

		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: <u>0050237</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Grove of Skokie Living & Rehab</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/12</u> to <u>12/31/12</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>9000 North Lavergne Avenue</u> <u>Skokie</u> <u>60077</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(847) 679-2322</u> Fax # <u>(847) 679-9325</u>																									
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____	(Signed) _____	(Date) _____														
Officer or Administrator of Provider	(Signed) _____																								
	(Date) _____																								
Paid Preparer	(Type or Print Name) _____																								
	(Title) _____																								
	(Signed) _____																								
	(Date) _____																								
Date of Initial License for Current Owners: <u>9/1/08</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																							
☐ Charitable Corp.	☐ Individual	☐ State																							
☐ Trust	☐ Partnership	☐ County																							
IRS Exemption Code _____	☐ Corporation	☐ Other _____																							
	☐ "Sub-S" Corp.	_____																							
	☒ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:																									
Name: <u>Amanda Springborn</u> Telephone Number: <u>(314) 925-3838</u>																									
Email Address: _____																									

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 of Skokie Living & Rehab# 0050237 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>51</u>	Intermediate (ICF)	<u>51</u>	<u>18,666</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>149</u>	TOTALS	<u>149</u>	<u>54,534</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>25,974</u>	<u>1,977</u>	<u>8,970</u>	<u>36,921</u>	8
9	SNF/PED					9
10	ICF	<u>13,719</u>	<u>828</u>	<u>454</u>	<u>15,001</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>39,693</u>	<u>2,805</u>	<u>9,424</u>	<u>51,922</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 95.21%

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?

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 09/01/2008

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

YES ☒Date 09/01/2008NO ☐

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

YES ☒NO ☐If YES, enter number
of beds certified 98 and days of care provided 8,970Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 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):* Home Ofc- EE 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			479,848	479,848		479,848	(479,848)	(0)			43
44	TOTAL Special Cost Centers		429,214	1,735,964	2,165,178		2,165,178	(479,848)	1,685,330			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,647,125	994,514	5,387,702	10,029,341		10,029,341	(951,806)	9,077,535			45

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

Facility Name & ID Number Grove of Skokie Living & Rehab # 0050237 Report Period Beginning: 01/01/12 Ending: 12/31/12
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.)

		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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,058)	30		9
10	Interest and Other Investment Income	(761)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,178)	43		18
19	Entertainment				19
20	Contributions	(87,624)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,719)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(196,094)	43		24
25	Fund Raising, Advertising and Promotional	(85,429)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(119,535)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (496,398)		\$	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	2	
		Amount	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)	(455,408)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (455,408)		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (951,806)		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	2	3	4	
		Yes	No	Amount	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 of Skokie Living & Rehab

ID# 0050237
Report Period Beginning: 01/01/12
Ending: 12/31/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	X-Rays - Part A	\$ (19,818)	43	1
2	Patient Personal Items	(1,893)	43	2
3	Cable TV	(4,639)	43	3
4	Cost of prescription	(25,786)	43	4
5	Admitting non Certified	(26,458)	43	5
6	PY Adjustment	(25,838)	43	6
7	Discount	6,103	43	7
8	Charity Discounts	(11,194)	43	8
9	Disallow travel & seminar	(10,012)	24	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				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	(119,535)		49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Chaim Rajchenbach	29	See Pg 6-Supp		See Pg6-Supp		
Menachem Shabat	29					
Jack Rajchenbach	6.1					
The Rajchenbach Family Trust	15.5					
Ronald Shabat	15.5					
The Robert Hartman Family Trust	4.9					

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Dietary	\$	Legacy Healthcare Financial Services, LLC	100.00%	\$ 21	\$ 21	1
2	V	3	Housekeeping Salaries		Legacy Healthcare Financial Services, LLC	100.00%	897	897	2
3	V	3	Housekeeping Supplies		Legacy Healthcare Financial Services, LLC	100.00%	24	24	3
4	V	5	Utilities		Legacy Healthcare Financial Services, LLC	100.00%	1,335	1,335	4
5	V	6	Repairs & Maintenance		Legacy Healthcare Financial Services, LLC	100.00%	2,178	2,178	5
6	V	10	Nursing Salary		Legacy Healthcare Financial Services, LLC	100.00%			6
7	V	17	Administrative Salary - Mgmt. Alloc.	725,987	Legacy Healthcare Financial Services, LLC	100.00%	40,000	(685,987)	7
8	V	19	Other Professional Fees		Legacy Healthcare Financial Services, LLC	100.00%	1,997	1,997	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%	1,307	1,307	10
11	V	19	Data Processing		Legacy Healthcare Financial Services, LLC	100.00%	1,801	1,801	11
12	V	20	Dues, Licenses & Fees		Legacy Healthcare Financial Services, LLC	100.00%	48	48	12
13	V	21	Office Supplies		Legacy Healthcare Financial Services, LLC	100.00%	8,836	8,836	13
14	Total			\$ 725,987			\$ 58,444	\$ * (667,543)	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%	\$ 110,267	\$ 110,267	15
16	V	24	Travel		Legacy Healthcare Financial Services LLC	100.00%	168	168	16
17	V	25	Education & Seminars		Legacy Healthcare Financial Services LLC	100.00%			17
18	V	26	Insurance Expense		Legacy Healthcare Financial Services LLC	100.00%	585	585	18
19	V	27	Employee Benefits - Mgmt Alloc		Legacy Healthcare Financial Services LLC	100.00%	28,734	28,734	19
20	V	30	Depreciation Expense		Legacy Healthcare Financial Services LLC	100.00%	951	951	20
21	V	32	Interest Expense		Legacy Healthcare Financial Services LLC	100.00%	4	4	21
22	V	33	Real Estate Taxes		Legacy Healthcare Financial Services LLC	100.00%			22
23	V	34	Rent Expense		Legacy Healthcare Financial Services LLC	100.00%	10,163	10,163	23
24	V	35	Equipment Rental		Legacy Healthcare Financial Services LLC	100.00%			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			\$			\$ 150,872	\$ * 150,872	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%	1,912	1,912	17
18	V	32	Interest		Legacy Real Properties, LLC	100.00%	3,464	3,464	18
19	V	33	Real Estate Taxes		Legacy Real Properties, LLC	100.00%	3,370	3,370	19
20	V	34	Rent		Legacy Real Properties, LLC	100.00%			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			\$			\$ 8,746	\$ * 8,746	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 and Maintenance	\$	Grove Healthcare Properties, LLC	100.00%	\$		15
16	V	19	Computer Services		Grove Healthcare Properties, LLC	100.00%	3,806	3,806	16
17	V	20	License & fees		Grove Healthcare Properties, LLC	100.00%	144	144	17
18	V	21	Bank Service Charges		Grove Healthcare Properties, LLC	100.00%	513	513	18
19	V	30	Depreciation		Grove Healthcare Properties, LLC	100.00%	2,069	2,069	19
20	V	32	Interest Expense		Grove Healthcare Properties, LLC	100.00%	7,953	7,953	20
21	V	34	Rent	743,261	Grove Healthcare Properties, LLC	100.00%	743,261		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			\$ 743,261			\$ 757,746	\$ * 14,485	39

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

VII. RELATED PARTIES (continued)

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

☒ X

 YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	RN Salary	\$	Progressive Healthcare Consulting	100.00%	\$ 9,649	\$	9,649 15
16	V	12	Clergy Salary		Progressive Healthcare Consulting	100.00%	1,996		1,996 16
17	V	15	Emp Ben - Nursing		Progressive Healthcare Consulting	100.00%	1,307		1,307 17
18	V	17	Administrative Salary-Mmt Alloc		Progressive Healthcare Consulting	100.00%	20,356		20,356 18
19	V	19	Professional Fees		Progressive Healthcare Consulting	100.00%	133		133 19
20	V	20	Fees and Subscriptions		Progressive Healthcare Consulting	100.00%			
21	V	21	Clerical & General Office		Progressive Healthcare Consulting	100.00%	225		225 21
22	V	35	Auto Rental		Progressive Healthcare Consulting	100.00%	109		109 22
23	V	17	Administrative Salary-Mgmt Alloc		Progressive Healthcare Consulting	100.00%	4,257		4,257 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			\$			\$ 38,032	\$ *	38,032 39

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

Facility Name & ID Number

Grove of Skokie Living & Rehab

0050237

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

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	See Attached	See Att.	See Att.	Mgmt. Salary	\$ 20,000	17(3)	1
2	Menachem Shabat	Owner	Administrative	29.00	See Attached	See Att.	See Att.	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

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

X

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 Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Dietary	Bed Days Available	716,018	13	\$ 270	\$	54,534	\$ 21	1
2	3	Housekeeping Salaries	Bed Days Available	716,018	13	11,779	11,779	54,534	897	2
3	3	Housekeeping Supplies	Bed Days Available	716,018	13	318		54,534	24	3
4	5	Utilities	Bed Days Available	716,018	13	17,526		54,534	1,335	4
5	6	Repairs & Maintenance	Bed Days Available	716,018	13	28,596		54,534	2,178	5
6	10	Nursing Salary	Bed Days Available	716,018	13			54,534	0	6
7	17	Administrative Salary - Mgmt. Al	Hours	100	13	400,000		10	40,000	7
8	19	Other Professional Fees	Bed Days Available	716,018	13	26,219		54,534	1,997	8
9	19	Legal Fees	Bed Days Available	716,018	13	17,158		54,534	1,307	9
10	19	Data Processing	Bed Days Available	716,018	13	23,653		54,534	1,801	10
11	20	Dues, Licenses & Fees	Bed Days Available	716,018	13	625		54,534	48	11
12	21	Office Supplies	Bed Days Available	716,018	13	116,015		54,534	8,836	12
13	21	Clerical Salaries	Bed Days Available	716,018	13	1,447,779	1,447,779	54,534	110,267	13
14	24	Travel	Bed Days Available	716,018	13	2,200		54,534	168	14
15	25	Education & Seminars	Bed Days Available	716,018	13			54,534	0	15
16	26	Insurance Expense	Bed Days Available	716,018	13	7,687		54,534	585	16
17	27	Employee Benefits - Mgmt Alloc	Bed Days Available	716,018	13	228,907		54,534	17,434	17
18	27	Employee Benefits - Mgmt Alloc	Hours	100	13	113,000		10	11,300	18
19	30	Depreciation Expense	Bed Days Available	716,018	13	12,480		54,534	951	19
20	32	Amortization Expense	Bed Days Available	716,018	13	51		54,534	4	20
21	33	Real Estate Taxes	Bed Days Available	716,018	13			54,534	0	21
22	34	Rent Expense	Bed Days Available	716,018	13	133,442		54,534	10,163	22
23	35	Equipment Rental	Bed Days Available	716,018	13				0	23
24										24
25	TOTALS					\$ 2,587,705	\$ 1,459,558		\$ 209,316	25

Facility Name & ID Number Grove of Skokie Living & Rehab # 0050237 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	9	\$ 88,262	\$ 265,681	54,534	\$ 9,649	1
2	12	Clergy Salary	Patient Days	498,858	9	18,263		54,534	1,996	2
3	15	Emp Ben - Nursing	Patient Days	498,858	9	11,955		54,534	1,307	3
4	17	Administrative Salary-Mgmt Allo	Patient Days	498,858	9	186,212		54,534	20,356	4
5	19	Professional Fees	Patient Days	498,858	9	1,215		54,534	133	5
6	20	Fees and Subscriptions	Patient Days	498,858	9			54,534		6
7	21	Clerical & General Office	Patient Days	498,858	9	2,058		54,534	225	7
8	35	Auto Rental	Patient Days	498,858	9	999		54,534	109	8
9	17	Administrative Salary-Mgmt Allo	Hours Worked	40	9	38,969		4	4,257	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					\$ 347,933	\$ 265,681		\$ 38,032	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Private Bank		X	Capital Expenditures	\$10,186.00	10/23/08	\$ 671,440	\$ 58,639	10/1/13	3.7606	\$ 14,463	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$10,186.00		\$ 671,440	\$ 58,639			\$ 14,463	9	
	B. Non-Facility Related*												
10							Interest Income Offset				(761)	10	
11							Allocated from Management Company				4	11	
12							Allocated from Legacy Real Properties, LLC				3,464	12	
13							Allocated from Grove Healthcare Properties				7,953	13	
14	TOTAL Non-Facility Related						\$	\$			\$ 10,660	14	
15	TOTALS (line 9+line14)						\$ 671,440	\$ 58,639			\$ 25,123	15	

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.			\$	353,522	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 & 2012	\$	538,053	2
3. Under or (over) accrual (line 2 minus line 1).			\$	184,531	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	173,669	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 Home Office		3,370	
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.			\$	361,570	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007		8	
		2008	83,959	9	
		2009	183,952	10	
		2010	336,689	11	
		2011	347,131	12	
Estimated accrual based on PY tax plus a 5% increase.					
FY11 Taxes = \$347,131 / FY12 Taxes = \$190,922					
		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 of Skokie Living & Rehab
COUNTY
Cook

FACILITY IDPH LICENSE NUMBER
0050237

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)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 10-16-411-018-0000	9000 Lavergne Ave.	\$ 70,363.00	\$ 70,363.00
2. 10-16-411-017-0000	9000 Gross Point Rd.	\$ 276,768.00	\$ 276,768.00
3. 10-35-104-076-0000	7040 Ridgeway Avenue	\$ 42,154.05	\$ 3,370.00
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 389,285.05	\$ 350,501.00

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

17,350

B. General Construction Type:

Exterior

Brick

Frame

Number of Stories

2

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☐

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

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			\$ 6,231	1
2					2
3	TOTALS			\$ 6,231	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				\$ 48,277	\$		\$ 896	\$ 896	\$ 5,632	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Landscaping			2009	10,000	666	15	666		2,331	9
10	Landscaping			2009	32,000	2,134	15	2,134		7,469	10
11	Built-in Cabinets			2009	66,890	1,672	40	1,672		5,852	11
12	Satellite System Installation			2009	11,305	283	40	283		990	12
13	Exterior Painting			2009	44,020	1,101	40	1,101		3,853	13
14	1st Floor remodel			2009	18,589	465	40	465		1,627	14
15	Electrical Work			2009	11,488	287	40	287		1,005	15
16	Painting & Décor			2009	107,803	2,695	40	2,695		9,433	16
17	Rehab Bathrooms			2009	25,000	625	40	625		2,188	17
18	2nd Floor & Nurses Station Remodel			2009	131,292	3,282	40	3,282		11,487	18
19	Install Locks			2009	8,500	213	40	213		745	19
20	New Roof			2009	39,725	993	40	993		3,476	20
21	Call Light System			2009	15,988	400	40	400		1,400	21
22	Kitchen Remodel			2009	46,284	1,157	40	1,157		4,050	22
23	Vent System Installation			2009	15,466	387	40	387		1,354	23
24	Therapy Room Remodel			2009	29,544	739	40	739		2,586	24
25	Elevator Repairs			2009	16,128	403	40	403		1,411	25
26	Rehab DON Office			2009	5,767	144	40	144		504	26
27	Rehab 34 Resident Bathrooms			2009	14,593	365	40	365		1,277	27
28	Building Improvement			2009	5,767	144	40	144		504	28
29	Electrical & Lighting			2009	4,025	101	40	101		353	29
30	Fire Sprinkler System			2009	7,952	199	40	199		696	30
31	Ventilation System Installation			2009	15,466	387	40	387		1,354	31
32	Window Coverings & Installation			2009	29,706	743	40	743		2,600	32
33	Ceiling Fixtures			2009	4,530	113	40	113		396	33
34	Flooring			2009	51,071	1,277	40	1,277		4,469	34
35	Smoke Detectors			2009	6,174	154	40	154		539	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Grove of Skokie Living & Rehab

0050237

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	Irrigation System	2009	\$ 21,000	\$ 525	40	\$ 525	\$	\$ 1,838	37
38	Patch & Paint Conference Room	2009	1,860	47	40	47		164	38
39	Fire Sprinkler System	2009	2,100	53	40	53		185	39
40	Nurse Call System	2009	15,556	389	40	389		1,362	40
41	Tile Installation on 2nd Floor	2009	2,700	68	40	68		238	41
42	Rewire for Cable	2009	2,703	68	40	68		238	42
43	MDS Office Cabinetry	2009	7,400	185	40	185		648	43
44	Tile installation	2010	3,908	98	40	98		245	44
45	Electrical for new sign	2010	14,447	361	40	361		903	45
46									46
47	Demolition & Replacement of walls, retiling to include plumbing,	2011	21,977	1,466	15	1,466		2,199	47
48	electrical, and replacement of fixtures, tub, etc.								48
49									49
50	Doors	2011	3,228	462	7	462		693	50
51	Storm Sewer	2011	3,500	175	20	175		263	51
52	Landscaping	2011	3,020	202	15	202		303	52
53	Replacement of Water Heating Pipe	2011	3,377	85	40	85		127	53
54	Storm Sewer Repair	2011	3,500	88	40	88		132	54
55									55
56	Railings for Existing Stairways	2012	5,500	69	40	69		69	56
57	Remove Windows and Repair after Removal	2012	6,045	76	40	76		76	57
58	Replace Leaking Pipes in Dining Room	2012	4,146	52	40	52		52	58
59	Flooring in Dining Room	2012	5,055	64	40	64		64	59
60	Replace Leaking Pipes in Dining Room	2012	3,275	41	40	41		41	60
61									61
62	Allocated from Legacy Real Properties	2009	27,416			221	221	3,770	62
63	Allocated from Legacy Real Properties	2010	8,337			67	67	834	63
64	Allocated from Legacy Real Properties	2011	11,849			96	96	1,185	64
65									65
66	Allocated from Legacy Healthcare Financial Services	2012	2,172			165	165	109	66
67									67
68	Reconcile to Book Depreciation			(6,973)			6,973		68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,007,421	\$ 18,730		\$ 27,148	\$ 8,418	\$ 95,319	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 211,228	\$ 34,829	\$ 28,869	\$ (5,960)	10	\$ 102,399	71
72	Current Year Purchases	13,302	1,119	1,119		7	1,119	72
73	Fully Depreciated Assets							73
74	See Schedule 13A	16,697		1,416	1,416	7	4,359	74
75	TOTALS	\$ 241,227	\$ 35,948	\$ 31,404	\$ (4,544)		\$ 107,877	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)	\$ 1,254,879	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 54,678	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 58,552	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,874	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 203,196	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	Sprinklers	\$ 34,481	92
93	Air Cooled Chiller	60,896	93
94	Dining Room	28,000	94
95		\$ 123,377	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	4,126		785	785	7	877
2 Allocated from Legacy Real Properties	12,571		631	631	7	3,482
Totals	16,697	-	1,416	1,416		4,359

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

X YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1983	149	9/1/08	\$ 743,261	3	7	3
4	Additions							4
5								5
6	Home Office Allocation				10,163			6
7	TOTAL		149		\$ 753,424			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized

by the length of the lease N/A .

N/A

N/A

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 64,131 Description: Nursing Equipment: \$21,830; Bed Rental \$42,301

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	See Schedule 14A	See Schedule 14A	\$ 2,665.00	\$ 23,282	17
18					18
19	Home Office Allocation			109	19
20					20
21	TOTAL		\$ 2,665.00	\$ 23,391	21

10. Effective dates of current rental agreement:

Beginning 9/1/08

Ending 8/31/18

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.

Grove of Skokie Living and Rehab Center
0050237
12/31/2012
Schedule 14A

Use	Model Year and Make	Monthly Lease Payment	Rental Expense for this Period
Facility Related	Lexus GX 470	915.00	2,795
Facility Related	Toyota Camry	600.06	6,661
Facility Related	2011 Nissan Maxima	425.08	5,101
Facility Related	2011 Acura MDX	725.00	8,725
		2,665	23,282

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	\$	4,729	\$ 397,212	\$	4,729	\$ 397,212
2	Licensed Speech and Language Development Therapist	39(3)	hrs		896	75,248		896	75,248	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		5,257	441,620		5,257	441,620	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				420,134		420,134	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	39(2)					9,080		9,080	12
13	Other (specify): _____									13
14	TOTAL			\$	10,882	\$ 914,080	\$ 429,214	10,882	\$ 1,343,294	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,554,876	\$ 2,554,876	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (412,913))	2,506,899	2,506,899	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	99,615	99,615	6
7	Other Prepaid Expenses	163,257	163,257	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Sch17A	1,251,436	1,251,436	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,576,083	\$ 6,576,083	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	(9,800)	6,231	13
14	Buildings, at Historical Cost		48,277	14
15	Leasehold Improvements, at Historical Cost	1,019,128	959,144	15
16	Equipment, at Historical Cost	253,694	241,227	16
17	Accumulated Depreciation (book methods)	(182,057)	(203,196)	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): CIP		127,377	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,080,965	\$ 1,179,060	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,657,048	\$ 7,755,143	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 324,680	\$ 324,680	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	398,625	398,625	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	173,669	173,669	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch17A	1,263,412	1,263,412	36
37	Federal Unemployment Tax	941	941	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,161,327	\$ 2,161,327	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	58,639	58,639	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)	\$ 58,639	\$ 58,639	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,219,966	\$ 2,219,966	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,437,082	\$ 5,535,177	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,657,048	\$ 7,755,143	48

*(See instructions.)

Schedule 17A

XV: Special Services

Line 9 - Other Current Assets

	Operating	After Consolidation
Trust Clearing Acct	29,864	29,864
Lease Deposit	521,500	521,500
Due to Medicare	488,876	488,876
Due to Others	2,175	2,175
Accrued Illinois Bed Tax	40,454	40,454
Leg. Charity	1,249	1,249
Lagrange	134	134
Due to 1st Health	7,660	7,660
Due To/From Legacy	159,524	159,524
	1,251,436	1,251,436

Line 36 - Other Current Liabilities

	Operating	After Consolidation
HDSI Transfer Acct	450	450
State Assessment Fee	66,296	66,296
Accrued Management Fees	131,059	131,059
Accrued W/C	7,626	7,626
Accrued FICA	23,170	23,170
FICA Withheld	7,951	7,951
Fed Withhold Tax	13,225	13,225
Illinois E/H	50	50
GHCP	802,949	802,949
Members	172,300	172,300
Due Lessor/Prior Own	23,336	23,336
Due T/F Progressive	15,000	15,000
	1,263,412	1,263,412

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,821,193	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,821,193	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,215,891	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	(600,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	(2)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,615,889	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)	\$ 5,437,082	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Grove of Skokie Living & Rehab# 0050237Report Period Beginning: 01/01/12Ending: 12/31/12

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	\$ 10,229,180	1
2	Discounts and Allowances for all Levels	1,866,436	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,095,616	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	148,085	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 148,085	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	601	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	169	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 770	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	761	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 761	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)	\$ 12,245,232	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	1,823,142	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)*	\$ 10,029,341	40
41	Income before Income Taxes (line 30 minus line 40)**	2,215,891	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,215,891	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 6,509,286	44
45	Private Pay - Net Inpatient Revenue	477,023	45
46	Medicare - Net Inpatient Revenue	4,829,943	46
47	Other-(specify) <u>Insurance</u>	279,364	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,095,616	49

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

** Does this agree with taxable income (loss) per Federal Income

Tax Return? No If not, please attach a reconciliation.

*** 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.

^ - LLC members are cash basis tax payers.

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	1,994	2,109	\$ 114,950	\$ 54.50	1
2	Assistant Director of Nursing	1,844	2,179	86,582	39.73	2
3	Registered Nurses	24,519	26,541	732,279	27.59	3
4	Licensed Practical Nurses	11,735	12,631	307,814	24.37	4
5	CNAs & Orderlies	84,570	89,401	912,782	10.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,307	5,937	88,459	14.90	8
9	Activity Director	1,858	2,047	38,612	18.86	9
10	Activity Assistants	7,657	8,240	112,557	13.66	10
11	Social Service Workers	8,222	8,594	133,551	15.54	11
12	Dietician					12
13	Food Service Supervisor	3,076	3,367	60,072	17.84	13
14	Head Cook	4,888	5,332	71,929	13.49	14
15	Cook Helpers/Assistants	16,040	17,077	174,358	10.21	15
16	Dishwashers					16
17	Maintenance Workers	5,312	5,790	70,234	12.13	17
18	Housekeepers	16,108	17,395	160,907	9.25	18
19	Laundry	3,163	3,570	38,523	10.79	19
20	Administrator	4,841	4,951	224,679	45.38	20
21	Assistant Administrator	2,842	3,131	112,506	35.93	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,255	8,187	116,148	14.19	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	1,208	1,282	33,378	26.04	30
31	Medical Records	2,785	3,079	56,805	18.45	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	215,224	230,840	\$ 3,647,125 *	\$ 15.80	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	246	\$ 25,626	1(3)	35
36	Medical Director	Monthly	72,500	9(3)	36
37	Medical Records Consultant	35	4,888	10(3)	37
38	Nurse Consultant	628	27,000	10(3)	38
39	Pharmacist Consultant	Monthly	8,307	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	50	2,496	11(3)	44
45	Social Service Consultant	62	4,995	12(3)	45
46	Other(specify) <u>MDS Consulting</u>	Monthly	48,000	10(3)	46
47	<u>Medical Consultant</u>	Monthly	10,000	10(3)	47
48	<u>Nursing Consultant</u>	Monthly	4,200	10(3)	48
49	TOTAL (lines 35 - 48)	1,021	\$ 208,012		49

C. CONTRACT NURSES

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

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

** See instructions.

Provider Name: Grove of Skokie Living and Rehab Center
Provider #: 0050237
Year End 12/31/2012
Schedule 21C

XIX.C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
McGladrey LLP	Accounting	28,422
FR&R	Accounting	6,647
Scott and Kraus	Legal	2,796
Meyer Magence	Legal	3,188
Sheryl E. Fuhr & Associates	Legal	1,577
Skidelsky & Associates	Legal	185
Stone, McGuire & Siegal	Legal	7,618
Much Shelist	Legal	1,484
Ashman & Stein	Legal	1,054
Ogletree	Legal	6,335
Law Offices of Thomas E. Brewer	Legal	1,012
Korey Cotter Heather & Richard	Legal	187
Julie Fox	Legal	825
Gutnicki	Legal	285
Personnel Planners	Workers Comp Consultant	1,271
IIT/Sourcetech	Purchasing Consultant	1,195
Prospect Resources	Risk Management	800
Commitment Consulting	Other	11,994
Accruals		4,420
E-Health Data	Computer	33,684
Singer Networks	Computer	10,175
American Data	Computer	3,335
Ivans	Computer	210
Tintek IT Solutions	Computer	1,825
Wescom Solutions	Computer	1,216
Accruals		2,557
	Schedule V, Line 19, Column 3	134,297

Legacy HC Finance Svcs, LLC Allocation
 5,105

Grove Healthcare Properties, LLC Allocation	3,806
Progressive Healthcare Consulting Allocation	133
Out of Period Legal	(4,719)

Schedule V, Line 19, Column 8 138,622

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. ILCLTC: \$14,528

(3)

Did the nursing home make political contributions or payments to a political action organization?

Yes

If YES, have these costs been properly adjusted out of the cost report?

Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A

(5)

Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

7 Yrs.

(6)

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

\$ 34,572

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?

X

YES

NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 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?

N/A

Indicate the amount.

\$ N/A

(16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

0

d. Have vehicle usage logs been maintained?

Adequate records have been maintained.

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

N/A

Indicate the amount of income earned from providing such transportation during this reporting period.

\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:

N/A

(18)

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

Yes

(19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

Yes

Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT

Grove of Skokie Living f

03:58 PM

6/13/2013

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-951,806	equal to	-951,806	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	25,123	equal to	25,123	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	361,570	equal to	361,570	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	58,552	equal to	58,552	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	753,424	equal to	753,424	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	87,522	equal to	87,522	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	#VALUE!	#VALUE!	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	914,080	equal to	914,080	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	429,214	equal to	429,214	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,169,019	equal to	1,169,019	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	2,974,932	equal to	2,974,932	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	2,462,198	equal to	2,462,198	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	1,258,015	equal to	1,258,015	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	1,823,142	equal to	1,823,142	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	342,036	equal to	342,036	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	2,333,049	equal to	2,333,049	0	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	151,169	equal to	151,169	0	FAILED	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	133,551	equal to	133,551	0	FAILED	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	306,359	equal to	306,359	0	FAILED	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	70,234	equal to	70,234	0	FAILED	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	160,907	equal to	160,907	0	FAILED	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	38,523	equal to	38,523	0	FAILED	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	337,185	equal to	337,185	0	FAILED	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	116,148	equal to	116,148	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	3,647,125	equal to	3,647,125	0	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	25,626	< or = to	27,736	-2,110	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	72,500	< or = to	72,500	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	40,195	< or = to	102,395	-62,200	O.K.	Pg20 X14..X16+	B. & C.	i7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	2,496	< or = to	2,496	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	4,995	< or = to	4,995	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	337,185	equal to	337,185	0	FAILED	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	725,987	equal to	725,987	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3

Supp. Sched.- Prof. Serv.	134,297	equal to	134,297	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	678,112	equal to	678,112	0	FAILED	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	30,063	equal to	30,063	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	1,986	equal to	1,986	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	342,036	equal to	342,036	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	8,970	equal to	8,970	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-455,408	equal to	-455,408	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balance	58,639	equal to	58,639	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	173,669	equal to	173,669	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	6,231	equal to	6,231	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,007,421	equal to	1,007,421	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	241,227	equal to	241,227	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	203,196	equal to	203,196	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	5,437,082	equal to	5,437,082	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	2,215,891	equal to	2,215,891	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31...S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	7,657,048	equal to	7,657,048	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

Enter Cost Center Expenses

YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINKED TO THE COST REPORT!!!!

6/13/201303:58:24 PM

HSA Number:

Name:

Grove of Skokie Living & Rehab

Cost report period

From:

01/01/12

To:

12/31/12

Base Number:

444

If this is an ICF/DD 16 facility, enter a 1 in cell C6

N

Licensed bed days:

54,534

Occupancy:

51,922

Pct. of occupancy:

95.21%

Illinois Public Aid Support Rate:

\$

Genl Services Salary/Wage:

576,024

Col 1, Line 8 ---Audit Adj:

Genl Admin Salary/Wage:

453,333

Col 1, Line 28 ---Audit Adj:

Total Salary Wage:

3,647,125

Col 1, Line 44 ---Audit Adj:

Employee Benefits:

678,112

Col 8, Line 22 ---Audit Adj:

Total General Services:

1,173,474

Col 8, Line 8 ---Audit Adj:

Total General Admin:

1,945,964

Col 8, Line 28 ---Audit Adj:

Instructions and Calculation Steps

STEP I

Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes.

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amount out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration.

A.

General Services

1

Determine the proportion of general services wages to total wages.

2

Multiply the total lump sum fringe amount by this proportion to get the fringe amount for General Services.

3

Add the proportioned fringe amount to you total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8)
Divided by Total Wages (Column 1, Line 44)
General service wages as percent of total wages
Employee Benefits (Column 10, Line 22)

Allocation of Employee Benefits to General Services Costs
Plus Total General Services (Column 10, Line 8)
New Total General Services Cost

B.

General Administration

1

Determine the proportion of General Administration wages to total wages.

2

Multiply the total lump sum fringe amount by this proportion to get the fringes amount for General Administration.

3

Add the proportioned fringe amount to your total General Administration expenses.

4

Subtract the total lump sum fringe amount from your General Administration expenses to get your new total General Administration Cost.

General Administration Wages (Column 1, Line 28).
Divided by Total Wages (Column 1, Line 45)
General administration wages as a percent of total wages

Employee Benefits (Column 10, Line 22)
Allocation of Emplayee Benefits to General Admin. Costs
Plus Total General Administration (Column 10, Line 28)
Minus Total Fringe (Column 10, Line 22)
New Total General Administration Cost

STEP II Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month = 13 divided by 2 =
Beginning Day + Ending Day = 32 divided by 60.8 =
Beginning Year + Ending Year = 224 multiplied by 6 =

Sum of the three lines
Subtract from the sum

Base Number (expressed as a whole number, fraction dropped)

B. Select the Appropriate Inflation Multipliers

Refer to Table I, inflation Multipliers, and find the multipliers which correspond with the base number you have calculated.

General Services Multiplier:
General Administration Multiplier:

C. Apply Inflation Multipliers to Update Cost

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-A)
General Services Multiplier (Step II-B)

Updated General Services Cost

2 Multiply New Total General Administration Cost
(from Step I-B)by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-B)
General Administration Multiplier (Step II-B)

Updated General Services Cost

3 Total Updated Support Costs (1 + 2)

STEP III Convert Total Updated Support Costs (C-3) to Per Diem Costs

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT COSTS

A. If the occupancy (Cost Report, Page 2, Schedule III-C) is
equal to or above 93 percent, divide your total updated
support costs (Step II, C, 3, above) by the total patient
days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14).

Total Support Costs (Step II, C, 3, above)
Total Patient Days (Cost Report)

Support Costs per Diem

OR

B. If the occupancy is below 93 percent, calculate 93 percent
of the licensed bed days (Cost Report, Page 2, Schedule III-A,
Column 4, Line 7). Then subtract the total patient
days (Cost Report, Page 2, Schedule III-B, Column 5,
Line 14) from the result and calculate one-third of the
difference. Then add the one-third difference to the total
patient days to obtain your adjusted occupancy. Next
divide your total updated Support Costs (Step II, C, 3 above)
by your adjusted occupancy.

Licensed Bed Days
Multiplied by

Minus total Patient Days

One-third of difference

Plus Total Patient Days

Adjusted Occupancy

Total Support Costs (Step II, C, 3, above)
Divided by Adjusted Occupany

Support Costs Per Diem

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA. Use one of the three procedures below and refer to Table II to calculate your support rate.

- A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table II.
- B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA
Minus Support Costs Per Diem

Difference

Multiply the Difference by

One-Half of the Difference

Plus Support Costs Per Diem

Support Rate if costs are between 35th and 75th percentile

- C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus \$.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA
Minus Support Costs Per Diem

Difference

Multiply the Difference by

One-Half of the Difference

Compare one-half the difference to the
profit ceiling for your HSA in Table II and

Enter the Lower of the Two Amounts

Plus Support Costs Per Diem

Support Rate if support costs less than 35th percentile

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C above

75th Percentile is
35th Percentile is

Table I
Inflation Multipliers

Base Number	General Services Multiplier	General Administration Multiplier
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

\$576,024
\$3,647,125
15.7939%
\$678,112

\$107,100
\$1,173,474
\$1,280,574

\$453,333
\$3,647,125
12.4299%

Table II
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	40.08	32.10	4.040
2	37.33	31.77	2.830
3	34.36	29.73	2.365
4	37.33	31.77	2.830
5	32.69	27.53	2.630
6	43.80	31.76	6.070
7	43.80	31.76	6.070
8	43.80	31.76	6.070
9	39.02	30.77	4.175
10	40.08	32.10	4.040
11	35.80	29.99	2.955

Table II (For ICF
SupportRate per

HSA
1
2
3
4
5
6
7
8
9
10
11

\$678,112
\$84,289
\$1,945,964
\$678,112
\$1,352,141

6.5
0.526315789
1344
1351.026316
907.00
444

1
1

\$1,280,574
1

\$1,280,574

\$1,352,141

1

\$1,352,141

\$2,632,715

\$50.71

\$2,632,715

51,922

\$50.71

54,534

0.93

50,717

51,922

-1,205

-402

51,922

51,520

\$2,632,715
51520
\$51.10

#N/A
\$50.71
#N/A
0.5
#N/A
\$50.71
#N/A

#N/A
\$50.71
#N/A

0.5
#N/A
#N/A
#N/A
\$50.71
#N/A
#N/A
#N/A

7DD 16 Facilities)
centiles by HSA

75th Percentile	35th Percentile	Below 35th Profit Ceiling
34.86	27.19	3.885
33.30	25.97	3.715
32.74	25.54	3.650
33.30	25.97	3.715
30.46	23.75	3.405
40.44	31.54	4.500
40.44	31.54	4.500
40.44	31.54	4.500
37.60	29.32	4.190
34.86	27.19	3.885
32.73	25.52	3.655

Capital Rate Data

Change print Orientation!

Facility Name:

=PG1!E14

HSA No.:

IF RENTED, have facilities been continuously rented from an unrelated party since prior to January 1, 1978 (Y or N): or since the first day of operation for buildings constructed since January 1, 1978?

Cost Report Pd:

Begin

End

1989 Property Tax COST:

1991 Property Tax RATE:

FY 1991 Capital Rate:

YOU HAVE CHOSEN THE CAPITAL CALC. THAT IS LINKED

TO THE COST REPORT!!!!

6/13/2013

03:58:24 PM

COSTS INCLUDED ON PAGES 12 THRU 12D START AT CELL O6

ID:

=pg1!j12

Own or Rent? (O or R)

O

Own or Rent Beginning:

O

N

Licensed Beds:

149

Total Patient Days

51,922

Licensed Bed Days:

54,534

% Occupied

95.21%

=PG1!AD16

Capital Days

51,922

(Actual dollar amount 1989 taxes)

(Inflated dollar amount divided by 1991 capital days)

(From form 787)

2011 rate #N/A

2010 rate

Variance #N/A

CAPITAL CALCULATIONS

=PG1!E14

Estimate of revised capital rate due to improvements 2000-200?

A. Determine the base year for your building from Work Table A

B. Determine the Building Specific historical cost per bed:

1. Work Table A, Line 24, Column (B)
2. Total licensed beds from cost report Page 2, Line 7, column 3
3. Line 1 divided by Line 2
4. Regional construction inflator from Table 2
5. Building specific historical Cost ber bed (Line 3 * Line 4, round to even \$)

C. Obtain the Uniform Building Value from Table 1

D. The capital rate will be calculated through a blending of the uniform building value from Line C and the building specific historical cost per bed from Line B5

1. Building specific historical cost from Line B5
2. Uniform building value from Line C
3. Add Lines 1 and 2
4. Divide by 2 to obtain average
5. Enter 120% of line C
6. The blended value is the lesser of Line 4 or Line 5

E. Divide the blended value from step D by 339 days to obtain a per diem blended value investment

F. Multiply the per diem blended value from step E by the applicable rate of return to obtain the building rate factor. (The rate of return is 11% for 1979 and later base years and 9.13% for 1978 and older base years.)

G. Add \$2.50 to Line F for equipment, rent, vehicle and working capital.

H. Add Lines F & G to obtain the preliminary capital rate

I. Implementation Capital Rate. (This step does not apply if the facility has been constructed or purchased after FY91.)

1. Enter the FY 91 capital rate
2. Subtract the FY 91 property tax rate
3. FY 91 rate without tax
4. Multiply Line I3 by 115%
5. Implementation capital rate

J. Property Tax

Property taxes are taken from the Long Term Care Property Tax Statement which was submitted to the Department of Public Aid during FY93. Reimbursement for real estate taxes is based upon the actual 1991 taxes for which the nursing homes were assessed. The formula used is a follows:

1. Property Tax Expense (Long Term Care Property Tax Statement, Column D, Total.)
2. Divided by: Capital Days (see below)

- 3. Equals: Per Diem Cost
- 4. Times: Property Tax Inflator (Table 3)
- 5. Equals: Updated Property Tax Cost

Capital Days
The capital days are the higher of the actual census (Page 2, Schedule III-B, Column 5, Line 14) or 93% of licensed bed days (page 2, Schedule III-A, Column 4, Line 7 * .93.)

- 1. Total Patient Days
- 2. Total Licensed Bed Days * .93
- 3. Capital Days (higher of Line 1 or Line 2)

K. Total Capital Rate for FY 94

- 1. Enter the greater of the simplified system rate from Line H or the implementation capital rate from Line I
- 2. Add Property Tax from Line J5
- 3. Total capital rate (add Lines 1 & 2)

Adjust above for rate cut & COLAs (L74) x .941 x 1.03 x 1.03

Capital rate as of ?

Potential Rate Increase

Estimate of annual Medicaid days

Estimated increase in annual Medicaid revenue

=PG1!E14

Estimate of revised capital rate due to improvements 2000-200?

	\$0.00	51	51	111	3500	388500	12A	147	0	0	0	12D
#N/A		52	52	0	0	0	12A	148	0	0	0	12D
#N/A		53	53	112	5500	616000	12A	149	0	0	0	12D
		54	54	112	6045	677040	12A	150	0	0	0	12D
		55	55	112	4146	464352	12A	151	0	0	0	12D
		56	56	112	5055	566160	12A	152	0	0	0	12D
		57	57	112	3275	366800	12A	153	0	0	0	12D
		58	58	0	0	0	12A	154	0	0	0	12D
		59	59	109	27416	2988344	12A	155	0	0	0	12D
51,922		60	60	110	8337	917070	12A	156	0	0	0	12D
50717		61	61	111	11849	1315239	12A	157	0	0	0	12D
51,922		62	62	0	0	0	12A	158	0	0	0	12D
		63	63	112	2172	243264	12A	159	0	0	0	12D
		64	64	0	0	0	12A	160	0	0	0	12D
		65	65	0	0	0	12A	161	0	0	0	12D
#N/A		66	66	0	0	0	12A	162	0	0	0	12D
		67	67	0	0	0	12B					
#N/A		68	68	0	0	0	12B					
#N/A		69	69	0	0	0	12B					
#N/A		70	70	0	0	0	12B					
		71	71	0	0	0	12B					
		72	72	0	0	0	12B					
#N/A		73	73	0	0	0	12B					
		74	74	0	0	0	12B					
		75	75	0	0	0	12B					
#N/A		76	76	0	0	0	12B					
		77	77	0	0	0	12B					
		78	78	0	0	0	12B					
		79	79	0	0	0	12B					
		80	80	0	0	0	12B					
		81	81	0	0	0	12B					
		82	82	0	0	0	12B					
		83	83	0	0	0	12B					
		84	84	0	0	0	12B					
		85	85	0	0	0	12B					
		86	86	0	0	0	12B					
		87	87	0	0	0	12B					
		88	88	0	0	0	12B					
		89	89	0	0	0	12B					
		90	90	0	0	0	12B					
		91	91	0	0	0	12B					
		92	92	0	0	0	12B					
		93	93	0	0	0	12B					
		94	94	0	0	0	12B					
		95	95	0	0	0	12B					
		96	96	0	0	0	12B					

Calculation of Base Year, AKA Weighted Average Year

Base year:
Total of Column C/Total of Column B = Base Year

104752869

959144

109.2149552

Base Year =

2009

=PG1!E14

Estimate of revised capital rate due to improvements 2000-20

Calculation of Base Year, AKA Weighted Average Year

Base year:

Total of Column C/Total of Column B = Base Year

104752869	959144	109.2149552
Base Year =		2009

=PG1!E14

Estimate of revised capital rate due to improvements 2000-2007?

TABLE 2

#N/A

TABLE 3

Property Tax Inflation

TABLE 4

Table 2 column

<u>1, 2, 3, 4, 5, 10 & 11</u>	<u>Year</u>	<u>1, 2 & 10</u>	<u>3, 4 & 5</u>	<u>11</u>	<u>6, 7, 8 & 9</u>
3766	1960	6.26	6.08	6.29	6.54
4896	1961	5.67	5.52	5.66	5.87
6026	1962	5.67	5.52	5.66	5.87
7155	1963	5.67	5.52	5.66	5.87
8285	1964	5.67	5.52	5.66	5.87
9415	1965	5.67	5.52	5.66	5.87
10545	1966	5.36	5.23	5.35	5.55
11675	1967	5.1	4.97	5.08	5.28
12804	1968	4.85	4.71	4.83	5.03
13934	1969	4.61	4.48	4.59	4.79
15064	1970	4.38	4.25	4.36	4.56
16194	1971	4.01	3.89	3.98	4.15
17324	1972	3.64	3.53	3.63	3.78
18453	1973	3.36	3.26	3.36	3.48
19583	1974	3.08	3	3.09	3.19
20713	1975	2.83	2.77	2.8	2.91
21843	1976	2.73	2.65	2.74	2.82
22973	1977	2.57	2.48	2.55	2.68
24102	1978	2.37	2.29	2.38	2.49
25232	1979	2.18	2.12	2.21	2.32
26362	1980	1.96	1.92	2.02	2.08
27492	1981	1.8	1.76	1.86	1.91
28622	1982	1.67	1.63	1.72	1.76
29751	1983	1.54	1.5	1.57	1.65
30881	1984	1.51	1.47	1.55	1.62
32011	1985	1.48	1.45	1.5	1.59
33141	1986	1.46	1.42	1.46	1.55
34271	1987	1.44	1.4	1.43	1.52
35400	1988	1.4	1.36	1.39	1.46
36530	1989	1.35	1.33	1.35	1.41
37660	1990	1.32	1.31	1.33	1.34
Prior to 1970	1991	1.29	1.29	1.3	1.31
	1992	1.26	1.26	1.27	1.26
	1993	1.25	1.24	1.25	1.23
	1994	1.22	1.22	1.22	1.19
	1995	1.2	1.2	1.19	1.17
	1996	1.12	1.11	1.13	1.12
	1997	1.1	1.09	1.1	1.1
	1998	1.08	1.07	1.07	1.07
	1999	1.04	1.04	1.04	1.04
	2000	1.02	1.02	1.02	1.03
	2001	1.00	1.00	1.00	1.00
	2002	1.00	1.00	1.00	1.00

HSA	Rate	HSA	Column
1	1.05723	1	1
2	1.0395	2	1
3	1.0333	3	2
4	1.03302	4	2
5	1.03753	5	2
6	1.02368	6	4
7	1.02054	7	4
8	1.02613	8	4
9	1.01315	9	4
10	1.0815	10	1
11	1.03527	11	3