

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 0051581 Facility Name: Grove At The Lake Living And Rehabilitation Llc Address: 2534 Elim Avenue Zion 60099 County: Lake Telephone Number: (847) 746-8435 Fax #: (847) 746-1744 HFS ID Number: Date of Initial License for Current Owners: 10/10/82 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. X Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Steve Lavenda Telephone Number: (847) 236-1111 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. Officer or Administrator of Provider (Signed) (Type or Print Name) (Title) Paid Preparer (Signed) (Print Name and Title) Kimberley A. Waite, C.P.A. (Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015 (Telephone) (847) 236-1111 Fax #: (847) 236-1155 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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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove At The Lake Living And Rehabilitation Llc

0051581 Report Period Beginning: 01/01/12 Ending: 12/31/12

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>67</u>	Skilled (SNF)	<u>67</u>	<u>24,522</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>163</u>	Intermediate (ICF)	<u>163</u>	<u>59,658</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>230</u>	TOTALS	<u>230</u>	<u>84,180</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>228</u>		<u>8,635</u>	<u>8,863</u>	8
9	SNF/PED					9
10	ICF	<u>51,715</u>	<u>3,015</u>	<u>171</u>	<u>54,901</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>51,943</u>	<u>3,015</u>	<u>8,806</u>	<u>63,764</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.75%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

N/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☐ NO ☒

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 10/10/1982

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 10/10/1982 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number of beds certified 67 and days of care provided 8,567

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: 12/31/2012 Fiscal Year: 12/31/2012

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number

Grove At The Lake Living And Rehabilitation

#0051581

Report Period Beginning:

01/01/12

Ending:

12/31/12

Page 3

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	380,110	32,701	17,561	430,372		430,372		430,372			1
2	Food Purchase		381,070		381,070	(54,450)	326,620	(148)	326,472			2
3	Housekeeping	185,025	38,035	1,322	224,382		224,382	1,422	225,804			3
4	Laundry	140,566	9,977	17,259	167,802		167,802		167,802			4
5	Heat and Other Utilities			253,443	253,443		253,443	(14,647)	238,796			5
6	Maintenance	157,267		225,262	382,529		382,529	28,098	410,627			6
7	Other (specify):*											7
8	TOTAL General Services	862,968	461,783	514,847	1,839,598	(54,450)	1,785,148	14,725	1,799,873			8
	B. Health Care and Programs											
9	Medical Director			24,800	24,800		24,800		24,800			9
10	Nursing and Medical Records	3,493,381	300,216	154,529	3,948,126		3,948,126	(1,429)	3,946,697			10
10a	Therapy	202,888		20,520	223,408		223,408		223,408			10a
11	Activities	165,072	17,411		182,483		182,483		182,483			11
12	Social Services	139,514		10,160	149,674		149,674		149,674			12
13	CNA Training											13
14	Program Transportation			2,408	2,408		2,408		2,408			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,000,855	317,627	212,417	4,530,899		4,530,899	(1,429)	4,529,470			16
	C. General Administration											
17	Administrative	174,964		39,999	214,963		214,963		214,963			17
18	Directors Fees											18
19	Professional Services			407,522	407,522		407,522	(247,020)	160,502			19
20	Dues, Fees, Subscriptions & Promotions			235,609	235,609		235,609	(201,944)	33,665			20
21	Clerical & General Office Expenses	174,007	9,685	298,534	482,226		482,226	(37,001)	445,225			21
22	Employee Benefits & Payroll Taxes			952,491	952,491	54,450	1,006,941		1,006,941			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,629	3,629		3,629	(1,063)	2,566			24
25	Other Admin. Staff Transportation			15,165	15,165		15,165		15,165			25
26	Insurance-Prop.Liab.Malpractice			88,360	88,360		88,360	(2,628)	85,732			26
27	Other (specify):*							38,212	38,212			27
28	TOTAL General Administration	348,971	9,685	2,041,309	2,399,965	54,450	2,454,415	(451,444)	2,002,970			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,212,794	789,095	2,768,573	8,770,462		8,770,462	(438,149)	8,332,313			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			285,839	285,839		285,839	369,796	655,635			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			63,830	63,830		63,830	1,032,546	1,096,376			32
33	Real Estate Taxes			277,036	277,036		277,036	5,202	282,238			33
34	Rent-Facility & Grounds			1,384,964	1,384,964		1,384,964	(1,384,964)				34
35	Rent-Equipment & Vehicles			44,685	44,685		44,685		44,685			35
36	Other (specify):*											36
37	TOTAL Ownership			2,056,354	2,056,354		2,056,354	22,580	2,078,934			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		411,365	915,491	1,326,856		1,326,856		1,326,856			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			473,858	473,858		473,858	(6,187)	467,671			42
43	Other (specify):*			863,122	863,122		863,122	(863,122)	0			43
44	TOTAL Special Cost Centers		411,365	2,252,471	2,663,836		2,663,836	(869,308)	1,794,528			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,212,794	1,200,460	7,077,398	13,490,652		13,490,652	(1,284,877)	12,205,775			45

*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

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	(16,708)	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	64,690	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(180)	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	(2,985)	21		18
19	Entertainment				19
20	Contributions	(94,560)	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	(197,019)	21		24
25	Fund Raising, Advertising and Promotional	(103,250)	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	(953,802)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,303,814)		\$	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)	18,937		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 18,937		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,284,877)		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

STATE OF ILLINOIS
Grove At The Lake Living And Rehabilitation Llc

	ID#	0051581
Report Period Beginning:		01/01/12
Ending:		12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	COPE Dues	\$ (743)	20	1
2	Building Co. - Professional Fees	(14,217)	19	2
3	Building Co. - Bank Service Charges	(128)	21	3
4	Building Co. - Amortization	(45,750)	36	4
5	Building Co. - Licenses and Permits	(250)	20	5
6	Building Co. - Penalties	(1,961)	21	6
7	Building Co. - State Income Tax	(5,369)	21	7
8	Patient Personal Items	(1,429)	10	8
9	Bank Charges	(9,179)	21	9
10	Insurance - Executive Life	(3,532)	26	10
11	Discount	(11,668)	21	11
12	Building Co. - Additional R&M	15,641	06	12
13	Additional R&M	14,473	06	13
14	Capitalized R&M	(5,378)	06	14
15	Marketing Expenses	(4,123)	43	15
16	Prior Year Bed Tax Assessment	(6,187)	42	16
17	Non-Allowable Seminar	(1,322)	24	17
18	Non-Allowable Expense	(858,999)	43	18
19	Non-Allowable Legal	(10,218)	19	19
20	Prior Period Dues	(3,465)	20	20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(953,802)		49

Report Period Beginning:

Ending:

ID#

0051581

01/01/12

12/31/12

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

Summary A

12/31/12

[illegible]

Summary B

Facility Name & ID Number	Grove At The Lake Living And Rehabilitation Llc	#	0051581	Report Period Beginning:	01/01/12	Ending:	12/31/12
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[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 6-Supplemental		

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

☒ YES

☐ 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	Rent	\$ 1,384,964	Grove at the Lake Realty, LLC		\$	(1,384,964)	1
2	V	32	Interest	93	Grove at the Lake Realty, LLC		1,027,285	1,027,192	2
3	V	19	Professional Fees		Grove at the Lake Realty, LLC		14,217	14,217	3
4	V	21	Bank Service Charge		Grove at the Lake Realty, LLC		128	128	4
5	V	30	Depreciation		Grove at the Lake Realty, LLC		300,688	300,688	5
6	V	36	Amortization		Grove at the Lake Realty, LLC		45,750	45,750	6
7	V	20	License and Permits		Grove at the Lake Realty, LLC		250	250	7
8	V	21	Penalties		Grove at the Lake Realty, LLC		1,961	1,961	8
9	V	21	State Income Tax		Grove at the Lake Realty, LLC		5,369	5,369	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,385,057			\$ 1,395,648	\$ * 10,591	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%	\$ 32	\$ 32	15
16	V	3	HOUSEKEEPING		Legacy Healthcare Financial Services	100.00%	1,422	1,422	16
17	V	5	UTILITIES		Legacy Healthcare Financial Services	100.00%	2,061	2,061	17
18	V	6	GROUPS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	3,362	3,362	18
19	V	17	MANAGEMENT FEES		Legacy Healthcare Financial Services	100.00%			19
20	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	7,880	7,880	20
21	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	73	73	21
22	V	21	CLERICAL & GENERAL		Legacy Healthcare Financial Services	100.00%	183,850	183,850	22
23	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	259	259	23
24	V	25	AUTO AND TRAVEL		Legacy Healthcare Financial Services	100.00%			24
25	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	904	904	25
26	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	26,912	26,912	26
27	V	30	DEPRECIATION		Legacy Healthcare Financial Services	100.00%	1,467	1,467	27
28	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	6	6	28
29	V	33	REAL ESTATE TAX		Legacy Healthcare Financial Services	100.00%			29
30	V	34	RENT		Legacy Healthcare Financial Services	100.00%	15,688	15,688	30
31	V	35	AUTO RENTAL		Legacy Healthcare Financial Services	100.00%			31
32	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services	100.00%			32
33	V	17	MANAGEMENT FEES	40,000	Legacy Healthcare Financial Services	100.00%		(40,000)	33
34	V	19	BOOKKEEPING FEES	244,683	Legacy Healthcare Financial Services	100.00%		(244,683)	34
35	V	17	MANAGEMENT FEES- C. RAJCHENBACH		Legacy Healthcare Financial Services	100.00%	20,000	20,000	35
36	V	17	MANAGEMENT FEES- M. SHABAT		Legacy Healthcare Financial Services	100.00%	20,000	20,000	36
37	V	27	HEALTH INSURANCE/BENEFITS- C. RAJCHENBACH		Legacy Healthcare Financial Services	100.00%	5,650	5,650	37
38	V	27	HEALTH INSURANCE/BENEFITS- M. SHABAT		Legacy Healthcare Financial Services	100.00%	5,650	5,650	38
39	Total			\$ 284,683			\$ 295,216	\$ * 10,533	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	30	DEPRECIATION		Legacy Real Properties	100.00%	2,951	\$	2,951
16	V	32	INTEREST EXPENSE		Legacy Real Properties	100.00%	5,348		5,348
17	V	33	REAL ESTATE TAXES		Legacy Real Properties	100.00%	5,202		5,202
18	V								
19	V								
20	V								
21	V								
22	V	34	RENT	15,688	Legacy Real Properties	100.00%			(15,688)
23	V								
24	V								
25	V								
26	V								
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ 15,688			\$ 13,501	\$ *	(2,187)

* 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

* 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

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

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	CHAIM RAJCHENBACH	28.000%	ASTORIA PLACE LIVING AND REHABILITATION CENTER,LLC	CHICAGO	THE GROVE AT THE LAKE REALTY		BUILDING CO	1
2	MENACHEM SHABAT	28.000%	ELMBROOK NURSING,LLC	ELMHURST	LEGACY REAL PROPERTIES , L	LINCOLNWOOD	BUILDING CO	2
3	RAJCHENBACH FAMILY TRUST	14.500%	THE GROVE NORTH LIVING AND REHAB CENTER,LLC	SKOKIE	LEGACY HEALTHCARE & FINA	LINCOLNWOOD	HOME OFFICE / BOOKK	3
4	JIM KOUZIOS	5.000%	THE GROVE OF EVANSTON,LLC	EVANSTON	LIFELINE AMBULANCE	CHICAGO	AMBULANCE	4
5	RONALD SHABAT	24.500%	THE GROVE OF LAGRANGE PARK,LLC	LAGRANGE PARK				5
6			THE GROVE AT LINCOLN PARK LIVING AND REHAB CENTER,LLC	CHICAGO				6
7			LAKEFRONT NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO				7
8			PARK VILLA NURSING AND REHABILITATION CENTER,LLC	MELROSE PARK				8
9			PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO				9
10			WINDSOR PARK	CHICAGO				10
11			CHALET LIVING & REHAB CENTER	CHICAGO				11
12			THE GROVE OF NORTHBROOK	NORTHBROOK				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	28.00%	See Attached	5.00	10.00%	Alloc Mgt Fee	\$ 20,000	17-7	1
2	Menachem Shabat	Owner	Administrative	28.00%	See Attached	5.00	10.00%	Alloc Mgt Fee	20,000	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 40,000		13

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

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

Facility Name & ID Number Grove At The Lake Living And Rehabilitation Llc # 0051581 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 At The Lake Living And Rehabilitation Llc # 0051581 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	716,018	13	\$ 270	\$	84,180	\$ 32	1
2	3	HOUSEKEEPING	AVAIL. BED DAYS	716,018	13	12,097	11,779	84,180	1,422	2
3	5	UTILITIES	AVAIL. BED DAYS	716,018	13	17,526		84,180	2,061	3
4	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	716,018	13	28,596		84,180	3,362	4
5	17	MANAGEMENT FEES	AVAIL. BED DAYS	716,018	13			84,180		5
6	19	PROFESSIONAL FEES	AVAIL. BED DAYS	716,018	13	67,029		84,180	7,880	6
7	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	716,018	13	625		84,180	73	7
8	21	CLERICAL & GENERAL	AVAIL. BED DAYS	716,018	13	1,563,793	1,447,779	84,180	183,850	8
9	24	SEMINARS	AVAIL. BED DAYS	716,018	13	2,200		84,180	259	9
10	25	AUTO AND TRAVEL	AVAIL. BED DAYS	716,018	13			84,180		10
11	26	INSURANCE	AVAIL. BED DAYS	716,018	13	7,687		84,180	904	11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	716,018	13	228,907		84,180	26,912	12
13	30	DEPRECIATION	AVAIL. BED DAYS	716,018	13	12,480		84,180	1,467	13
14	32	INTEREST	AVAIL. BED DAYS	716,018	13	51		84,180	6	14
15	33	REAL ESTATE TAX	AVAIL. BED DAYS	716,018	13			84,180		15
16	34	RENT	AVAIL. BED DAYS	716,018	13	133,442		84,180	15,688	16
17	35	AUTO RENTAL	AVAIL. BED DAYS	716,018	13			84,180		17
18	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	716,018	13			84,180		18
19										19
20	17	MANAGEMENT FEES- C. RAJ	AVG HOURS WKD	50	12	200,000		5	20,000	20
21	17	MANAGEMENT FEES- M. SHA	AVG HOURS WKD	50	12	200,000		5	20,000	21
22	27	HEALTH INSURANCE/BENEF	AVG HOURS WKD	50	12	56,500		5	5,650	22
23	27	HEALTH INSURANCE/BENEF	AVG HOURS WKD	50	12	56,500		5	5,650	23
24										24
25	TOTALS					\$ 2,587,703	\$ 1,459,558		\$ 295,216	25

Facility Name & ID Number Grove At The Lake Living And Rehabilitation Llc # 0051581 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 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	30	DEPRECIATION	AVAIL. BED DAYS	716,018	13	25,098		84,180	2,951	1
2	32	INTEREST EXPENSE	AVAIL. BED DAYS	716,018	13	45,486		84,180	5,348	2
3	33	REAL ESTATE TAXES	AVAIL. BED DAYS	716,018	13	44,250		84,180	5,202	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					\$ 114,834	\$		\$ 13,501	25

Facility Name & ID Number Grove At The Lake Living And Rehabilitation Llc # 0051581 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 At The Lake Living And Rehabilitation Llc # 0051581 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 At The Lake Living And Rehabilitation Llc # 0051581 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 At The Lake Living And Rehabilitation Llc # 0051581 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 At The Lake Living And Rehabilitation Llc # 0051581 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 At The Lake Living And Rehabilitation Llc # 0051581 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 At The Lake Living And Rehabilitation Llc # 0051581 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

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	Mortgage			\$	11,225,000			\$ 1,027,285	1
2	Capex		X	Line of Credit				1,755,006				2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Private Bank		X	Line of Credit				695,000			61,882	6
7												7
8	See Supplemental Schedule										7,302	8
9	TOTAL Facility Related						\$	13,675,006			\$ 1,096,469	9
	B. Non-Facility Related*											
10	Interest Income - Bldg Co.		X								(93)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						\$				\$ (93)	14
15	TOTALS (line 9+line14)						\$	13,675,006			\$ 1,096,376	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	IDFS		X	Working Capital/Liab. Insur.			\$	\$			\$ 1,948	8	
9	Allocated from Legacy Healthcare		X								6	9	
10	Allocated from Legacy Real Prop		X								5,348	10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital										7,302	14	
	B. Non-Facility Related*												
15							\$	\$			\$	15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											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

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	215,411	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.)				\$	245,420	2																				
3. Under or (over) accrual (line 2 minus line 1).				\$	30,009	3																				
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	252,229	4																				
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5																				
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6																				
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	282,238	7																				
Real Estate Tax History:																										
Real Estate Tax Bill for Calendar Year:		2007	202,950	8	<table><tr><td></td><td colspan="2">FOR BHF USE ONLY</td><td></td></tr><tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2011</td><td>\$</td><td>13</td></tr><tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr><tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr><tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr></table>			FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2011	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
	FOR BHF USE ONLY																									
13	FROM R. E. TAX STATEMENT FOR 2011	\$	13																							
14	PLUS APPEAL COST FROM LINE 5	\$	14																							
15	LESS REFUND FROM LINE 6	\$	15																							
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																							
	2008	213,512	9																							
	2009	224,434	10																							
	2010	209,137	11																							
	2011	240,218	12																							
2012 Accrual: \$240,218 x 1.05 = \$252,229																										
Allocated from Legacy Real Properties: \$5,202																										

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 At The Lake Living And Rehabilitation Llc</u>	COUNTY	<u>Lake</u>
---------------	--	--------	-------------

CONTACT PERSON REGARDING THIS REPORT

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)		(B)	(C)	(D)
<u>Tax Index Number</u>		<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	04-22-301-007	Long Term Care Property	\$ 221,304.15	\$ 221,304.15
2.	04-22-301-009	Long Term Care Property	\$ 18,913.91	\$ 18,913.91
3.	See Attached	See Attached	\$ 42,154.05	\$ 4,955.92
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 282,372.11	\$ 245,173.98

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grove At The Lake Living And Rehabilitation Llc COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0051581

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)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
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:

83,793

B. General Construction Type:

Exterior

Brick

Frame

Number of Stories

4

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

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	50,091	1990	\$ 28,460	1
2	Alloc. Legacy Real Prop			9,618	2
3	TOTALS	50,091		\$ 38,078	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	230		1990	1975	\$ 5,384,307	\$ 208,332	39	\$ 138,059	\$ (70,273)	\$ 450,264	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1980	5,655		20				5,655	9
10	Various		1981	13,906		20				13,906	10
11	Various		1982	1,171		20				1,171	11
12	Various		1983	17,000		20				16,819	12
13	Various		1984	36,737		20				36,737	13
14	Various		1985	135,882		20				135,840	14
15	Various		1986	63,852		20				63,018	15
16	Various		1987	60,439		20				60,094	16
17	Various		1988	24,257		20				23,967	17
18	Various		1989	102,083		20	27		27	102,015	18
19	Various		1990	84,998		20				84,998	19
20	Various		1991	10,496		20				10,496	20
21	Various		1992	18,109		20	614		614	18,109	21
22	Various		1993	39,981		20	1,999		1,999	39,331	22
23	Various		1994	123,996		20	6,200		6,200	115,227	23
24	Various		1995	157,007		20	7,850		7,850	139,523	24
25	Various		1996	210,423		20	10,521		10,521	172,374	25
26	Various		1997	97,938		20	4,897		4,897	76,358	26
27	Various		1998	76,538		20	3,827		3,827	54,579	27
28	Various		1999	232,757		20	11,331		11,331	151,639	28
29	Various		2000	88,771		20	4,409		4,409	55,908	29
30	Various		2001	147,900		20	7,383		7,383	88,169	30
31	Various		2002	156,984		20	5,812		5,812	143,203	31
32	Various		2003	473,434		20	39,570		39,570	441,461	32
33	Various		2004	276,659		20	15,379		15,379	226,458	33
34	Various		2005	89,356		20	5,725		5,725	66,917	34
35	Various		2006	90,306		20	6,521		6,521	42,804	35
36	Various		2007	115,795		20	8,336			46,054	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	Various	2008	\$ 117,156	\$	20	\$ 14,415	\$ 14,415	\$ 63,365	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		2,420,799	92,356		100,664	8,308	100,663	67
68	Related Party Allocations (Pages 12H & 12I)		151,353	2,232		6,198	3,966	17,798	68
69	Financial Statement Depreciation			285,839			(285,839)		69
70	TOTAL (lines 4 thru 69)		\$ 11,026,045	\$ 588,759		\$ 399,736	\$ (197,360)	\$ 3,064,918	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 At The Lake Living And Rehabilitation Llc

0051581

Report Period Beginning:

01/01/12

Ending:

12/31/12

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		\$ 11,026,045	\$ 588,759		\$ 399,736	\$ (189,023)	\$ 3,064,918	1
2	Repair Leak, Replace Main & Circulating Pumps	2009	4,387		20	439	439	1,755	2
3	Boiler Room Pump Repair	2009	6,306		20	526	526	2,102	3
4	Overhead Line On Elevator Hoistway	2009	6,475		20	648	648	2,536	4
5	Tile & Coving Installation In Foyer Area	2009	3,396		20	340	340	1,302	5
6	Replace T-Couple On Cleaver Brook Boiler	2009	2,883		20	288	288	1,105	6
7	Replace Domestic Water Piping	2009	4,261		20	426	426	1,633	7
8	North Town Mechanical	2009	32,686		20	3,269	3,269	12,257	8
9	Hot Water Line	2009	2,511		20	251	251	900	9
10	Water Pipes	2009	4,260		20	426	426	1,633	10
11	Water Pipes	2009	4,080		20	408	408	1,462	11
12	Exterior Brick Work	2009	36,000		20	3,600	3,600	12,300	12
13	Roof Repairs	2009	4,960		20	496	496	1,695	13
14	Doors, Ramp, & Decking	2009	20,165		20	2,017	2,017	6,722	14
15	Windows	2009	8,909		20	891	891	2,821	15
16	Roof Drains	2009	14,156		20	1,416	1,416	4,483	16
17	Ahu Bearings	2009	2,546		20	255	255	785	17
18	Cooling Tank	2009	4,355		20	436	436	1,343	18
19	Jockey Pump	2009	2,601		20	260	260	802	19
20	Bearing Assembly	2009	3,043		20	304	304	963	20
21	Boiler Maintenance	2009	4,008		20	401	401	1,269	21
22	Electrical Circuit Work	2009	6,750		20	675	675	2,138	22
23	Painting	2009	3,720		20	372	372	1,426	23
24	Painting	2009	3,720		20	372	372	1,395	24
25	2Nd Floor Flooring	2010	43,195		20	3,960	3,960	11,879	25
26	Handrails	2010	24,153		20	2,013	2,013	6,038	26
27	Elevator Motor	2010	6,030		20	603	603	1,809	27
28	Window Installation	2010	31,620		20	2,372	2,372	7,115	28
29	New Circuits	2010	7,110		20	260	260	779	29
30	Roofing	2010	7,774		20	648	648	1,944	30
31	Security System	2010	9,739		20	730	730	2,191	31
32	Wallcoverings	2010	6,597		20	550	550	1,649	32
33	Laminate Countertop	2010	3,658		20	366	366	1,097	33
34	TOTAL (lines 1 thru 33)		\$ 11,352,098	\$ 588,759		\$ 429,749	\$ (159,010)	\$ 3,164,245	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 At The Lake Living And Rehabilitation Llc

0051581

Report Period Beginning:

01/01/12

Ending:

12/31/12

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 12B, Carried Forward		\$ 11,352,098	\$ 588,759		\$ 429,749	\$ (159,010)	\$ 3,164,245	1
2	Dining Room Buildout	2010	5,974		20	548	548	1,643	2
3	Concrete Steps & Rail	2010	4,400		20	296	296	888	3
4	Wall Coverings	2010	2,844		20	190	190	569	4
5	Wallcoverings	2010	4,211		20	246	246	737	5
6	Handrails-3Rd Floor	2010	31,195		20	1,560	1,560	4,679	6
7	Refrigeration Fan	2010	2,990		20	150	150	449	7
8	Air Conditioner Compressor	2010	5,429		20	226	226	679	8
9	Volt 30 Amp Circuit	2010	3,313		20	138	138	414	9
10	Insulation	2010	36,145		20	904	904	2,711	10
11	Fire Dampers	2010	3,587		20	60	60	179	11
12	Privacy Curtains	2010	11,063		20	1,291	1,291	3,872	12
13	Roller Shades	2010	9,752		20	975	975	2,926	13
14	3 Fire Dampers	2010	3,587		20	60	60	179	14
15	Exhaust Fan	2010	6,674		20	56	56	167	15
16	Glass	2010	2,971		20	74	74	223	16
17	Wiring	2010	6,037		20	101	101	302	17
18	Pump And Piping	2010	13,527		20	1,353	1,353	4,058	18
19	New Windows And Doors	2010	7,200		20	360	360	1,080	19
20	New Windows	2010	56,746		20	2,837	2,837	8,512	20
21	Flooring	2010	60,516		20	3,026	3,026	9,077	21
22	Penthouse Air Handler & Laundry Rm Exhaust Fan Maintenance	2010	4,272		20	214	214	641	22
23	Electrical Maintenance:Panels,Receptacles,Generator	2010	3,065		20	153	153	460	23
24	Building Improvements - Arch/Planners	2011	9,003		20	900	900	1,200	24
25	Bimp - Sas Arch/Planners	2011	44,586		20	4,586	4,586	5,350	25
26	Bimp - Supply Counter	2011	4,278		20	428	428	463	26
27	Exhaust Fan	2011	6,674		20	334	334	667	27
28	Kitchen Air Handler	2011	9,829		20	491	491	983	28
29	Kitchen Air Handler	2011	19,956		20	998	998	1,996	29
30	Boiler Maintenance, Compressor Repair,	2011	38,184		20	1,909	1,909	3,818	30
31	Fence Post	2011	2,875		20	144	144	288	31
32	Drapery	2011	4,139		20	414	414	828	32
33	Repair Nurse Call	2011	4,897		20	245	245	490	33
34	TOTAL (lines 1 thru 33)		\$ 11,782,016	\$ 588,759		\$ 455,011	\$ (133,748)	\$ 3,224,772	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 11,782,016	\$ 588,759		\$ 455,011	\$ (133,748)	\$ 3,224,772	1
2	Replace Leaking Gaskets On Emergency Generator	2011	2,760		20	138	138	276	2
3	Hvac Repair	2011	2,855		20	143	143	286	3
4	3Rd Floor Nurse Call System	2011	14,070		20	704	704	1,407	4
5	Fire Station And Bezels To Passenger Elevators	2011	5,198		20	260	260	520	5
6	Electrical Wiring	2011	3,135		20	157	157	314	6
7	New Condenser Motor, Brackets, And Fan Blade For Condenser F	2012	3,477		20	522	522	522	7
8	Replace Nurse Call System And Sound Alert Buzzer System For 2	2012	10,195		20	1,529	1,529	1,529	8
9	Installed 2 Inspection Stations And Fire Service Phase For 2 Passe	2012	5,198		20	1,040	1,040	1,040	9
10	Planting Crabtree And Shrubs	2012	7,590		20	506	506	506	10
11	Landscaping - 4 Loads Of Topsoil, Perennials, Mulch	2012	2,670		20	134	134	134	11
12	Installed Series 90 Modulating Control For Boilers	2012	2,708		20	135	135	135	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)		\$ 11,841,872	\$ 588,759		\$ 460,278	\$ (128,481)	\$ 3,231,439	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		\$ 11,841,872	\$ 588,759		\$ 460,278	\$ (128,481)	\$ 3,231,439	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		\$ 11,841,872	\$ 588,759		\$ 460,278	\$ (128,481)	\$ 3,231,439	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 At The Lake Living And Rehabilitation Llc

0051581

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	4Th Floor Nurse Call System	2012	5,054		20	168	168	168	9
10	36 Master Unit, Bathroom Stations, Double Stations, Single Station	2012	14,070		20	469	469	469	10
11	Framing/Drywall For Nurses Stations	2012	6,000		20	200	200	200	11
12	1St Flr Flooring, Masonry, Doors, Windows, Painting, Electrical	2012	797,114		20	27,936	27,936	27,936	12
13	1St Floor Sas Architect Fees	2012	39,728		20	1,938	1,938	1,938	13
14	Install new framing, drywall, and taping in corridors.	2012	15,375		20	512	512	512	14
15	Installation of cable jacks, patching and sanding of sprinkler pipe.	2012	47,760		20	1,590	1,590	1,590	15
16	Install receptacles for TV in residence bedrooms	2012	6,204		20	207	207	207	16
17	Complete installation of Landscape, irrigation system per proposa	2012	14,500		20	483	483	483	17
18	Add additional soffits for nurses stations, patching	2012	9,000		20	300	300	300	18
19	New lighting system, new exit sign.	2012	24,845		20	1,242	1,242	1,242	19
20	Room 313,319,334,405-411-Repair dry wall, new tiles	2012	12,775		20	425	425	425	20
21	Remove baseboard and prep for paint, work throughtout guestroom	2012	48,339		20	1,610	1,610	1,610	21
22	116 VT-Door	2012	31,933		20	1,063	1,063	1,063	22
23	Remove all existing baseboard and prep for paint in guest baths, p	2012	22,505		20	749	749	749	23
24	Complete the framing and installation of drywall for all soffits, re	2012	32,084		20	1,068	1,068	1,068	24
25	Replace 117 new and four old doors, install seven diving walls, inst	2012	13,908		20	463	463	463	25
26	TV plates installed behind the TV's	2012	3,745		20	125	125	125	26
27	Provide and install drywall patches and tape due to springler pipe,	2012	11,830		20	394	394	394	27
28	All damaged drywall and electrical debris as requested, install new	2012	19,413		20	646	646	646	28
29	Completed all work throughout guestrooms, additional drywall an	2012	26,747		20	891	891	891	29
30	Repair drywall, sanding, soffits	2012	4,897		20	163	163	163	30
31	Checked existing bx wiring, installed 63 new receptacles	2012	13,058		20	435	435	435	31
32	Installed i-box for microwave, steam table outlet, wall light	2012	5,158		20	172	172	172	32
33	Install 2 new shrub zones for plantings, electric solenoid valves, sh	2012	3,000		20	100	100	100	33
34									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 At The Lake Living And Rehabilitation Llc

0051581

Report Period Beginning:

01/01/12

Ending:

12/31/12

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 Continued		\$	\$		\$	\$	\$	1
2	Low voltage installations	2012	28,475		20	948	948	948	2
3	81.25 X 59.00 General Suppliers	2012	2,696		20	225	225	225	3
4	Window treatments and installation	2012	11,605		20	774	774	774	4
5	Lounge chair, swivel chair, end table with glass top, game table, arm c	2012	42,165		20	2,811	2,811	2,811	5
6	Cut away drywall throughout the 3rd floor	2012	3,420		20	114	114	114	6
7	Rmored Nurse Station lights; Installed 4 ceiling lights, 1 exit sign, 2 c	2012	24,185		20	805	805	805	7
8	Suburban Elevator	2012	10,640		20	354	354	354	8
9	Triton DVR	2012	14,818		20	493	493	493	9
10	Telepone System and wiring	2012	24,241		20	807	807	807	10
11	Triton DVR CCTV Sytem with installation and cutover	2012	14,876		20	495	495	495	11
12	3rd Floor Corridor & Patient Room-Installed lights, exit signs, sprinkl	2012	46,079		20	1,534	1,534	1,534	12
13	3rd & 4th Floor-Framing, drywall & taping; Installed all 2x2 ultima w	2012	20,000		20	666	666	666	13
14	Building Permit, City of Zion for Interior Remodel- Office Space	2012	8,300		20	276	276	276	14
15	Exterior Signage and Lighting	2012	37,709		20	1,885	1,885	1,885	15
16									16
17									17
18	Depreciation			92,356			(92,356)		18
19									19
20	Items that were in Construction in Progress, but now are completed								20
21	1st Floor, 2nd Floor, 3rd Floor, and 4th Floor - Fire Sprinklers	2012	210,000		20	10,500	10,500	10,500	21
22	2nd Floor Res Rms, 3rd Floor Rms, Nurse Stations, Bathrooms								22
23	Remove exisiting wall tile, install new light fixtures, ceramic wall tile								23
24	Remove exisiting cove base, floor prep, and installed cornicles	2012	264,819		20	13,241	13,241	13,241	24
25	Nurse Stations, 2nd-4th Floors Corridors, dining & res rooms, bathrooms								25
26	Light fixtures, floor prep, handrails, wallcoverings, cornicles								26
27	cove bases, ceramic tiles, millwork base, and signage	2012	427,729		20	21,386	21,386	21,386	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		\$ 2,420,799	\$ 92,356		\$ 100,664	\$ 8,308	\$ 100,663	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	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									3
4	Allocated from Legacy Real Properties	2009	74,521	1,383	35	2,484	1,101	8,694	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Legacy Real Properties	2009	42,320	342	20	2,116	1,774	5,819	9
10	Allocated from Legacy Real Properties	2010	12,869	104	20	515	411	1,288	10
11	Allocated from Legacy Real Properties	2011	18,291	148	20	915	767	1,829	11
12									12
13	Allocated from Legacy Healthcare	2012	3,352	255	20	168	(87)	168	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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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)		\$ 151,353	\$ 2,232		\$ 6,198	\$ 3,966	\$ 17,798	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	\$ 1,514,205	\$ 1,653	\$ 177,632	\$ 175,979	10	\$ 808,965	71
72	Current Year Purchases		533	15,401	14,868	10	15,401	72
73	Fully Depreciated Assets	1,124,504				10	1,124,504	73
74								74
75	TOTALS	\$ 2,638,709	\$ 2,186	\$ 193,033	\$ 190,847		\$ 1,948,870	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		VAN	2008	\$ 15,461	\$	\$ 2,324	\$ 2,324	5	\$ 11,587	76
77										77
78										78
79										79
80	TOTALS			\$ 15,461	\$	\$ 2,324	\$ 2,324		\$ 11,587	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)	\$ 14,534,121	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 590,945	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 655,635	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 64,690	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,191,896	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	LAND - 1994	\$ 199,000	\$	\$	86
87	REMODEL STORAGE ROOM - 1999	4,000			87
88	REMODEL STORAGE RM - 1999	10,000			88
89	REMODEL STORAGE ROOM - 1999	4,300			89
90	DAYCARE CTR ARCHITEC - 2000	787			90
91	TOTALS	\$ 218,087	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$ 1,180,489	92
93			93
94			94
95		\$ 1,180,489	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?
If NO, see instructions.
- ☐ YES☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
-
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$ 24,039
- Description: See Attached Schedule
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2010 Acura RL	\$ 831.53	\$ 9,978	17
18	Facility	Lexus	799.00	10,669	18
19					19
20					20
21	TOTAL		\$ 1,630.53	\$ 20,647	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. /2013 \$
13. /2014 \$
14. /2015 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

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

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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	\$		\$ 294,411	\$		\$ 294,411	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			203,047			203,047	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			308,133			308,133	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				377,331		377,331	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					109,900	34,034		143,934	13
14	TOTAL			\$		\$ 915,491	\$ 411,365		\$ 1,326,856	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	\$ (316,498)	\$ 247,051	1
2	Cash-Patient Deposits	5,858	5,858	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,372,608	2,372,608	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	147,120	147,120	6
7	Other Prepaid Expenses	30,674	30,674	7
8	Accounts Receivable (owners or related parties)	444,271	(9,806)	8
9	Other(specify): See Attached Schedule	67,228	67,228	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,751,261	\$ 2,860,733	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,000,000	13
14	Buildings, at Historical Cost		8,124,901	14
15	Leasehold Improvements, at Historical Cost	64,875	1,808,796	15
16	Equipment, at Historical Cost	1,949,208	2,042,502	16
17	Accumulated Depreciation (book methods)	(362,109)	(729,073)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	2,500,000	3,756,739	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,151,974	\$ 16,003,865	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,903,235	\$ 18,864,598	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 594,961	\$ 1,175,246	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	695,000	2,450,006	29
30	Accrued Salaries Payable	448,726	448,726	30
31	Accrued Taxes Payable (excluding real estate taxes)	66,502	66,502	31
32	Accrued Real Estate Taxes(Sch.IX-B)		252,229	32
33	Accrued Interest Payable	3,755	87,620	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	156,866	3,311,066	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,965,810	\$ 7,791,395	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,225,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 11,225,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,965,810	\$ 19,016,395	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,937,425	\$ (151,797)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,903,235	\$ 18,864,598	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,421,787	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,421,787	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(484,362)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (484,362)	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)	\$ 4,937,425	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			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 11,047,226	1
2	Discounts and Allowances for all Levels	(167,360)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,879,866	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,764,757	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,764,757	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	304,056	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	45,413	20
21	Other Medical Services	530	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 349,999	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	11,668	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,668	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,006,290	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,839,598	31
32	Health Care	4,530,899	32
33	General Administration	2,399,965	33
	B. Capital Expense		
34	Ownership	2,056,354	34
	C. Ancillary Expense		
35	Special Cost Centers	2,189,978	35
36	Provider Participation Fee	473,858	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,490,652	40
41	Income before Income Taxes (line 30 minus line 40)**	(484,362)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (484,362)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 7,700,280	44
45	Private Pay - Net Inpatient Revenue	545,208	45
46	Medicare - Net Inpatient Revenue	2,579,616	46
47	Other-(specify) Insurance	54,762	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,879,866	49

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.
*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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	1,700	2,109	\$ 100,077	\$ 47.45	1
2	Assistant Director of Nursing	1,246	1,367	43,330	31.70	2
3	Registered Nurses	34,981	37,560	1,091,361	29.06	3
4	Licensed Practical Nurses	29,011	31,181	846,217	27.14	4
5	CNAs & Orderlies	107,825	116,168	1,386,830	11.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13,209	14,321	202,888	14.17	8
9	Activity Director	2,370	2,651	55,661	21.00	9
10	Activity Assistants	5,653	6,299	109,411	17.37	10
11	Social Service Workers	6,470	7,077	139,514	19.71	11
12	Dietician					12
13	Food Service Supervisor	1,778	1,939	46,806	24.14	13
14	Head Cook	4,904	5,148	57,904	11.25	14
15	Cook Helpers/Assistants	22,871	25,457	275,400	10.82	15
16	Dishwashers					16
17	Maintenance Workers	8,064	8,765	157,267	17.94	17
18	Housekeepers	16,182	17,549	185,025	10.54	18
19	Laundry	11,113	12,483	140,566	11.26	19
20	Administrator	1,704	2,070	104,416	50.44	20
21	Assistant Administrator	1,976	2,151	70,548	32.80	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,077	12,487	174,007	13.94	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	864	1,187	25,566	21.54	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	282,998	307,969	\$ 5,212,794 *	\$ 16.93	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	\$ 17,561	01-03	35
36	Medical Director	Monthly	24,800	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	21,810	10-03	38
39	Pharmacist Consultant	Monthly	13,455	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	20,520	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	154	9,840	12-03	45
46	Other(specify)				46
47	Clergy	Monthly	320	12-03	47
48					48
49	TOTAL (lines 35 - 48)	154	\$ 108,306		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	4,631	\$ 119,264	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	4,631	\$ 119,264		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	%	Amount	Description		Amount	Description		Amount		
Julie Stangel	Administrator	0.00%	\$ 104,416	Workers' Compensation Insurance		\$ 138,827	IDPH License Fee		\$ 2,432		
Eliyahu Waldman	Asst. Admin	0.00%	70,548	Unemployment Compensation Insurance		119,330	Advertising: Employee Recruitment		2,401		
				FICA Taxes		393,757	Health Care Worker Background Check		1,474		
				Employee Health Insurance		240,957	(Indicate # of checks performed	147.4			
				Employee Meals		54,450	Patient Background Checks				
				Illinois Municipal Retirement Fund (IMRF)*			Dues and Subscriptions		24,281		
				Union Pension		43,742	License and Permits		3,003		
				Other Employee Benefits		15,878	Allocated from Legacy Healthcare		73		
							Allocated from Legacy Real Prop				
							Less: Public Relations Expense	(			
							Non-allowable advertising	(			
							Yellow page advertising	(			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						\$ 174,964	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 33,664		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT**

****See instructions.**

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													
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9													
10													
11													
12													
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14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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. IL Council on LTC \$30,719

(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. \$ 74,982 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Sheridan Healthcare #0027680

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 467,671
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. \$ 54,450 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? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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. \$ No

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A

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

(19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT