	Clergy	Per Visit	3,525	12-03	47
48					48
49	TOTAL (lines 35 - 48)	96	\$ 170,036		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				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Grove Of Evanston

0050948Report Period Beginning: 01/01/11Page 21Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership %

Amount

Colleen Rodney

Administrator

0.00%

\$ 99,721

Yair Zuckerman

Assist. Administrator

5.00%

100,862

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 200,583

B. Administrative - Other

Description

Amount

Legacy Healthcare

\$ 636,676

Menachem Berger - Mgmt. Fees

60,000

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$ 696,676

C. Professional Services

Vendor/Payee

Type

Amount

Legacy Healthcare

Bookkeeping

\$ 240,000

Frost, Ruttenberg & Rothblatt

Accounting

19,950

RSM McGladrey

Accounting

2,156

See Attached

Legal

56,318

Health Data Systems, Inc.

Data Processing

13,253

E-Health Data Solutions

Data Processing

8,062

Personnel Planners, Inc.

Unemployment Consulting

1,000

IIT/Sourcetechn

Computer Services

1,105

ML Enterprises

Purchasing Consultant

3,850

Elderlife Development, Ltd.

Architectural Services

2,154

Murphy Consulting

REAC Inspections

500

See Supplemental Schedule

15,802

TOTAL (agree to Schedule V, line 19, column 3)

(If total legal fees exceed \$5,000, attach copy of invoices.)

\$ 364,149

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 94,008

Unemployment Compensation Insurance

73,432

FICA Taxes

242,074

Employee Health Insurance

122,187

Employee Meals

36,252

Illinois Municipal Retirement Fund (IMRF)*

Pension Expense

13,069

Other Employee Benefits

18,750

Employee Physicals

1,440

TOTAL (agree to Schedule V, line 22, col.8)

\$ 601,212

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description

Line #

Amount

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$ 3,412

Advertising: Employee Recruitment

30,763

Health Care Worker Background Check

4,310

(Indicate # of checks performed 431)

Patient Background Checks

110

Dues & Subscriptions

19,378

Licenses & Permits

8,307

Advertising & Promotions

156,754

Allocated from Legacy Healthcare

38

See Supplemental Schedule

43

Less: Public Relations Expense

()

Non-allowable advertising

(156,754)

Yellow page advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 69,537

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

1,706

Allocated from Legacy Healthcare

272

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 1,978

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number		Grove Of Evanston		STATE OF ILLINOIS	#	0050948	Report Period Beginning:	01/01/11	Ending:	12/31/11	Page 23
XX. GENERAL INFORMATION:											
(1)	Are nursing employees (RN,LPN,NA) represented by a union?			Yes							
(2)	Are there any dues to nursing home associations included on the cost report?			Yes							
	If YES, give association name and amount.			Illinois Council on LTC - \$12,611							
(3)	Did the nursing home make political contributions or payments to a political action organization?			Yes							
	If YES, have these costs been properly adjusted out of the cost report?			Yes							
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?			No							
	If YES, what is the capacity?			N/A							
(5)	Have you properly capitalized all major repairs and equipment purchases?			Yes							
	What was the average life used for new equipment added during this period?			10 Years							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$ 29,801							
	Line			10							
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports?			Yes							
	If NO, attach a complete explanation.										
(8)	Are you presently operating under a sale and leaseback arrangement?			No							
	If YES, give effective date of lease.			N/A							
(9)	Are you presently operating under a sublease agreement?			YES X NO							
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?			YES NO X							
	If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.			N/A							
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.			\$ 67,890							
	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.			\$ 36,252							
	Has any meal income been offset against related costs?			No							
	Indicate the amount.			\$ N/A							
(16)	Travel and Transportation										
	a. Are there costs included for out-of-state travel?			No							
	If YES, attach a complete explanation.										
	b. Do you have a separate contract with the Department to provide medical transportation for residents?			No							
	If YES, please indicate the amount of income earned from such a program during this reporting period.			\$ N/A							
	c. What percent of all travel expense relates to transportation of nurses and patients?			100% Ln 14							
	d. Have vehicle usage logs been maintained?			N/A							
	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?			No							
	Firm Name:			N/A							
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?			Yes							
(19)	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.										

SEE ACCOUNTANTS' COMPILATION REPORT