

		FOR BHF USE					

LL1

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: 0050245

Facility Name: Grove Lincoln Park Lvg & Rehab

Address: 2732 N Hampden Ct Chicago 60614
Number City Zip Code

County: Cook

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

HFS ID Number:

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

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Amanda Springborn Telephone Number: (314) 925-3838
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) _____ (Date) _____
(Type or Print Name) _____
(Title) _____

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) McGladrey LLP
20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Grove Lincoln Park Lvg & Rehab# 0050245 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 bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>98</u>	Skilled (SNF)	<u>98</u>	<u>35,868</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>11</u>	Intermediate (ICF)	<u>11</u>	<u>4,026</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>109</u>	TOTALS	<u>109</u>	<u>39,894</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>10,615</u>	<u>3,480</u>	<u>16,343</u>	<u>30,438</u>	8
9	SNF/PED					9
10	ICF			<u>507</u>	<u>507</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>10,615</u>	<u>3,480</u>	<u>16,850</u>	<u>30,945</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 77.57%

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

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

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 09/01/08

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

YES ☒Date 09/01/08NO ☐

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

YES ☒NO ☐If YES, enter number
of beds certified 109 and days of care provided 16,343Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/12Fiscal Year: 12/31/12

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	306,359	18,390	27,736	352,485		352,485		352,485			1
2	Food Purchase		298,345		298,345		298,345	21	298,366			2
3	Housekeeping	160,907	29,586	188	190,681		190,681	921	191,602			3
4	Laundry	38,523	12,772	7,526	58,821		58,821		58,821			4
5	Heat and Other Utilities			114,016	114,016		114,016	1,335	115,351			5
6	Maintenance	70,234		84,436	154,670		154,670	2,178	156,848			6
7	Other (specify):*											7
8	TOTAL General Services	576,024	359,093	233,902	1,169,019		1,169,019	4,455	1,173,474			8
	B. Health Care and Programs											
9	Medical Director			72,500	72,500		72,500		72,500			9
10	Nursing and Medical Records	2,333,049	163,470	102,395	2,598,914		2,598,914	9,649	2,608,563			10
10a	Therapy											10a
11	Activities	151,169	11,307	2,496	164,972		164,972		164,972			11
12	Social Services	133,551		4,995	138,546		138,546	1,996	140,542			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,617,769	174,777	182,386	2,974,932		2,974,932	11,645	2,986,577			16
	C. General Administration											
17	Administrative	337,185		725,987	1,063,172		1,063,172	(661,374)	401,798			17
18	Directors Fees											18
19	Professional Services			134,297	134,297		134,297	4,325	138,622			19
20	Dues, Fees, Subscriptions & Promotions			29,871	29,871		29,871	192	30,063			20
21	Clerical & General Office Expenses	116,148	31,430	276,223	423,801		423,801	119,841	543,642			21
22	Employee Benefits & Payroll Taxes			678,112	678,112		678,112		678,112			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,830	11,830		11,830	(9,844)	1,986			24
25	Other Admin. Staff Transportation			21,736	21,736		21,736		21,736			25
26	Insurance-Prop.Liab.Malpractice			99,379	99,379		99,379	585	99,964			26
27	Other (specify):* Mgmt Alloc of Benefi							30,041	30,041			27
28	TOTAL General Administration	453,333	31,430	1,977,435	2,462,198		2,462,198	(516,234)	1,945,964			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,647,125	565,300	2,393,723	6,606,148		6,606,148	(500,134)	6,106,014			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			54,678	54,678		54,678	3,874	58,552			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,463	14,463		14,463	10,660	25,123			32
33	Real Estate Taxes			358,200	358,200		358,200	3,370	361,570			33
34	Rent-Facility & Grounds			743,261	743,261		743,261	10,163	753,424			34
35	Rent-Equipment & Vehicles			87,413	87,413		87,413	109	87,522			35
36	Other (specify):*											36
37	TOTAL Ownership			1,258,015	1,258,015		1,258,015	28,176	1,286,191			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		429,214	914,080	1,343,294		1,343,294		1,343,294			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			342,036	342,036		342,036		342,036			42
43	Other (specify):* Non-Allowable Co			379,848	379,848		379,848	(479,848)	(100,000)			43
44	TOTAL Special Cost Centers		429,214	1,635,964	2,065,178		2,065,178	(479,848)	1,585,330			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,647,125	994,514	5,287,702	9,929,341		9,929,341	(951,806)	8,977,535			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(3,213)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	11,335	30		9
10	Interest and Other Investment Income	(1,448)	32		10
11	Discounts, Allowances, Rebates & Refunds		43		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(4,873)	43		18
19	Entertainment				19
20	Contributions	(102,778)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,469)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(190,315)	43		24
25	Fund Raising, Advertising and Promotional	(171,487)	43		25
	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(344,007)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (809,255)		\$	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)	(628,038)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (628,038)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,437,293)		37

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

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

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

STATE OF ILLINOIS
Grove Lincoln Park Lvg & Rehab

Report Period Beginning: ID# 0050245
Ending: 01/01/12
12/31/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Adj Prior Year Expenses	\$ (57,233)	43	1
2	Labs - Part A	(3,784)	43	2
3	X-Rays - Part A	(53,726)	43	3
4	Pharm House stock	(37,803)	43	4
5	Charity Discounts	(31,000)	43	5
6	Discount	25,737	43	6
7	Personal Items	(940)	43	7
8	Admitting	(182,210)	43	8
9	Non-Allowable Travel & Seminar	(1,549)	24	9
10	RE Tax	(1,499)	33	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				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	(344,007)		49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Chaim Rajchenbach	28	See Pg 6-Supp		See Pg6-Supp		
Menachem Shabat	28					
Ronald Shabat	14					
Shari Borenstein	5					
Jamie Dlatt	5					
Howard Borenstein	5					

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	\$	Legacy Healthcare Financial Services, LLC	100.00%	\$ 15	\$ 15	1
2	V	3	Housekeeping Salaries		Legacy Healthcare Financial Services, LLC	100.00%	656	656	2
3	V	3	Housekeeping Supplies		Legacy Healthcare Financial Services, LLC	100.00%	18	18	3
4	V	5	Utilities		Legacy Healthcare Financial Services, LLC	100.00%	976	976	4
5	V	6	Repairs & Maintenance		Legacy Healthcare Financial Services, LLC	100.00%	1,593	1,593	5
6	V								6
7	V	17	Administrative Salary - Mgmt. Alloc.	838,310	Legacy Healthcare Financial Services, LLC	100.00%	40,000	(798,310)	7
8	V	19	Other Professional Fees		Legacy Healthcare Financial Services, LLC	100.00%	1,461	1,461	8
9	V	19	Accounting		Legacy Healthcare Financial Services, LLC	100.00%			9
10	V	19	Legal Fees		Legacy Healthcare Financial Services, LLC	100.00%	956	956	10
11	V	19	Data Processing		Legacy Healthcare Financial Services, LLC	100.00%	1,318	1,318	11
12	V	20	License Fee		Legacy Healthcare Financial Services, LLC	100.00%	35	35	12
13	V	21	Office Supplies		Legacy Healthcare Financial Services, LLC	100.00%	6,464	6,464	13
14	Total			\$ 838,310			\$ 53,492	\$ * (784,818)	14

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

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Clerical Salaries	\$	Legacy Healthcare Financial Services, LLC	100.00%	\$ 80,665	\$ 80,665	15
16	V	24	Travel and Seminar		Legacy Healthcare Financial Services, LLC	100.00%	123	123	16
17	V	26	Insurance Expense		Legacy Healthcare Financial Services, LLC	100.00%	428	428	17
18	V	27	Employee Benefits		Legacy Healthcare Financial Services, LLC	100.00%	24,054	24,054	18
19	V	30	Depreciation		Legacy Healthcare Financial Services, LLC	100.00%	695	695	19
20	V	32	Amortization		Legacy Healthcare Financial Services, LLC	100.00%	3	3	20
21	V	34	Rent Expense		Legacy Healthcare Financial Services, LLC	100.00%	7,435	7,435	21
22	V	6	R & M Salary		Legacy Healthcare Financial Services, LLC	100.00%	0		22
23	V	34	Rent Expense		Legacy Healthcare Financial Services, LLC	100.00%			23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 113,403	\$ * 113,403	39

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

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Repairs & Maintenance	\$	Legacy Real Properties, LLC	100.00%	\$	\$	15
16	V	21	Office Expense		Legacy Real Properties, LLC	100.00%			16
17	V	30	Depreciation		Legacy Real Properties, LLC	100.00%	1,398	1,398	17
18	V	32	Interest		Legacy Real Properties, LLC	100.00%	2,534	2,534	18
19	V	33	Real Estate Taxes		Legacy Real Properties, LLC	100.00%	2,465	2,465	19
20	V	34	Rent						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			\$			\$ 6,397	\$ * 6,397	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Computer Services	\$	Grove Healthcare Properties, LLC		\$ 2,785	\$ 2,785	15
16	V	20	License & Fees		Grove Healthcare Properties, LLC		106	106	16
17	V	21	Bank Service Charges		Grove Healthcare Properties, LLC		375	375	17
18	V	30	Depreciation		Grove Healthcare Properties, LLC		70	70	18
19	V	32	Interest Expense		Grove Healthcare Properties, LLC		5,818	5,818	19
20	V	34	Rent	543,728	Grove Healthcare Properties, LLC		543,728		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			\$ 543,728			\$ 552,882	\$ * 9,154	39

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

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	RN Salary	\$	Progressive Healthcare Consulting	100.00%	\$ 7,058	\$ 7,058	15
16	V	12	Clergy Salary		Progressive Healthcare Consulting	100.00%	1,461	1,461	16
17	V	17	Administrator		Progressive Healthcare Consulting	100.00%	14,891	14,891	17
18	V	19	Professional Fees		Progressive Healthcare Consulting	100.00%	97	97	18
19	V	20	Fees and Subscriptions		Progressive Healthcare Consulting	100.00%			19
20	V	21	Clerical & General		Progressive Healthcare Consulting	100.00%	165	165	20
21	V	22	Emp. Ben - Nursing		Progressive Healthcare Consulting	100.00%	956	956	21
22	V	35	Auto Rental		Progressive Healthcare Consulting	100.00%	80	80	22
23	V	17	Administrative Salar-Mgmt Alloc		Progressive Healthcare Consulting	100.00%	3,118	3,118	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			\$			\$ 27,826	\$ * 27,826	39

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

Facility Name & ID Number

Grove Lincoln Park Lvg & Rehab

0050245

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	29.00	Grove Lincoln Park Living & Rehab Ctr.	Chicago	Legacy Healthcare	Skokie	Management Co.	1
2	Menachem Shabat	29.00	Pine Acres Rehab & Living Center	Dekalb	Financial Svcs, LLC			2
3	Jack Rajchenback	6.10	Astoria Place Living & Rehab	Chicago				3
4	Ronald Shabat	15.50	The Grove of Evanston	Evanston	Legacy Real	Skokie	Real Estate	4
5	Menachem Berger		Grove North Living & Rehab Center	Chicago	Properties, LLC			5
6	Jake Weiss		Elmbrook Nursing	Elmbrook				6
7	The Rajchenbach Family Trust	15.50	The Grove of LaGrange Park	LaGrange Park	Grove Healthcare	Skokie	Real Estate	7
8	The Robert Hartman Family Trust	4.90	Lakefront Nursing & Rehab Center	Chicago	Properties, LLC			8
9			Bridgeview Health Care Center	Bridgeview				9
10			The Carlton at the Lake	Chicago	Shabat &	Chicago	Management Co.	10
11			Clark Manor Convalescent Center	Chicago	Associates, LLC			11
12			Springfield Terrace	Springfield				12
13			Tower Hill Healthcare Center	South Elgin	JLR Management	Chicago	Management Co.	13
14			Glenview Terrace Nursing Center	Glenview				14
15			The Imperial Grove Pavilion	Chicago				15
16			The Arc of Jacksonville, Ltd.	Jacksonville				16
17			Peterson Park Health Care Center	Chicago				17
18			Embassy Health Care Center	Wilmington				18
19			Whitehall North	Deerfield				19
20			Harmony Nursing & Rehab Center	Chicago				20
21			Florence Nursing Home	Marengo				21
22			The Fountain's	Marion				22
23			Friendship Care Center - Herrin	Herrin				23
24			City Care Center of Cobden	Combden				24
25			Ridgeway Manor	Ridgeway				25
26			Sheridan Health Care Center	Zion				26
27			Oak Grove Rehab & Skilled Care	Carbondale				27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

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

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

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

Facility Name & ID Number Grove Lincoln Park Lvg & Rehab # 0050245 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, LLC
Street Address 7040 North Ridgeway Avenue
City / State / Zip Code Lincolnwood, IL 60712
Phone Number (847) 679-9797
Fax Number (847) 679-3676

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference				Allocated Among	Allocated	in Column 6			
1	2	Dietary	Bed Days Available	716,018	13	\$ 270	\$	39,894	\$ 15	1
2	3	Housekeeping Salaries	Bed Days Available	716,018	13	11,779	11,779	39,894	656	2
3	3	Housekeeping Supplies	Bed Days Available	716,018	13	318		39,894	18	3
4	5	Utilities	Bed Days Available	716,018	13	17,526		39,894	976	4
5	6	Repairs & Maintenance	Bed Days Available	716,018	13	28,596		39,894	1,593	5
6	10	Nursing Salary	Bed Days Available	716,018	13			39,894	0	6
7	17	Administrative Salary - Mgmt All	Hours	100	12	400,000	400,000	10	40,000	7
8	19	Other Professional Fees	Bed Days Available	716,018	13	26,219		39,894	1,461	8
9	19	Legal Fees	Bed Days Available	716,018	13	17,158		39,894	956	9
10	19	Data Processing	Bed Days Available	716,018	13	23,653		39,894	1,318	10
11	20	Dues, Licenses, & Fees	Bed Days Available	716,018	13	625		39,894	35	11
12	21	Office Supplies	Bed Days Available	716,018	13	116,015		39,894	6,464	12
13	21	Clerical Salaries	Bed Days Available	716,018	13	1,447,779	1,447,779	39,894	80,665	13
14	24	Travel	Bed Days Available	716,018	13	2,200		39,894	123	14
15	25	Education & Seminars	Bed Days Available	716,018	13			39,894	0	15
16	26	Insurance Expense	Bed Days Available	716,018	13	7,687		39,894	428	16
17	27	Employee Benefits - Mgmt Alloc	Bed Days Available	716,018	13	228,907		39,894	12,754	17
18	27	Employee Benefits - Mgmt Alloc	Hours	100	12	113,000		10	11,300	18
19	30	Depreciation Expense	Bed Days Available	716,018	13	12,480		39,894	695	19
20	32	Amortization Expense	Bed Days Available	716,018	13	51		39,894	3	20
21	33	Real Estate Taxes	Bed Days Available	716,018	13			39,894	0	21
22	34	Rent Expense	Bed Days Available	716,018	13	133,442		39,894	7,435	22
23	35	Equipment Rental	Bed Days Available	716,018	13			39,894	0	23
24										24
25	TOTALS					\$ 2,587,705	\$ 1,859,558		\$ 166,895	25

Facility Name & ID Number Grove Lincoln Park Lvg & Rehab # 0050245 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 Progressive Healthcare Consulting
Street Address 7040 North Ridgeway Avenue
City / State / Zip Code Lincolnwood, IL 60712
Phone Number (847) 679-9797
Fax Number (847) 679-3676

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	RN Salary	Patient Days	498,858	10	\$ 88,262	\$ 88,262	39,894	\$ 7,058	1
2	12	Clergy Salary	Patient Days	498,858	10	18,263	18,263	39,894	1,461	2
3	17	Administrator	Patient Days	498,858	10	186,212	186,212	39,894	14,891	3
4	19	Professional Fees	Patient Days	498,858	10	1,215		39,894	97	4
5	20	Fees and Subscriptions	Patient Days	498,858	10			39,894		5
6	21	Clerical & General	Patient Days	498,858	10	2,058		39,894	165	6
7	22	Emp. Ben - Nursing	Patient Days	498,858	10	11,955		39,894	956	7
8	35	Auto Rental	Patient Days	498,858	10	999		39,894	80	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					\$ 308,964	\$ 292,737		\$ 24,708	25

12/31/12

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	CAPEX #3001		X	Capital Expenditures	\$10,186.00	10/23/08	\$ 482,205	\$ 46,576	10/01/13	0.0373	\$ 3,915	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	See Sch 9A		X	Working Capital	\$31,235.81	Var.	325,811		Var.	0.0280	2,207	6	
7												7	
8												8	
9	TOTAL Facility Related				\$41,421.81		\$ 808,016	\$ 46,576			\$ 6,122	9	
	B. Non-Facility Related*												
10							Interest Income Offset				(1,448)	10	
11							Allocated from Management Company				5,818	11	
12							Allocated from Real Estate Entity				2,534	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 6,904	14	
15	TOTALS (line 9+line14)						\$ 808,016	\$ 46,576			\$ 13,026	15	

Line # **N/A**

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

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)**

Grove at Lincoln Park Living and Rehabilitation Center, LLC
0050245
12/31/2012

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				
Diamond Insurance		X	Working Capital	9,527.00	9/1/2011	76,989	0	2/1/2012		385	Fr 9.1 cw
Diamond Insurance		X	Working Capital	5,733.33	9/1/2012	69,495	0	6/1/2013	0.028	348	Fr 9.1 cw
IPFS		X	Working Capital	7,116.73	9/1/2011	71,167	0	8/1/2013		856	Fr 9.1 cw
IPFS		X	Working Capital	8,858.75	9/1/2012	108,160	0	8/1/2013		618	Fr 9.1 cw
Total				31,235.81		325,811	0			2,207	

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.			\$	110,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2011	\$	147,032	2
3. Under or (over) accrual (line 2 minus line 1).			\$	37,032	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	51,578	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
		Allocation from LRP		2,465	
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.			\$	91,075	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007		8	
		2008	115,863	9	
		2009	97,732	10	
		2010	101,987	11	
		2011	147,032	12	
2012 Accrual of \$110,000 based on 2011 Bill rounded (\$101,563--> \$110,000)					
Real estate taxes for FY11 include 101,562 and 45,470 for FY12					
				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

- 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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grove Lincoln Park Lvg & Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050245

CONTACT PERSON REGARDING THIS REPORT Chaim Rajchenbach

TELEPHONE (773) 248-6000 FAX #: (773) 248-9703

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</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>14-28-308-008-0000</u>	<u>Nursing Home</u>	\$ <u>101,562.50</u>	\$ <u>101,562.50</u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u><u>101,562.50</u></u>	\$ <u><u>101,562.50</u></u>

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 X 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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,325

B. General Construction Type: Exterior Brick Frame

Number of Stories 4

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred: N/A

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

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Allocated from Legacy Real Properties			\$ 4,558	1
2					2
3	TOTALS			\$ 4,558	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4		Allocated from Legacy Real Properties			\$ 35,317	\$		\$ 655	\$ 655	\$ 4,120
5										
6										
7										
8										
	Improvement Type**									
9		Office Remodel - carpeting & built in cabinets	2009		54,635	1,366	40	1,366		4,781
10		Satellite system purchase & installation	2009		11,600	290	40	290		1,015
11		New Roof	2009		34,325	858	40	858		3,003
12		1st Floor Remodel								
13		- Flooring, wallpaper & paint, carpeting, permits, update	2009		32,473	812	40	812		2,842
14		survey & architectural drawings								
15		Electrical work	2009		8,645	216	40	216		756
16		Painting, Decor & Wallcoverings	2009		104,931	2,623	40	2,623		9,181
17		2nd Floor Remodel	2009		108,080	2,722	40	2,722		9,615
18		- Built in resident room furniture, handrails & baseboards								
19		Outdoor Improvements - Awnings, Red Stucco	2009		42,033	1,051	40	1,051		3,678
20		Landscaping	2009		36,271	907	40	907		3,174
21		- install new flower bed, remove existing cement sidewalk,								
22		remove gravel base, install new gravel base, brick pavers,								
23		tuckpointing, remove/repair and transplant existing								
24		landscaping, install new landscaping and plants								
25		Install new phone system	2009		21,675	542	40	542		1,897
26		Sprinkler system	2009		3,047	76	40	76		266
27		Lock installation	2009		10,773	269	40	269		942
28		Patient Room Update - built in resident room furniture	2009		65,040	1,626	40	1,626		5,689
29		Chandeliers	2009		2,542	64	40	64		224
30										
31		Landscaping	2009		26,271	1,751	15	1,751		6,129
32		- install new flower bed, remove existing cement sidewalk,								
33		remove gravel base, install new gravel base, brick pavers,								
34		tuckpointing, remove/repair and transplant existing								
35		landscaping, install new landscaping and plants								
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Grove Lincoln Park Lvg & Rehab

0050245

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	
37	Install 2 cab systems in elevators	2009	\$ 16,042	\$ 401	40	\$ 401	\$	\$ 1,404	37
38	Window treatments, cubicle curtains	2009	2,564	64	40	64		224	38
39	Flooring	2009	15,995	400	40	400		1,400	39
40	Window treatments, cubicle curtains	2009	18,149	454	40	454		1,589	40
41	Installed new air cooled condensing unit	2009	3,500	88	40	88		308	41
42	Sidewalk extension	2009	3,985	100	40	100		350	42
43	4 Floors hand railings, baseboards, lights above beds	2009	10,120	253	40	253		886	43
44	Install new 30HO motor on fire pump	2009	3,844	96	40	96		336	44
45	Plumbing work	2009	7,751	194	40	194		679	45
46	Project design fee	2009	10,000	250	40	250		875	46
47									47
48	Installation of 19 jacks on 3rd floor	2010	2,578	64	40	64		160	48
49	New doors and trims, and window trims	2010	28,831	721	40	721		1,802	49
50	Doors and trims	2010	4,800	120	40	120		300	50
51	Resident room furniture	2010	14,135	353	40	353		883	51
52	Door frames, built in cabinets	2011	2,671	178	15	178		267	52
53	Floor tiles, kitchen cabinets, baseboards	2011	2,640	176	15	176		264	53
54	Outlets, switches	2011	2,860	286	10	286		429	54
55	Cabinets, counters, back splash, etc.	2011	9,535	636	15	636		954	55
56	Partitions w/ granite tops	2011	3,200	213	15	213		320	56
57	paint rooms, prime woodwork, various other	2011	2,765	277	10	277		415	57
58	Construction of New Metal wall and kitchen cabinets	2011	5,000	333	15	333		500	58
59	Construction of first floor halfway and Dumpster for therapy room	2011	2,690	179	15	179		269	59
60	Flooring	2011	42,763	6,109	7	6,109		9,163	60
61	Flooring for 3rd and 4th floor	2011	45,095	6,442	7	6,442		9,663	61
62	Landscaping	2011	7,400	493	15	493		740	62
63									63
64	Replace ceiling in Therapy room	2012	3,275	41	40	41		41	64
65	Hallway electrical	2012	6,025	75	40	75		75	65
66	1st floor bathroom: tiles, ceiling, extend walls, electric	2012	3,975	50	40	50		50	66
67	2nd & 3rd fl. bathrooms: electric, plumbing, tiles, exhaust pipes	2012	9,775	122	40	122		122	67
68	4th floor bathroom: electric, water lines, tiles, exhaust pipes	2012	3,575	45	40	45		45	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 893,193	\$ 34,385		\$ 35,040	\$ 655	\$ 91,824	70

**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 12A, Carried Forward		\$ 893,193	\$ 34,385		\$ 35,040	\$ 655	\$ 91,824	1
2									2
3	Sprinkler system improvements	2012	4,975	62	40	62		62	3
4	Install 16 roof mounted exhaust fans	2012	32,896	411	40	411		411	4
5	Vertical railing bars for existing stairways	2012	6,900	86	40	86		86	5
6									6
7									7
8	Allocated from Legacy Real Properties		34,823			351	351	4,235	8
9									9
10	Allocated from LHFS	2012	1,589			121	121	79	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 974,376	\$ 34,945		\$ 36,072	\$ 1,127	\$ 96,698	34

**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	\$ 175,367	\$ 6,404	\$ 15,257	\$ 8,853	3 to 10	\$ 45,239	71
72	Current Year Purchases	45,419		2,482	2,482	7 to 10	2,482	72
73	Fully Depreciated Assets							73
74	See Schedule 13A	12,214		1,036	1,036	10	3,189	74
75	TOTALS	\$ 233,000	\$ 6,404	\$ 18,775	\$ 12,371		\$ 50,910	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,211,934	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 41,349	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 54,847	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 13,498	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 147,608	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

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

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

Schedule 13A

Category of Equipment	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Component Life	Accumulated Depreciation
1 Allocation from LHFS, Inc	3,018		574	389	10	642
2 Allocated from Legacy Real Properties	9,196		462	1,167	10	2,547
Totals	12,214	-	1,036	1,556		3,189

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Park Terrace Partnership
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☒ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		109	Sep-08	\$ 543,728			3
4	Additions							4
5								5
6	Home Office Allocation				7,438			6
7	TOTAL		109		\$ 551,166			7

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

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: \$ 106,049
- Description: Bed Equip:\$102,267; Dietary Equip.\$3,782
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	See Schedule 14C	Various	\$ 2,439.86	\$ (394)	17
18					18
19					19
20					20
21	TOTAL		\$ 2,439.86	\$ (394)	21

10. Effective dates of current rental agreement:

Beginning 09/01/2008

Ending 08/31/2018

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

	Fiscal Year Ending	Annual Rent
12.	/2013	\$ 563,621
13.	/2014	\$ 583,513
14.	/2015	\$ 603,406

* 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.

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Business	Toyota Land Cruiser	\$ 1,199.99	\$ 1,200	17
18	Business	Infiniti 3087	539.87	2,747	18
19	Business	Lexus RX 350	700.00	1,400	19
20	Reimbursement			(5,821)	20
	Allocation from Management			80	
21	TOTAL		\$ 2,439.86	\$ (394)	21

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

It is the policy of this facility to only hire certified nurses aides.
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

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

COMPLETED

1. From this facility

2. From other facilities (f)

DROP-OUTS

1. From this facility

2. From other facilities (f)

TOTAL TRAINED

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

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

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

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

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

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

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(3)	hrs	\$	10,689	\$ 662,688	\$	10,689	\$ 662,688	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		3,564	220,977		3,564	220,977	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		12,499	774,913		12,499	774,913	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				824,512		824,512	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	39(2)					9,953		9,953	12
13	Other (specify): <u></u>									13
14	TOTAL			\$	26,752	\$ 1,658,578	\$ 834,465	26,752	\$ 2,493,043	14

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (288,208))	3,019,000	3,019,000	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	197,660	197,660	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Sch17A	2,460,268	2,460,268	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,676,928	\$ 5,676,928	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		4,558	13
14	Buildings, at Historical Cost		35,317	14
15	Leasehold Improvements, at Historical Cost	903,039	939,059	15
16	Equipment, at Historical Cost	212,993	233,000	16
17	Accumulated Depreciation (book methods)	(121,645)	(147,608)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 994,387	\$ 1,064,326	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,671,315	\$ 6,741,254	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 806,014	\$ 806,014	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	353,023	353,023	30
31	Accrued Taxes Payable (excluding real estate taxes)	26,443	26,443	31
32	Accrued Real Estate Taxes(Sch.IX-B)	51,578	51,578	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch17A	280,985	280,985	36
37	Federal Unemployment Tax	3,265	3,265	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,521,308	\$ 1,521,308	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	46,576	46,576	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 46,576	\$ 46,576	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,567,884	\$ 1,567,884	46
47	TOTAL EQUITY (page 18, line 24)	\$ 5,692,981	\$ 5,173,370	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,260,865	\$ 6,741,254	48

*(See instructions.)

Schedule 17A

XV: Special Services

Line 9 - Other Current Assets

	Operating	After Consolidation
GLP EMP LOAN, ADV, W/A	18,000	18,000
GLP LEASE DEPOSIT	481,500	481,500
GLP DUE TO MEDICARE	302,337	302,337
GLP ACCRUED ILLINOIS BED TAX	29,594	29,594
GLP LEG CHARITY	1,249	1,249
GLP DUE TO/FROM CHALET	285,200	285,200
GLP DUE T/F GTL	2,763	2,763
GLP LEGACY	144,285	144,285
GLP GHCP	1,173,406	1,173,406
GLP AP	995	995
GLP EVANSTON	1,348	1,348
GLP T/F CHALET REALTY	100,000	100,000
GLP DUE T/F PROGRESSIVE	(1,827)	(1,827)
	2,538,850	2,538,850

Line 36 - Other Current Liabilities

	Operating	After Consolidation
GLP TRUST CLEARING ACCT	8,192	8,192
GLP PREPAID INS - LIAB	(72,107)	(72,107)
GLP NEW BED TAX LIAB	22,149	22,149
GLP ACC MGMT FEE	140,059	140,059
GLP ACCRUED F I C A	15,333	15,333
GLP GN	7,660	7,660
GLP DUE TO MEMBERS	76,083	76,083
GLP RELATED LESSOR	100,000	100,000
	280,985	280,985

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,186,175	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(1,774,530)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,411,645	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,281,336	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)	\$ 2,281,336	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)	\$ 5,692,981	24 *

* This must agree with page 17, line 47.

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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,064,428	1
2	Discounts and Allowances for all Levels	4,003,396	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,067,824	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	141,405	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 141,405	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,448	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,448	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,210,677	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,169,019	31
32	Health Care	2,974,932	32
33	General Administration	2,462,198	33
	B. Capital Expense		
34	Ownership	1,258,015	34
	C. Ancillary Expense		
35	Special Cost Centers	1,723,142	35
36	Provider Participation Fee	342,036	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,929,341	40
41	Income before Income Taxes (line 30 minus line 40)**	2,281,336	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,281,336	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,726,292	44
45	Private Pay - Net Inpatient Revenue	1,067,954	45
46	Medicare - Net Inpatient Revenue	9,273,578	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,067,824	49

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,803	2,143	\$ 98,451	\$ 45.94	1
2	Assistant Director of Nursing	2,015	2,227	73,271	32.90	2
3	Registered Nurses	28,651	31,383	904,261	28.81	3
4	Licensed Practical Nurses	6,868	7,608	193,516	25.44	4
5	CNAs & Orderlies	58,197	64,323	751,544	11.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,164	8,966	150,656	16.80	8
9	Activity Director	1,718	2,045	30,307	14.82	9
10	Activity Assistants	7,252	7,769	110,653	14.24	10
11	Social Service Workers	2,414	2,522	47,646	18.89	11
12	Dietician					12
13	Food Service Supervisor	2,981	2,981	65,559	21.99	13
14	Head Cook	4,349	4,482	52,508	11.72	14
15	Cook Helpers/Assistants	11,460	11,985	116,873	9.75	15
16	Dishwashers					16
17	Maintenance Workers	1,724	2,015	32,866	16.31	17
18	Housekeepers	11,814	12,963	141,362	10.91	18
19	Laundry	56	56	476	8.50	19
20	Administrator	9,045	6,338	288,753	45.56	20
21	Assistant Administrator	1,017	1,306	32,152	24.62	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,319	9,335	123,972	13.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	659	740	14,539	19.65	31
32	Other Health Care(specify)					32
33	Other(specify) Care Plan Coordin	1,708	1,708	54,227	31.75	33
34	TOTAL (lines 1 - 33)	171,214	182,895	\$ 3,283,592 *	\$ 17.95	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	\$ 90	1(3)	35
36	Medical Director	Monthly	40,800	9(3)	36
37	Medical Records Consultant	96	4,512	10(3)	37
38	Nurse Consultant	1,040	24,000	10(3)	38
39	Pharmacist Consultant	Monthly	6,377	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	9,470	12(3)	45
46	Other(specify) Physician	168	45,000	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,304	\$ 130,249		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	490	12,000	10(3)	52
53	TOTAL (lines 50 - 52)	490	\$ 12,000		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Grove Lincoln Park Lvg & Rehab

0050245

Report Period Beginning: 01/01/12

Page 21

Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Henri, Ashleigh

Administrator

0

\$ 79,039

Zuckerman, Yair

Administrator

0

209,714

Cohen, Aaron

Asst. Administrator

0

10,193

Garfinkel, Yaakov

Asst. Administrator

0

21,959

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

(List each licensed administrator separately.)

\$ 320,905

B. Administrative - Other

Description

Amount

Management Fees (eliminated in Col. 7)

\$ 838,310

(Eliminated in Col. 7)

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

(Attach a copy of any management service agreement)

\$ 838,310

C. Professional Services

Vendor/Payee

Type

Amount

See Schedule 21C

Various

\$ 137,272

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

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

\$ 137,272

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 116,185

Unemployment Compensation Insurance

43,097

FICA Taxes

240,714

Employee Health Insurance

176,488

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Union Pension

22,522

Other Employee Benefits

10,869

Chicago Head Tax

2,792

Unreimbursed Payroll Taxes

16,055

Employee Physical Exam

68

State Income Tax

8,000

Allocation from Management

956

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

\$ 637,746

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

Description

Line #

Amount

N/A

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$ 620

Advertising: Employee Recruitment

933

Health Care Worker Background Check

(Indicate # of checks performed 397)

3,970

Patient Background Checks

45

Miscellaneous Licenses & fees

1,491

Miscellaneous Dues & Subscriptions

3,109

IL Council on LTC

18,501

Allocated from Management Co.

141

Less: Public Relations Expense

()

Non-allowable advertising

()

Yellow page advertising

()

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

\$ 30,125

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

1,876

Allocated from Management Co.

123

Entertainment Expense

()

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

TOTAL

\$ 1,999

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor/Payee	Type	Amount
Legacy Reimbursed Expenses	Legal	217.82
Meyer Magence	Legal	125.00
Much Selist	Legal	1,459.09
Ogletree Deakins	Legal	14,956.12
Scott & Kraus, LLC	Legal	1,108.75
Legacy Reimbursed Expenses	Legal	1,408.32
Skidelsky & Associates	Legal	185.00
Stone, McGuire & Siegel	Legal	8,739.78
McGladrey LLP	Accounting	26,420.44
FR&R	Accounting	3,186.62
Krupnick Bokor Kagda & Brooks	Accounting	375.00
ML Enterprises	Purchasing Consultant	350.00
Personnel Planners, Inc	Unemployment Tax Consultant	1,085.00
Prospect Resources, Inc.	Energy Procurement Resources	750.00
IIT Sourcetech	Data Processing	1,495.00
Joy Cases	Medicare Consultant	2,500.00
Paymed LLC	Medical Billing Services	7,835.47
Legacy Reimbursed Expenses	Other Professional Allocation	(270.97)
Collaborative Health Care	LTC Consulting	28,200.00
Building Consultants	Building Consultants	7,611.00
HDSI	Data Processing	10,016.43
E-Health Data Solutions	Data Processing	4,002.21
Singer Networks	Data Processing	12,854.05
Accu-Med Services	Data Processing	2,662.32
TOTAL (agree to Schedule V, line 19, column 3)		137,272
Disallowed Legal		(2,469)

Plus: Allocation from Management Company	MCD 4	5,298
Plus: Allocation from Real Estate Entity	MCD 13	1,318
TOTAL (agree to Schedule V, line 19, column 8)		<u>141,420</u>

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			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3										N/A			
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC: \$18501

(3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 6.5 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 31,862 Line 10(2)

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 342,036
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? 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.