

		FOR BHF USE					

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0051243 Facility Name: Windsor Park Nursing And Living Center Address: 2649 E. 75Th Street Chicago 60649 County: Cook Telephone Number: (773) 356-9300 Fax # (773) 356-9384 HFS ID Number: Date of Initial License for Current Owners: 05/28/98 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. X Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Steve Lavenda Telephone Number: (847) 236-1111 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. Officer or Administrator of Provider (Signed) (Type or Print Name) (Title) Paid Preparer (Signed) (Print Name and Title) Kimberley A. Waite, C.P.A. (Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015 (Telephone) (847) 236-1111 Fax # (847) 236-1155 MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Windsor Park Nursing And Living Center

0051243 Report Period Beginning: 01/01/12 Ending: 12/31/12

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	240	Skilled (SNF)	240	87,840	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	240	TOTALS	240	87,840	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	9,214	1,056	16,508	26,778	8
9	SNF/PED					9
10	ICF	41,977	594	19	42,590	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	51,191	1,650	16,527	69,368	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.97%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES NO X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES NO X

I. On what date did you start providing long term care at this location? Date started 11/1/10

J. Was the facility purchased or leased after January 1, 1978? YES X Date 11/1/10 NO

K. Was the facility certified for Medicare during the reporting year? YES X NO If YES, enter number of beds certified 240 and days of care provided 16,067

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL X MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES X NO

Tax Year: 12/31/12 Fiscal Year: 12/31/12

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

STATE OF ILLINOIS

Facility Name & ID Number

Windsor Park Nursing And Living Center

#0051243

Report Period Beginning:

01/01/12

Ending:

12/31/12

Page 3

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 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	372,730	20,015	19,744	412,489		412,489		412,489			1
2	Food Purchase		344,821		344,821	(44,798)	300,023	(49)	299,974			2
3	Housekeeping	264	30,792	304,305	335,361		335,361	1,484	336,845			3
4	Laundry			217,744	217,744		217,744		217,744			4
5	Heat and Other Utilities			273,795	273,795		273,795	(5,669)	268,126			5
6	Maintenance	187,762		159,985	347,747		347,747	12,047	359,794			6
7	Other (specify):*											7
8	TOTAL General Services	560,756	395,628	975,573	1,931,957	(44,798)	1,887,159	7,813	1,894,972			8
	B. Health Care and Programs											
9	Medical Director			63,000	63,000		63,000		63,000			9
10	Nursing and Medical Records	3,887,299	217,498	44,433	4,149,230		4,149,230	(3,366)	4,145,864			10
10a	Therapy	168,709	147	21,530	190,386		190,386		190,386			10a
11	Activities	190,353	14,478		204,831		204,831		204,831			11
12	Social Services	330,711		2,475	333,186		333,186		333,186			12
13	CNA Training											13
14	Program Transportation			30,290	30,290		30,290		30,290			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,577,072	232,123	161,728	4,970,923		4,970,923	(3,366)	4,967,557			16
	C. General Administration											
17	Administrative	192,425		16,000	208,425		208,425		208,425			17
18	Directors Fees											18
19	Professional Services			131,651	131,651	(24,015)	107,636	(2,966)	104,670			19
20	Dues, Fees, Subscriptions & Promotions			187,941	187,941		187,941	(124,196)	63,745			20
21	Clerical & General Office Expenses	214,402	3,699	287,801	505,902		505,902	26,952	532,854			21
22	Employee Benefits & Payroll Taxes			1,105,498	1,105,498	44,798	1,150,296		1,150,296			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,461	1,461		1,461	270	1,731			24
25	Other Admin. Staff Transportation			13,136	13,136		13,136		13,136			25
26	Insurance-Prop.Liab.Malpractice			249,517	249,517		249,517	943	250,460			26
27	Other (specify):*							32,602	32,602			27
28	TOTAL General Administration	406,827	3,699	1,993,005	2,403,531	20,783	2,424,314	(66,396)	2,357,919			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,544,655	631,450	3,130,306	9,306,411	(24,015)	9,282,396	(61,948)	9,220,448			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' COMPILATION REPORT
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			271,807	271,807		271,807	(126,466)	145,341			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			89,549	89,549		89,549	5,563	95,112			32
33	Real Estate Taxes			359,115	359,115	24,015	383,130	(94,571)	288,559			33
34	Rent-Facility & Grounds			1,530,445	1,530,445		1,530,445		1,530,445			34
35	Rent-Equipment & Vehicles			12,835	12,835		12,835		12,835			35
36	Other (specify):*			6,000	6,000		6,000		6,000			36
37	TOTAL Ownership			2,269,751	2,269,751	24,015	2,293,766	(215,474)	2,078,292			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		681,796	1,784,200	2,465,996		2,465,996		2,465,996			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			459,230	459,230		459,230		459,230			42
43	Other (specify):*	97,900		883,169	981,069		981,069	(981,069)				43
44	TOTAL Special Cost Centers	97,900	681,796	3,126,599	3,906,295		3,906,295	(981,069)	2,925,226			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,642,555	1,313,246	8,526,656	15,482,457		15,482,457	(1,258,491)	14,223,966			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(7,819)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(184,208)	30		9
10	Interest and Other Investment Income	(23)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(82)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(4,198)	21		18
19	Entertainment				19
20	Contributions	(7,044)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(149,505)	21		24
25	Fund Raising, Advertising and Promotional	(106,992)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,008,761)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,468,632)		\$	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)	210,141		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 210,141		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,258,491)		37

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

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

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

Report Period Beginning:

Ending:

ID#

0051243

01/01/12

12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Misc Income	\$ (214)	21	1
2	Patient Personal Items	(3,366)	10	2
3	Bank Charges	(10,975)	21	3
4	Marketing Salary	(97,900)	43	4
5	Non-Allowable Legal	(11,189)	19	5
6	Non- Allowable Fees	(868,724)	43	6
7	Additional R&M	4,591	06	7
8	COPE Dues	(10,237)	20	8
9	Additional R&M Building Co	3,948	06	9
10	Marketing fees	(14,446)	43	10
11	Building Co- Dues & Subscriptions	(250)	20	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	(1,008,761)		49

ID#0051243

Report Period Beginning:01/01/12

Ending:12/31/12

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

Summary A

12/31/12

[illegible]

Summary B

12/31/12

[illegible]

VII. RELATED PARTIES

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

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

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 1,524,960	Windsor Park Realty	100.00%	\$ 1,524,960	\$	1
2	V	20	Dues and Subscriptions		Windsor Park Realty	100.00%	250	250	2
3	V	30	Depreciation		Windsor Park Realty	100.00%	53,132	53,132	3
4	V	33	Real Estate Taxes	100,000	Windsor Park Realty	100.00%		(100,000)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,624,960			\$ 1,578,342	\$ * (46,618)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	FOOD	\$	Legacy Healthcare Financial Services	100.00%	\$ 33	\$ 33	15
16	V	3	HOUSEKEEPING		Legacy Healthcare Financial Services	100.00%	1,484	1,484	16
17	V	5	UTILITIES		Legacy Healthcare Financial Services	100.00%	2,150	2,150	17
18	V	6	GROUPS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	3,508	3,508	18
19	V	17	MANAGEMENT FEES		Legacy Healthcare Financial Services	100.00%			19
20	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	8,223	8,223	20
21	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	77	77	21
22	V	21	CLERICAL & GENERAL		Legacy Healthcare Financial Services	100.00%	191,844	191,844	22
23	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	270	270	23
24	V	25	AUTO AND TRAVEL		Legacy Healthcare Financial Services	100.00%			24
25	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	943	943	25
26	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	28,082	28,082	26
27	V	30	DEPRECIATION		Legacy Healthcare Financial Services	100.00%	1,531	1,531	27
28	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	6	6	28
29	V	33	REAL ESTATE TAX		Legacy Healthcare Financial Services	100.00%			29
30	V	34	RENT		Legacy Healthcare Financial Services	100.00%	16,370	16,370	30
31	V	35	AUTO RENTAL		Legacy Healthcare Financial Services	100.00%			31
32	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services	100.00%			32
33	V	17	MANAGEMENT FEES	16,000	Legacy Healthcare Financial Services	100.00%		(16,000)	33
34	V	19	BOOKKEEPING FEES		Legacy Healthcare Financial Services	100.00%			34
35	V	17	MANAGEMENT FEES- C. RAJCHENBACH		Legacy Healthcare Financial Services	100.00%	8,000	8,000	35
36	V	17	MANAGEMENT FEES- M. SHABAT		Legacy Healthcare Financial Services	100.00%	8,000	8,000	36
37	V	27	HEALTH INSURANCE/BENEFITS- C. RAJCHENBACH		Legacy Healthcare Financial Services	100.00%	2,260	2,260	37
38	V	27	HEALTH INSURANCE/BENEFITS- M. SHABAT		Legacy Healthcare Financial Services	100.00%	2,260	2,260	38
39	Total			\$ 16,000			\$ 275,041	\$ * 259,041	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	DEPRECIATION		Legacy Real Properties	100.00%	3,079	\$	3,079
16	V	32	INTEREST EXPENSE		Legacy Real Properties	100.00%	5,580		5,580
17	V	33	REAL ESTATE TAXES		Legacy Real Properties	100.00%	5,429		5,429
18	V								
19	V								
20	V								
21	V								
22	V	34	RENT	16,370	Legacy Real Properties	100.00%			(16,370)
23	V								
24	V								
25	V								
26	V								
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ 16,370			\$ 14,088	\$ *	(2,282)

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	10.000%	ASTORIA PLACE LIVING AND REHABILITATION CENTER,LLC	CHICAGO				1
2	MENACHEM SHABAT	10.000%	ELMBROOK NURSING,LLC	ELMHURST	LEGACY REAL PROPERTIES , L	LINCOLNWOOD	BUILDING CO	2
3	MENACHEM BERGER	45.000%	LAKEFRONT NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO	LEGACY HEALTHCARE & FINA	LINCOLNWOOD	HOME OFFICE / BOOKK	3
4	ATIED ASSOCIATES, LLC	35.000%	PARK VILLA NURSING AND REHABILITATION CENTER,LLC	MELROSE PARK	LIFELINE AMBULANCE, LLC	CHICAGO	AMBULANCE	4
5			PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO	WINDSOR PARK REALTY	CHICAGO	BUILDING CO	5
6			THE GROVE AT LINCOLN PARK LIVING AND REHAB CENTER,LLC	CHICAGO				6
7			THE GROVE NORTH LIVING AND REHAB CENTER,LLC	SKOKIE				7
8			THE GROVE OF EVANSTON,LLC	EVANSTON				8
9			THE GROVE OF LAGRANGE PARK,LLC	LAGRANGE PARK				9
10			THE GROVE AT THE LAKE	ZION				10
11			CHALET LIVING	CHICAGO				11
12			THE GROVE OF NORTHBROOK	NORTHBROOK				12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Chaim Rajchenbach	Owner	Administrative	10.00	See Attached	2	4.00%	Alloc. Salary	\$ 8,000	17-07	1
2	Menachem Shabat	Owner	Administrative	10.00	See Attached	2	4.00%	Alloc. Salary	8,000	17-07	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 16,000		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Windsor Park Nursing And Living Center # 0051243 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Windsor Park Nursing And Living Center # 0051243 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Legacy Healthcare Financial Services
Street Address 7040 N. Ridgeway
City / State / Zip Code Lincolnwood, IL 60712
Phone Number (847) 679-9797
Fax Number (847) 679-1126

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	2	FOOD	AVAIL. BED DAYS	716,018	13	\$ 270	\$	87,840	\$ 33	1
2	3	HOUSEKEEPING	AVAIL. BED DAYS	716,018	13	12,097	11,779	87,840	1,484	2
3	5	UTILITIES	AVAIL. BED DAYS	716,018	13	17,526		87,840	2,150	3
4	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	716,018	13	28,596		87,840	3,508	4
5	17	MANAGEMENT FEES	AVAIL. BED DAYS	716,018	13			87,840		5
6	19	PROFESSIONAL FEES	AVAIL. BED DAYS	716,018	13	67,029		87,840	8,223	6
7	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	716,018	13	625		87,840	77	7
8	21	CLERICAL & GENERAL	AVAIL. BED DAYS	716,018	13	1,563,793	1,447,779	87,840	191,844	8
9	24	SEMINARS	AVAIL. BED DAYS	716,018	13	2,200		87,840	270	9
10	25	AUTO AND TRAVEL	AVAIL. BED DAYS	716,018	13			87,840		10
11	26	INSURANCE	AVAIL. BED DAYS	716,018	13	7,687		87,840	943	11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	716,018	13	228,907		87,840	28,082	12
13	30	DEPRECIATION	AVAIL. BED DAYS	716,018	13	12,480		87,840	1,531	13
14	32	INTEREST	AVAIL. BED DAYS	716,018	13	51		87,840	6	14
15	33	REAL ESTATE TAX	AVAIL. BED DAYS	716,018	13			87,840		15
16	34	RENT	AVAIL. BED DAYS	716,018	13	133,442		87,840	16,370	16
17	35	AUTO RENTAL	AVAIL. BED DAYS	716,018	13			87,840		17
18	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	716,018	13			87,840		18
19	17	MANAGEMENT FEES- C. RAJ	AVG HOURS WKD	50	12	200,000		2	8,000	19
20	17	MANAGEMENT FEES- M. SHA	AVG HOURS WKD	50	12	200,000		2	8,000	20
21	27	HEALTH INSURANCE/BENEF	AVG HOURS WKD	50	12	56,500		2	2,260	21
22	27	HEALTH INSURANCE/BENEF	AVG HOURS WKD	50	12	56,500		2	2,260	22
23										23
24										24
25	TOTALS					\$ 2,587,703	\$ 1,459,558		\$ 275,041	25

Facility Name & ID Number Windsor Park Nursing And Living Center # 0051243 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	AVAIL. BED DAYS	716,018	13	25,098		87,840	3,079	1
2	32	INTEREST EXPENSE	AVAIL. BED DAYS	716,018	13	45,486		87,840	5,580	2
3	33	REAL ESTATE TAXES	AVAIL. BED DAYS	716,018	13	44,250		87,840	5,429	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 114,834	\$		\$ 14,088	25

Facility Name & ID Number Windsor Park Nursing And Living Center # 0051243 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Windsor Park Nursing And Living Center # 0051243 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Windsor Park Nursing And Living Center # 0051243 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Windsor Park Nursing And Living Center # 0051243 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Windsor Park Nursing And Living Center # 0051243 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Windsor Park Nursing And Living Center # 0051243 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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Windsor Park Nursing And Living Center # 0051243 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10			
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense				
		YES	NO				Original	Balance							
	A. Directly Facility Related Long-Term														
1							\$					\$	1		
2													2		
3													3		
4													4		
5	See Supplemental Schedule												5		
	Working Capital														
6	Imperial		X	Property Insurance								3,236	6		
7	Private Bank		X	Capex Note				601,769	1,359,155			21,249	7		
8	See Supplemental Schedule											65,065	8		
9	TOTAL Facility Related						\$	601,769	\$	1,359,155			9		
	B. Non-Facility Related*														
10	Interest Income		X									(23)	10		
11	Aloc. From Legacy HC	X										6	11		
12	Alloc. From Legacy Real Prop	X										5,580	12		
13	See Supplemental Schedule												13		
14	TOTAL Non-Facility Related						\$		\$				14		
15	TOTALS (line 9+line14)						\$	601,769	\$	1,359,155			\$	95,112	15

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

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$					1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8	Private Bank		X	Line of Credit			\$				\$ 65,065	8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital										65,065	14	
	B. Non-Facility Related*												
15							\$				\$	15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.		\$	67,354	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.)		\$	331,898	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	264,544	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		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.		\$	24,015	5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	288,559	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	308,722	8	
		2008	311,820	9	
		2009	358,173	10	
		2010	447,822	11	
		2011	326,469	12	
Beginning Accrual Adjusted					
Allocated from Legacy: \$5,429					

		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.

SEE ACCOUNTANTS' COMPILATION REPORT

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Windsor Park Nursing And Living Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051243

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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 Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 21-30-200-001-0000	Long Term Care Property	\$ 265,555.41	\$ 265,555.41
2. 21-30-200-002-0000	Long Term Care Property	\$ 4,878.98	\$ 4,878.98
3. 21-30-200-008-0000	Long Term Care Property	\$ 51,905.86	\$ 51,905.86
4. 21-30-121-008-0000	Long Term Care Property	\$ 1,411.88	\$ 1,411.88
5. 21-30-121-009-0000	Long Term Care Property	\$ 2,716.61	\$ 2,716.61
6. See Attached	See Attached	\$ 42,154.05	\$ 5,171.39
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 368,622.79	\$ 331,640.13

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAMEWindsor Park Nursing And Living CenterCOUNTYCook

FACILITY IDPH LICENSE NUMBER0051243

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 96,000

B. General Construction Type: Exterior Brick Frame Steel & Masonry Number of Stories 3

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☒ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

E. Does this cost report reflect any organization or pre-operating costs which are being amortized?
If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Allocated from Legacy Real Properties			\$ 10,037	1
2					2
3	TOTALS			\$ 10,037	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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

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

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12F & 12G)	929,011	51,320		46,451	(4,869)	46,451	67
68	Related Party Allocations (Pages 12H & 12I)	157,933	2,328		6,467	4,139	18,572	68
69	Financial Statement Depreciation		271,807			(271,807)		69
70	TOTAL (lines 4 thru 69)	\$ 1,086,944	\$ 325,455		\$ 52,918	\$ (272,537)	\$ 65,023	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Windsor Park Nursing And Living Center

0051243

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,086,944	\$ 325,455		\$ 52,918	\$ (272,537)	\$ 65,023	1
2	Data Cables, Keypads, And Jacks	2010	5,300		20	530	530	1,104	2
3	Telephone System	2010	12,500		20	2,500	2,500	5,208	3
4	Bimp - Sign	2011	5,544		20	554	554	1,063	4
5	Air Conditioning Repairs	2011	23,981		20	4,796	4,796	7,594	5
6	Two Custom Signs	2011	6,418		20	642	642	856	6
7	Metal Door, Frame And Locks	2011	4,752		20	475	475	594	7
8	Landscaping Improvement	2011	10,762		20	717	717	1,016	8
9	Entrance Remodel: New Sliding Door, Tiling	2011	11,834		20	592	592	1,183	9
10	Built-In Lobby Reception Desk	2011	10,369		20	518	518	1,037	10
11	Millwork In Lobby	2011	24,116		20	1,206	1,206	2,412	11
12	Granite For 1St Flr Nurse Station	2011	3,947		20	197	197	395	12
13	Pt Room Remodel: Tiling, Flooring, Built-In Cabinets And Works	2011	67,021		20	3,351	3,351	6,702	13
14	1St Floor Corridor Remodel: Flooring, Wallcovering, Handrails, I	2011	113,232		20	5,662	5,662	11,323	14
15	Wallcoverings For Small Corridor	2011	4,953		20	248	248	495	15
16	Wallcoverings, Window Treatments And Flooring In Various Offi	2011	11,853		20	593	593	1,185	16
17	Remodel Dining Room: Flooring, Window Treatments, Light Fixt	2011	37,712		20	1,886	1,886	3,771	17
18	1St Flr Resident Room Remodel:Built-In Furniture, Window Trea	2011	180,395		20	9,020	9,020	18,040	18
19	Elevator Remodel: Flooring/Wallvocering	2011	14,349		20	717	717	1,435	19
20	1St Floor Painting And Wallcovering	2011	60,687		20	3,034	3,034	6,069	20
21	1St Floor Bathrooms Electrical And Built-In Vanity And Fixtures	2011	17,527		20	876	876	1,753	21
22	Additional Outlets And Cap Sinks	2011	2,377		20	119	119	238	22
23	Installation Of Electrical Outlets, 2Nd & 3Rd Floor	2011	8,500		20	425	425	850	23
24	Install New Motor, Install New Gauge And Clean Out Plugged Res	2012	4,597		20	211	211	211	24
25	Repair Two B&G Pumps. Installed New Motor.	2012	3,300		20	83	83	83	25
26	Fire Alarm Repair, Power Supply Assy, Fuel Surcharge	2012	2,734		20	137	137	137	26
27	Boiler Repair	2012	12,985		20	190	190	190	27
28	Lighting Rewire	2012	2,511		20	126	126	126	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,751,201	\$ 325,455		\$ 92,321	\$ (233,134)	\$ 140,090	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 1,751,201	\$ 325,455		\$ 92,321	\$ (233,134)	\$ 140,090	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 1,751,201	\$ 325,455		\$ 92,321	\$ (233,134)	\$ 140,090	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12C, Carried Forward		\$ 1,751,201	\$ 325,455		\$ 92,321	\$ (233,134)	\$ 140,090	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 1,751,201	\$ 325,455		\$ 92,321	\$ (233,134)	\$ 140,090	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 1,751,201	\$ 325,455		\$ 92,321	\$ (233,134)	\$ 140,090	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,751,201	\$ 325,455		\$ 92,321	\$ (233,134)	\$ 140,090	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Windsor Park Nursing And Living Center

0051243

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Painting 2Nd & 3Rd Floor Resident Rooms/Corridor	2012	90,370		20	4,519	4,519	4,519	9
10	Magnetic Locks Installed W/Push Button And Keypads	2012	25,853		20	1,293	1,293	1,293	10
11	New Camera System, Wiring And Labor	2012	3,224		20	161	161	161	11
12	Installation Of New Model 30Rbx Series 460 Volt Chiller	2012	199,579		20	9,979	9,979	9,979	12
13	2Nd Floor Corridor Remodel: Millwork/Handrails, Wallcoverings	2012	112,889		20	5,644	5,644	5,644	13
14	Granite For 2Nd Floor Built In Nurses Station	2012	4,857		20	243	243	243	14
15	2Nd Floor Dining Room Remodel: Flooring, Wallcovering And Li	2012	37,869		20	1,893	1,893	1,893	15
16	2Nd Flr Resident Room Remodel: Windsow Treatments, Cubicle C	2012	131,425		20	6,571	6,571	6,571	16
17	3Rd Flr Dining Room Remodel: Flooring And Wallcvoerings	2012	28,325		20	1,416	1,416	1,416	17
18	Built-In Work Station For Physicians Office	2012	3,330		20	167	167	167	18
19	3Rd Floor Corridor: Millwork, Wallcoverings Flooring And Signa	2012	115,885		20	5,794	5,794	5,794	19
20	Granite For 3Rd Floor Built In Nurses Station	2012	4,867		20	243	243	243	20
21	3Rd Floor Dining Room Remodel: Cornices And Light Fixtures	2012	9,081		20	454	454	454	21
22	3Rd Flr Resident Room Remodel: Built-In Furniture, Window Tr	2012	127,169		20	6,358	6,358	6,358	22
23	Granite Installation For Built-In Transacaion Areas	2012	5,380		20	269	269	269	23
24	Special order steel door, Rim Exit device aluminum, universal arm	2012	4,752		20	238	238	238	24
25	Convection Pallet Heater	2012	3,851		20	193	193	193	25
26	Weatherproof Camera, Dome Camera, Pigtail Connector, dvr, Po	2012	11,805		20	590	590	590	26
27	Install 76 power outlets and TV Cables in the 2nd and 3rd floors	2012	8,500		20	425	425	425	27
28	Depreciation Expense			51,320			(51,320)		28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company Information Continued		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		\$ 929,011	\$ 51,320		\$ 46,451	\$ (4,869)	\$ 46,451	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Legacy Real Properties	2009	77,761	1,443	35	2,592	1,149	9,072	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Legacy Healthcare Financial Services	2012	3,498	266	20	175	(91)	175	9
10	Allocated from Legacy Real Properties	2009	44,160	357	20	2,208	1,851	6,072	10
11	Allocated from Legacy Real Properties	2010	13,428	108	20	538	430	1,344	11
12	Allocated from Legacy Real Properties	2011	19,086	154	20	954	800	1,909	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		\$ 157,933	\$ 2,328		\$ 6,467	\$ 4,139	\$ 18,572	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 233,274	\$ 1,725	\$ 41,439	\$ 39,714	10	\$ 79,949	71
72	Current Year Purchases	66,842	2,368	11,579	9,211	10	11,579	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 300,116	\$ 4,093	\$ 53,018	\$ 48,925		\$ 91,528	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,061,354	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 329,548	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 145,340	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (184,208)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 231,618	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: South Shore Property, LLC
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:	1964	240		\$ 1,530,445			3
4	Additions							4
5								5
6								6
7	TOTAL		240		\$ 1,530,445			7

**

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

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

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 2,964
- Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Audi A4	\$ 687.52	\$ 9,871	17
18					18
19					19
20					20
21	TOTAL		\$ 687.52	\$ 9,871	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	\$
13.	/2014	\$
14.	/2015	\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

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

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

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

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 643,114	\$		\$ 643,114	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			357,917			357,917	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			679,144			679,144	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				608,894		608,894	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					104,025	72,902		176,927	13
14	TOTAL			\$		\$ 1,784,200	\$ 681,796		\$ 2,465,996	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 2,999	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,786,363	4,786,363	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	275,685	275,685	6
7	Other Prepaid Expenses	133,092	173,092	7
8	Accounts Receivable (owners or related parties)	1,871,408	1,871,408	8
9	Other(specify): See Attached Schedule	85,813	1,285,813	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,152,361	\$ 8,395,360	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	454,635	1,385,169	15
16	Equipment, at Historical Cost	759,503	775,471	16
17	Accumulated Depreciation (book methods)	(361,572)	(414,704)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 852,566	\$ 1,745,936	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,004,927	\$ 10,141,296	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,224,109	\$ 1,224,109	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	586,315	586,315	30
31	Accrued Taxes Payable (excluding real estate taxes)	37,069	37,069	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	6,229	6,229	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	198,710	1,688,456	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,052,432	\$ 3,542,178	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,359,155	1,359,155	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,359,155	\$ 1,359,155	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,411,587	\$ 4,901,333	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,593,340	\$ 5,239,963	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,004,927	\$ 10,141,296	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,935,556	1
2	Restatements (describe):		2
3	Prior Period Revenue Adjustment	851,052	3
4	Prior Period Depreciation, Medicaid Tax, Patient Care Expenses, &	(355,703)	4
5	Prior Period Adjusting Journal Entries	500,000	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,930,905	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,212,435	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	(550,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,662,435	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,593,340	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 13,714,553	1
2	Discounts and Allowances for all Levels	(56,842)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,657,711	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,379,636	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,379,636	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	559,506	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	97,802	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 657,308	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	23	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 23	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	214	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 214	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,694,892	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,931,957	31
32	Health Care	4,970,923	32
33	General Administration	2,403,531	33
	B. Capital Expense		
34	Ownership	2,269,751	34
	C. Ancillary Expense		
35	Special Cost Centers	3,447,065	35
36	Provider Participation Fee	459,230	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,482,457	40
41	Income before Income Taxes (line 30 minus line 40)**	2,212,435	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,212,435	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 8,054,955	44
45	Private Pay - Net Inpatient Revenue	260,822	45
46	Medicare - Net Inpatient Revenue	5,181,834	46
47	Other-(specify) Insurance	160,100	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 13,657,711	49

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

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

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,993	2,187	\$ 128,969	\$ 58.97	1
2	Assistant Director of Nursing	5,802	6,614	200,061	30.25	2
3	Registered Nurses	12,857	13,479	512,872	38.05	3
4	Licensed Practical Nurses	57,675	61,850	1,566,107	25.32	4
5	CNAs & Orderlies	125,698	134,424	1,446,696	10.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,017	9,608	168,709	17.56	8
9	Activity Director	3,597	3,951	64,770	16.39	9
10	Activity Assistants	10,072	11,191	125,583	11.22	10
11	Social Service Workers	17,201	18,299	330,711	18.07	11
12	Dietician	3,735	4,011	69,711	17.38	12
13	Food Service Supervisor	280	407	5,974	14.68	13
14	Head Cook	4,969	5,158	58,560	11.35	14
15	Cook Helpers/Assistants	20,064	22,036	238,485	10.82	15
16	Dishwashers					16
17	Maintenance Workers	7,764	8,251	187,762	22.76	17
18	Housekeepers	27	27	264	9.78	18
19	Laundry					19
20	Administrator	965	1,009	87,125	86.35	20
21	Assistant Administrator	2,026	2,091	105,300	50.36	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,578	14,021	214,402	15.29	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	1,107	1,230	32,594	26.50	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	5,089	5,414	97,900	18.08	33
34	TOTAL (lines 1 - 33)	302,516	325,258	\$ 5,642,555 *	\$ 17.35	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	425	\$ 19,744	01-03	35
36	Medical Director	Monthly	63,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	21,000	10-03	38
39	Pharmacist Consultant	Monthly	11,520	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	21,530	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	42	2,475	12-03	45
46	Other(specify)				46
47	Dental Consultant	Per Visit	1,413	10-03	47
48	Nurse Practitioner Consultant	Monthly	10,500	10-03	48
49	TOTAL (lines 35 - 48)	467	\$ 151,182		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount
Elizabeth Toohill	Administrator	0.00%	\$ 87,125	Workers' Compensation Insurance		\$ 154,633	IDPH License Fee		\$ 1,990
Yehoshua Baumol	Asst. Admin	0.00%	105,300	Unemployment Compensation Insurance		246,846	Advertising: Employee Recruitment		40,600
				FICA Taxes		416,176	Health Care Worker Background Check		1,788
				Employee Health Insurance		210,294	(Indicate # of checks performed 178)		
				Employee Meals		44,798	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions		18,985
				Chicago Head Tax		4,933	Licenses & Permits		305
TOTAL (agree to Schedule V, line 17, col. 1)				Union Pension		45,495	Allocated From Legacy HC Financial Services		77
(List each licensed administrator separately.)			\$ 192,425	Other Employee Benefits		26,979			
B. Administrative - Other				Holiday			Less: Public Relations Expense		()
Description			Amount	Employee Physical exam		142	Non-allowable advertising		()
Management Fees - Legacy Healthcare Financial Services			\$ 16,000				Yellow page advertising		()
							TOTAL (agree to Sch. V, line 20, col. 8)		\$ 63,745
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,150,296			
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 16,000	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description		Amount
Frost, Ruttenberg & Rothblatt	Accounting		\$ 26,490			\$	Out-of-State Travel		\$
HDSI	Data Processing		22,732						
Personnel Planners	Unemployment Consulting		7,264						
IIT Source Tech	Data Processing		295				In-State Travel		
Patrick M Gzehoviak	Accounting		276						
Madison Specs	Cost Segregation		12,236						
First Real Estate Services	R/E Appraisal		5,500				Seminar Expense		1,461
Documentation Solutions	Compliance Audit		1,723				Allocated From Legacy HC Financial Services		270
Innovative Therapy Partners	Compliance Audit		2,063						
Various	Legal		23,594						
Ivans	Data Processing		405				Entertainment Expense		()
See Supplemetal Schedule			29,076				(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	TOTAL		\$ 1,731
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 131,652						

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

****See instructions.**

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ILCLTC \$13,603

(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? No
What was the average life used for new equipment added during this period? N/A

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 45,258 Line 10

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

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

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

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO No 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. \$ 459,230
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. \$ 44,798 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? 100% ln 14
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
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.

SEE ACCOUNTANTS' COMPILATION REPORT