

		FOR BHF USE					

LL1

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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

I. IDPH License ID Number: 0050245

Facility Name: Grove Lincoln Park Lvg & Rehab

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

County: Cook

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

HFS ID Number: _____

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

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
Email Address: _____

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/13 to 12/31/13 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____ (Date) _____
	(Type or Print Name) _____
	(Title) _____
Paid Preparer	(Signed) _____ (Date) _____
	(Print Name and Title) _____
	(Firm Name & Address) <u>McGladrey LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u>
	(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u>
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Grove Lincoln Park Lvg & Rehab

0050245 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	109	Skilled (SNF)	109	39,785	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	109	TOTALS	109	39,785	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	9,437	2,301	18,173	29,911	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,437	2,301	18,173	29,911	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.18%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 09/01/08

J. Was the facility purchased or leased after January 1, 1978?
YES Date 09/01/08 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 109 and days of care provided 17,822

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

Facility Name & ID Number

Grove Lincoln Park Lvg & Rehab

0050245

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	252,262	21,395	120	273,777		273,777		273,777		1
2	Food Purchase		209,945		209,945		209,945	13	209,958		2
3	Housekeeping	141,831	31,354		173,185		173,185	702	173,887		3
4	Laundry		844	114,643	115,487		115,487		115,487		4
5	Heat and Other Utilities			109,600	109,600		109,600	812	110,412		5
6	Maintenance	64,828		86,565	151,393		151,393	2,227	153,620		6
7	Other (specify):*										7
8	TOTAL General Services	458,921	263,538	310,928	1,033,387		1,033,387	3,754	1,037,141		8
	B. Health Care and Programs										
9	Medical Director			42,000	42,000		42,000		42,000		9
10	Nursing and Medical Records	2,405,173	156,425	108,366	2,669,964		2,669,964	(41,246)	2,628,718		10
10a	Therapy										10a
11	Activities	99,862	21,813		121,675		121,675		121,675		11
12	Social Services	75,028		9,945	84,973		84,973	3,640	88,613		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,580,063	178,238	160,311	2,918,612		2,918,612	(37,606)	2,881,006		16
	C. General Administration										
17	Administrative	144,657		874,218	1,018,875		1,018,875	(845,023)	173,852		17
18	Directors Fees										18
19	Professional Services			211,414	211,414		211,414	2,276	213,690		19
20	Dues, Fees, Subscriptions & Promotions			21,040	21,040		21,040	(5,222)	15,818		20
21	Clerical & General Office Expenses	399,383	46,946	322,353	768,682		768,682	(187,788)	580,894		21
22	Employee Benefits & Payroll Taxes			652,382	652,382		652,382		652,382		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,896	4,896		4,896	(2,897)	1,999		24
25	Other Admin. Staff Transportation			39,069	39,069		39,069		39,069		25
26	Insurance-Prop.Liab.Malpractice			110,974	110,974		110,974	745	111,719		26
27	Other (specify):* Mgmt Alloc of Benefit							20,918	20,918		27
28	TOTAL General Administration	544,040	46,946	2,236,346	2,827,332		2,827,332	(1,016,991)	1,810,341		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,583,024	488,722	2,707,585	6,779,331		6,779,331	(1,050,843)	5,728,488		29

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

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

Facility Name & ID Number

Grove Lincoln Park Lvg & Rehab

#0050245

Report Period Beginning:

01/01/13

Ending:

12/31/13

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			48,888	48,888	48,888	18,929	67,817				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,604	2,604	2,604	(2,604)	0				32
33	Real Estate Taxes			172,467	172,467	172,467	4,246	176,713				33
34	Rent-Facility & Grounds			563,621	563,621	563,621	61,869	625,490				34
35	Rent-Equipment & Vehicles			77,822	77,822	77,822	457	78,279				35
36	Other (specify):*											36
37	TOTAL Ownership			865,402	865,402	865,402	82,897	948,299				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		925,002	1,834,933	2,759,935	2,759,935	(10,461)	2,749,474				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			136,465	136,465	136,465		136,465				42
43	Other (specify):* Non-Allowable Cos	166,636		715,918	882,554	882,554	(882,554)	(0)				43
44	TOTAL Special Cost Centers	166,636	925,002	2,687,316	3,778,954	3,778,954	(893,015)	2,885,939				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,749,660	1,413,724	6,260,303	11,423,687	11,423,687	(1,860,961)	9,562,726				45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(9,215)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	14,053	30		9
10	Interest and Other Investment Income	(10,678)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(386)	43		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	(120)	43		18
19	Entertainment				19
20	Contributions	(96,110)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(221,714)	43		24
25	Fund Raising, Advertising and Promotional	(171,797)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(395,813)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (891,780)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(969,181)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (969,181)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,860,961)		37

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

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

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

Grove Lincoln Park Lvg & Rehab

ID# 0050245

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Adj Prior Year Expenses	\$ (116,815)	43	1
2	Labs - Part A	(62,891)	43	2
3	X-Rays - Part A	(6,069)	43	3
4	Pharm House stock	(20,639)	43	4
5	Charity Discounts	(25,316)	43	5
6	Discount	22,539	43	6
7	Personal Items	(7,385)	43	7
8	Admitting	(166,636)	43	8
9	Non-Allowable Travel & Seminar	(3,805)	24	9
10	RE Tax	2,072	33	10
11	Chamber of Commerce	(1,000)	20	11
12	Out of Period Legal	(5,237)	19	12
13	ILCTC dues	(4,631)	20	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	(395,813)		49

Facility Name & ID Number Grove Lincoln Park Lvg & Rehab

0050245

Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Pg 6-Supp		See Pg 6-Supp		See Pg6-Supp		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	2 Food	\$	Legacy Healthcare Financial Services, LLC	100.00%	\$ 13	\$ 13	1
2	V	3 Housekeeping		Legacy Healthcare Financial Services, LLC	100.00%	702	702	2
3	V	5 Utilities		Legacy Healthcare Financial Services, LLC	100.00%	812	812	3
4	V	6 Grounds & Maintenance		Legacy Healthcare Financial Services, LLC	100.00%	2,227	2,227	4
5	V	17 Management Fees	874,218	Legacy Healthcare Financial Services, LLC	100.00%	19,652	(854,566)	5
6	V	19 Professional Fees		Legacy Healthcare Financial Services, LLC	100.00%	5,659	5,659	6
7	V	20 Fees, Subscriptions		Legacy Healthcare Financial Services, LLC	100.00%	372	372	7
8	V	21 Clerical	279,650	Legacy Healthcare Financial Services, LLC	100.00%	90,682	(188,968)	8
9	V	24 Seminars		Legacy Healthcare Financial Services, LLC	100.00%	867	867	9
10	V	26 Insurance		Legacy Healthcare Financial Services, LLC	100.00%	745	745	10
11	V	27 Employee Benefits		Legacy Healthcare Financial Services, LLC	100.00%	20,740	20,740	11
12	V	30 Depreciation		Legacy Healthcare Financial Services, LLC	100.00%	1,721	1,721	12
13	V	32 Interest		Legacy Healthcare Financial Services, LLC	100.00%	12	12	13
14	Total		\$ 1,153,868			\$ 144,204	\$ * (1,009,664)	14

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

Facility Name & ID Number Grove Lincoln Park Lvg & Rehab

0050245

Report Period Beginning: 01/01/13

Ending: 12/31/13

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	34 Rent Expense	\$	Legacy Healthcare Financial Services, LLC	100.00%	\$ 6,508	\$ 6,508	15
16	V	30 Depreciation		Legacy Healthcare Financial Services, LLC	100.00%	(901)	(901)	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		\$			\$ 5,607	\$ * 5,607	39

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

Facility Name & ID Number Grove Lincoln Park Lvg & Rehab

0050245

Report Period Beginning: 01/01/13

Ending: 12/31/13

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, LLC	100.00%	\$ 2,466	\$ 2,466	15
16	V	32 Interest		Legacy Real Properties, LLC	100.00%	2,061	2,061	16
17	V	33 Real Estate Taxes		Legacy Real Properties, LLC	100.00%	2,174	2,174	17
18	V	34 Rent	6,508	Legacy Real Properties, LLC	100.00%		(6,508)	18
19	V	20 Dues		Legacy Real Properties, LLC	100.00%	19	19	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		\$ 6,508			\$ 6,720	\$ * 212	39

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

Facility Name & ID Number Grove Lincoln Park Lvg & Rehab

0050245

Report Period Beginning: 01/01/13

Ending: 12/31/13

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19 Computer Services	\$	Grove Healthcare Properties, LLC		\$ 1,637	\$ 1,637	15
16	V	30 Depreciation		Grove Healthcare Properties, LLC		1,590	1,590	16
17	V	32 Interest Expense		Grove Healthcare Properties, LLC		6,001	6,001	17
18	V	34 Rent	736,088	Grove Healthcare Properties, LLC		563,621	(172,467)	18
19	V	34 Rent		Grove Healthcare Properties, LLC		234,336	234,336	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		\$ 736,088			\$ 807,185	\$ * 71,097	39

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

Facility Name & ID Number Grove Lincoln Park Lvg & Rehab

0050245

Report Period Beginning: 01/01/13

Ending: 12/31/13

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10 RN Salary	\$ 48,000	Progressive Healthcare Consulting	100.00%	\$ 6,754	\$ (41,246)	15
16	V	12 Clergy Salary		Progressive Healthcare Consulting	100.00%	446	446	16
17	V	17 Admissions Salary		Progressive Healthcare Consulting	100.00%	12,737	12,737	17
18	V	19 Professional Fees		Progressive Healthcare Consulting	100.00%	217	217	18
19	V	20 Fees and Subscriptions		Progressive Healthcare Consulting	100.00%	18	18	19
20	V	21 Clerical & General		Progressive Healthcare Consulting	100.00%	1,180	1,180	20
21	V	22 Emp. Ben - Nursing		Progressive Healthcare Consulting	100.00%	178	178	21
22	V	27 Non Nursing Taxes & Benefits		Progressive Healthcare Consulting	100.00%	457	457	22
23	V	24 Seminars		Progressive Healthcare Consulting	100.00%	41	41	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		\$ 48,000			\$ 22,028	\$ * (25,972)	39

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

Facility Name & ID Number Grove Lincoln Park Lvg & Rehab

0050245

Report Period Beginning: 01/01/13

Ending: 12/31/13

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	39 Ambulance	\$ 59,848	Lifeline Ambulance	100.00%	\$ 49,387	\$	(10,461)	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		\$ 59,848			\$ 49,387	\$ *	(10,461)	39

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

Facility Name & ID Number Grove Lincoln Park Lvg & Rehab # 0050245 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Chaim Rajchenbach	Owner	Administrative	29.00	See Attached	See Att.	See Att.	Mgmt. Salary	9,826	17(7)	1
2	Menachem Shabat	Owner	Administrative	29.00	See Attached	See Att.	See Att.	Mgmt. Salary	9,826	17(7)	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 19,652		13

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

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

Facility Name & ID Number Grove Lincoln Park Lvg & Rehab

0050245

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 Legacy Healthcare Financial Services, LLC
 Street Address 7040 North Ridgeway Avenue
 City / State / Zip Code Lincolnwood, IL 60712
 Phone Number (847) 679-9797
 Fax Number (847) 679-3676

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	2	Food	Bed Days Available	809,780	13	\$ 271	39,785	\$ 13	1
2	3	Housekeeping	Bed Days Available	809,780	13	14,291	39,785	702	2
3	5	Utilities	Bed Days Available	809,780	13	16,531	39,785	812	3
4	6	Grounds & Maintenance	Bed Days Available	809,780	13	45,337	39,785	2,227	4
5	17	Management Fees	Bed Days Available	809,780	13	400,000	400,000	19,652	5
6	19	Professional Fees	Bed Days Available	809,780	13	115,181	39,785	5,659	6
7	20	Fees, Subscriptions	Hours	809,780	12	7,563	39,785	372	7
8	21	Clerical	Bed Days Available	809,780	13	1,845,746	1,700,817	90,682	8
9	24	Seminars	Bed Days Available	809,780	13	17,652	39,785	867	9
10	26	Insurance	Bed Days Available	809,780	13	15,170	39,785	745	10
11	27	Employee Benefits	Bed Days Available	809,780	13	422,132	39,785	20,740	11
12	30	Depreciation	Bed Days Available	809,780	13	35,039	39,785	1,721	12
13	32	Interest	Bed Days Available	809,780	13	242	39,785	12	13
14	34	Rent Expense	Bed Days Available	809,780	13	132,473	39,785	6,508	14
15	30	Depreciation	Direct Allocation					(901)	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,067,628	\$ 2,113,562		\$ 149,811	25

Facility Name & ID Number Grove Lincoln Park Lvg & Rehab

0050245

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Progressive Healthcare Consulting
 Street Address 7040 North Ridgeway Avenue
 City / State / Zip Code Lincolnwood, IL 60712
 Phone Number (847) 679-9797
 Fax Number (847) 679-3676

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	RN Salary	Patient Days	550,071	11	\$ 93,385	39,785	\$ 6,754	1
2	12	Clergy Salary	Patient Days	550,071	11	44,165	39,785	3,194	2
3	17	Administrative Salary-Mgmt Allo	Patient Days	550,071	11	131,937	39,785	9,543	3
4	19	Professional Fees	Patient Days	550,071	11	3,003	39,785	217	4
5	20	Fees and Subscriptions	Patient Days	550,071	11	250	39,785	18	5
6	21	Clerical & General	Patient Days	550,071	11	16,314	11,963	1,180	6
7	15	Emp. Ben - Nursing	Patient Days	550,071	11	2,467	39,785	178	7
8	27	Non Nursing Tax/Benefits	Patient Days	550,071	11	6,314	39,785	457	8
9	24	Seminars	Patient Days	550,071	11	560	39,785	41	9
10	12	Admissions Salary	Patient Days	550,071	11	6,165	6,165	446	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					\$ 304,560	\$ 287,615	\$ 22,028	25

Facility Name & ID Number Grove Lincoln Park Lvg & Rehab

0050245

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 Lifeline Ambulance LLC
 Street Address 2424 S. Wabash Avenue
 City / State / Zip Code Chicago, IL 60616
 Phone Number (312)-949-9595
 Fax Number (312)949-9262

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	39	Ambulance	Direct Allocation		\$	\$		\$ 49,387	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				\$	\$		\$ 49,387	25

Facility Name & ID Number Grove Lincoln Park Lvg & Rehab # 0050245 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	The Private Bank		X	Capital Expenditures	\$10,247.56	12/16/13	\$ 20,000	\$ 1,090,000	12/16/14	Varies	\$ 2,604	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$10,247.56		\$ 20,000	\$ 1,090,000			\$ 2,604	9								
B. Non-Facility Related*																				
10							Interest Income Offset				(10,678)	10								
11							Allocated from Management Company				12	11								
12							Allocated from Real Properties				2,061	12								
13							Allocated from Grove Healthcare Properties				6,001	13								
14	TOTAL Non-Facility Related						\$	\$			(2,604)	14								
15	TOTALS (line 9+line14)						\$ 20,000	\$ 1,090,000			\$	15								

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

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

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

Facility Name & ID Number **Grove Lincoln Park Lvg & Rehab**

0050245

Report Period Beginning:

01/01/13

Ending:

12/31/13

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 2012 report.			\$ 51,578	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.)	2012		\$ 80,679	2
3.	Under or (over) accrual (line 2 minus line 1).			\$ 29,101	3
4.	Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ 145,438	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		Allocation from LRP	2,174	6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ 176,713	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
	2008	<u>115,863</u>	8		
	2009	<u>97,732</u>	9		
	2010	<u>101,987</u>	10		
	2011	<u>147,032</u>	11		
	2012	<u>136,539</u>	12		
2013 Accrual of \$136,539*1.05%=143,366 . Use 145,438					
				FOR BHF USE ONLY	
				13	FROM R. E. TAX STATEMENT FOR 2012 \$ 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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grove Lincoln Park Lvg & Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050245

CONTACT PERSON REGARDING THIS REPORT Chaim Rajchenbach

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(A)	(B)	(C)	(D) <u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1.	<u>14-28-308-008-0000</u>	<u>Nursing Home</u>	\$ <u>136,538.61</u>	\$ <u>136,538.61</u>
2.	<u>Home Office Allocation</u>	<u></u>	\$ <u>44,384.14</u>	\$ <u>2,174.00</u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u>180,922.75</u>	\$ <u>138,712.61</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,325 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Allocated from Legacy Real Properties</u>			\$ <u>4,019</u>	1
2					2
3	TOTALS			\$ 4,019	3

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

Report Period Beginning:

01/01/13 Ending: 12/31/13**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4		Allocated from Legacy Real Properties			\$ 31,142	\$		\$ 1,038	\$ 1,038	\$ 4,671	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		Office Remodel - carpeting & built in cabinets	2009		54,635	1,366	40	1,366		6,147	9
10		Satellite system purchase & installation	2009		11,600	290	40	290		1,305	10
11		New Roof	2009		34,325	858	40	858		3,861	11
12		1st Floor Remodel									12
13		- Flooring, wallpaper & paint, carpeting, permits, update	2009		32,473	812	40	812		3,654	13
14		survey & architectural drawings									14
15		Electrical work	2009		8,645	216	40	216		972	15
16		Painting, Decor & Wallcoverings	2009		104,931	2,623	40	2,623		11,804	16
17		2nd Floor Remodel	2009		108,080	2,722	40	2,722		12,337	17
18		- Built in resident room furniture, handrails & baseboards									18
19		Outdoor Improvements - Awnings, Red Stucco	2009		42,033	1,051	40	1,051		4,729	19
20		Landscaping	2009		36,271	907	40	907		4,081	20
21		- install new flower bed, remove existing cement sidewalk,									21
22		remove gravel base, install new gravel base, brick pavers,									22
23		tuckpointing, remove/repair and transplant existing									23
24		landscaping, install new landscaping and plants									24
25		Install new phone system	2009		21,675	542	40	542		2,439	25
26		Sprinkler system	2009		3,047	76	40	76		342	26
27		Lock installation	2009		10,773	269	40	269		1,211	27
28		Patient Room Update - built in resident room furniture	2009		65,040	1,626	40	1,626		7,315	28
29		Chandeliers	2009		2,542	64	40	64		288	29
30											30
31		Landscaping	2009		26,271	1,751	15	1,751		7,880	31
32		- install new flower bed, remove existing cement sidewalk,									32
33		remove gravel base, install new gravel base, brick pavers,									33
34		tuckpointing, remove/repair and transplant existing									34
35		landscaping, install new landscaping and plants									35
36											36

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

See Page 12A, Line 70 for total

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

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

Report Period Beginning:

01/01/13

Ending:

12/31/13**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	Install 2 cab systems in elevators	2009	\$ 16,042	\$ 401	40	\$ 401	\$	\$ 1,805	37
38	Window treatments, cubicle curtains	2009	2,564	64	40	64		288	38
39	Flooring	2009	15,995	400	40	400		1,800	39
40	Window treatments, cubicle curtains	2009	18,149	454	40	454		2,042	40
41	Installed new air cooled condensing unit	2009	3,500	88	40	88		395	41
42	Sidewalk extension	2009	3,985	100	40	100		449	42
43	4 Floors hand railings, baseboards, lights above beds	2009	10,120	253	40	253		1,139	43
44	Install new 30HO motor on fire pump	2009	3,844	96	40	96		432	44
45	Plumbing work	2009	7,751	194	40	194		873	45
46	Project design fee	2009	10,000	250	40	250		1,125	46
47									47
48	Installation of 19 jacks on 3rd floor	2010	2,578	64	40	64		224	48
49	New doors and trims, and window trims	2010	28,831	721	40	721		2,523	49
50	Doors and trims	2010	4,800	120	40	120		420	50
51	Resident room furniture	2010	14,135	353	40	353		1,236	51
52	Door frames, built in cabinets	2011	2,671	178	15	178		445	52
53	Floor tiles, kitchen cabinets, baseboards	2011	2,640	176	15	176		440	53
54	Outlets, switches	2011	2,860	286	10	286		715	54
55	Cabinets, counters, back splash, etc.	2011	9,535	636	15	636		1,589	55
56	Partitions w/ granite tops	2011	3,200	213	15	213		534	56
57	paint rooms, prime woodwork, various other	2011	2,765	277	10	277		691	57
58	Construction of New Metal wall and kitchen cabinets	2011	5,000	333	15	333		834	58
59	Construction of first floor hallway and Dumpster for therapy room	2011	2,690	179	15	179		449	59
60	Flooring	2011	42,763	6,109	7	6,109		15,272	60
61	Flooring for 3rd and 4th floor	2011	45,095	6,442	7	6,442		16,105	61
62	Landscaping	2011	7,400	493	15	493		1,234	62
63									63
64	Replace ceiling in Therapy room	2012	3,275	82	40	82		123	64
65	Hallway electrical	2012	6,025	151	40	151		226	65
66	1st floor bathroom: tiles, ceiling, extend walls, electric	2012	3,975	99	40	99		149	66
67	2nd & 3rd fl. bathrooms: electric, plumbing, tiles, exhaust pipes	2012	9,775	244	40	244		367	67
68	4th floor bathroom: electric, water lines, tiles, exhaust pipes	2012	3,575	89	40	89		134	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 889,018	\$ 34,718		\$ 35,756	\$ 1,038	\$ 127,093	70

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

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

Report Period Beginning:

01/01/13

Ending:

12/31/13**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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 889,018	\$ 34,718		\$ 35,756	\$ 1,038	\$ 127,093	1
2									2
3	Sprinkler system improvements	2012	4,975	124	40	124		187	3
4	Install 16 roof mounted exhaust fans	2012	32,895	822	40	822		1,234	4
5	Vertical railing bars for existing stairways	2012	6,900	173	40	173		259	5
6									6
7	Relocate Wall	2013	2,685	34	40	34		34	7
8	Fire Panels, steel panels, & Vertical rod exit	2013	4,347	54	40	54		54	8
9	Duct work for locker rooms, bathrooms	2013	5,701	71	40	71		71	9
10	Tie new tamper switches to tamper panel	2013	3,280	41	40	41		41	10
11	Fabrication of builtins in room #314	2013	8,349	104	40	104		104	11
12	Nurse call system- 2nd floor	2013	20,949	262	40	262		262	12
13	Install TVs and TV outlets	2013	2,520	32	40	32		32	13
14	Nurse call system- 3rd floor	2013	8,705	109	40	109		109	14
15	Paint 2nd Floor	2013	24,380	305	40	305		305	15
16									16
17									17
18	Allocated from Grove Healthcare Properties	2008	3,600			131	131	551	18
19	Allocated from Grove Healthcare Properties	2008	6,080			333	333	2,749	19
20	Allocated from Grove Healthcare Properties	2008	12,980			472	472	1,908	20
21	Allocated from Grove Healthcare Properties	2010	2,050			75	75	222	21
22	Allocated from Grove Healthcare Properties	2010	4,000			145	145	405	22
23									23
24									24
25	Allocated from Legacy Real Properties	2009	17,685			442	442	3,316	25
26	Allocated from Legacy Real Properties	2010	5,378			175	175	754	26
27	Allocated from Legacy Real Properties	2011	7,644					1,147	27
28									28
29									29
30									30
31	Allocated from LHFS	2012	1,401			70	70	140	31
32	Allocated from LHFS	2013	4,481			224	224	224	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,080,002	\$ 36,849		\$ 39,954	\$ 3,105	\$ 141,199	34

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

Facility Name & ID Number Grove Lincoln Park Lvg & Rehab

0050245

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	\$ 220,786	\$	\$ 20,221	\$ 20,221	3 to 10	\$ 67,942	71
72	Current Year Purchases	119,765	5,988	5,988		7 to 10	5,988	72
73	Fully Depreciated Assets							73
74	See Sch 13A	19,171		1,654	1,654	10	6,771	74
75	TOTALS	\$ 359,722	\$ 5,988	\$ 27,863	\$ 21,875		\$ 80,701	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,443,743	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 42,837	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 67,817	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 24,980	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 221,900	85

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

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

G. Construction-in-Progress

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

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

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

Grove at Lincoln Park Living and Rehabilitation Center, LLC

0050245

12/31/2013

Schedule 13A

Category of Equipment	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Component Life	Accumulated Depreciation
1 Allocation from LHFS, Inc	5,262		526	526	10	1,092
2 Allocated from Grove Healthcare Prop.	5,800		317	317	10	2,622
3 Allocated from Legacy Real Properties	8,109		811	811	10	3,057
Totals	19,171	-	1,654	1,654		6,771

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		109	Sep-08	\$ 563,621			3
4	Additions							4
5								5
6	Home Office Allocation				61,869			6
7	TOTAL		109		\$ 625,490			7

10. Effective dates of current rental agreement:

Beginning 09/01/2008

Ending 08/31/2018

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

Fiscal Year Ending Annual Rent

12.	<u>/2014</u>	\$ <u>583,513</u>
13.	<u>/2015</u>	\$ <u>603,406</u>
14.	<u>/2016</u>	\$ <u>616,668</u>

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

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

N/A

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 69,956 Description: Bed Equip:\$65,677; Dietary Equip.\$4,279

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	See Schedule 14A	Various	\$ 1,288.87	\$ 8,323	17
18					18
19					19
20					20
21	TOTAL		\$ 1,288.87	\$ 8,323	21

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

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

Grove at Lincoln Park Living and Rehabilitation Center, LLC

0050245

12/31/2013

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Business	Business Car-Ally 8042	\$ 749.00	\$ 7,213	17
18	Business	Infiniti 3087	539.87	2,708	18
19	Reimbursement			(2,055)	19
20					20
	Allocation from Management			457	
21	TOTAL		\$ 1,288.87	\$ 8,323	21

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1 Drop-outs	2 Completed	3 Contract	
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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Outside Practitioner (other than consultant)							
					Units	Cost						
1	Licensed Occupational Therapist	39(3)	hrs	\$	11,363	\$ 704,496			\$	11,363	\$ 704,496	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		3,591	222,670				3,591	222,670	2
3	Licensed Recreational Therapist		hrs		13,101	812,281				13,101	812,281	3
4	Licensed Physical Therapist	39(3)	hrs									4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39(2)	# of prescrpts					919,002			919,002	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education	39(3)	hrs			958					958	11
12	Other (specify): <u>Oxygen</u>	39(2)						6,000			6,000	12
13	Other (specify): <u>Ambulance</u>	39(3)				94,528					94,528	13
14	TOTAL			\$	28,055	\$ 1,834,933		\$ 925,002		28,055	\$ 2,759,935	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.

Facility Name & ID Number Grove Lincoln Park Lvg & Rehab# 0050245Report Period Beginning: 01/01/13Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>(361,494)</u>)	3,046,357	3,046,357	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	197,367	197,367	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Sch17A</u>	1,897,397	1,897,397	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,141,122	\$ 5,141,122	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		4,019	13
14	Buildings, at Historical Cost		31,142	14
15	Leasehold Improvements, at Historical Cost	983,954	1,048,860	15
16	Equipment, at Historical Cost	332,758	359,722	16
17	Accumulated Depreciation (book methods)	(170,533)	(221,900)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,146,179	\$ 1,221,843	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,287,301	\$ 6,362,965	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 453,208	\$ 453,208	26
27	Officer's Accounts Payable	2,916	2,916	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	339,680	339,680	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,006	6,006	31
32	Accrued Real Estate Taxes(Sch.IX-B)		145,438	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Sch17A</u>	75,493	75,493	36
37	<u>Federal Unemployment Tax</u>	4,466	4,466	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 881,769	\$ 1,027,207	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,090,000	1,090,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	_____			43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,090,000	\$ 1,090,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,971,769	\$ 2,117,207	46
47	TOTAL EQUITY (page 18, line 24)	\$ 4,315,532	\$ 4,245,758	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,287,301	\$ 6,362,965	48

*(See instructions.)

Grove at Lincoln Park Living and Rehabilitation Center, LLC
0050245
12/31/2013

Schedule 17A

Account	Operating	After Consolidation
112.8 EMP LOAN, ADV, W/A	40,111	40,111
118.4 LEASE DEPOSIT	481,500	481,500
120.7 DUE TO MEDICARE	110,885	110,885
121.0 ACCRUED SEQSTR	47,854	47,854
121.4 IL B L F	29,594	29,594
124.0 LEG CHARITY	(24,067)	(24,067)
124.1 DUE TO/FROM CHALET	-	-
124.2 T/F GTL	-	-
124.8 LEGACY	129,377	129,377
124.9 GHCP	1,046,051	1,046,051
125.1 AP	995	995
125.3 EVANSTON	-	-
125.6 T/F CHALET REALTY	100,000	100,000
126.0 DUE T/F PROGRESSIVE	(64,903)	(64,903)
	1,897,397	1,897,397

Account	Operating	After Consolidation
10.0 TRUST CLEARING ACCT	8,192	8,192
115.2 PREPAID INS - LIAB	80,520	80,520
121.5 NEW BED TAX LIAB	13,014	13,014
121.8 ADMIN BONUS	(10,000)	(10,000)
121.9 ACC MGMT FEE	(17,034)	(17,034)
122.5 ACCRUED F I C A	(6,551)	(6,551)
124.7 GN	(8,106)	(8,106)
125.0 DUE TO MEMBERS	(35,528)	(35,528)
125.7 RELATED LESSOR	(100,000)	(100,000)
Total	(75,493)	(75,493)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,223,745	1
2	Restatements (describe):		2
3	Prior Period Adjustment	879,687	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,103,432	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	812,100	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	(1,600,000)	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)	\$ (787,900)	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)	\$ 4,315,532	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number Grove Lincoln Park Lvg & Rehab

0050245

Report Period Beginning: 01/01/13

Ending: 12/31/13

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	\$ 12,113,520	1
2	Discounts and Allowances for all Levels	(75,269)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,038,251	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	111,523	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 111,523	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	9,743	17
18	Sale of Supplies to Non-Patients	10,932	18
19	Laboratory	32,552	19
20	Radiology and X-Ray	60	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 53,287	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	32,726	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 32,726	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,235,787	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,033,387	31
32	Health Care	2,918,612	32
33	General Administration	2,827,332	33
B. Capital Expense			
34	Ownership	865,402	34
C. Ancillary Expense			
35	Special Cost Centers	3,642,489	35
36	Provider Participation Fee	136,465	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,423,687	40
41	Income before Income Taxes (line 30 minus line 40)**	812,100	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 812,100	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,538,554	44
45	Private Pay - Net Inpatient Revenue	695,503	45
46	Medicare - Net Inpatient Revenue	9,804,194	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,038,251	49

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

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

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

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

Facility Name & ID Number Grove Lincoln Park Lvg & Rehab

0050245

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	1,324	1,681	\$ 72,095	\$ 42.89	1
2	Assistant Director of Nursing	1,935	2,159	76,549	35.46	2
3	Registered Nurses	28,607	31,244	910,607	29.15	3
4	Licensed Practical Nurses	7,274	8,155	211,363	25.92	4
5	CNAs & Orderlies	76,901	85,369	1,030,356	12.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,865	1,997	25,008	12.52	9
10	Activity Assistants	5,131	5,549	74,854	13.49	10
11	Social Service Workers	3,224	3,445	75,028	21.78	11
12	Dietician					12
13	Food Service Supervisor	4,032	6,328	73,336	11.59	13
14	Head Cook	5,826	6,237	72,560	11.63	14
15	Cook Helpers/Assistants	10,333	11,082	106,366	9.60	15
16	Dishwashers					16
17	Maintenance Workers	3,037	3,359	64,828	19.30	17
18	Housekeepers	11,572	12,918	141,831	10.98	18
19	Laundry					19
20	Administrator	1,988	2,065	118,055	57.17	20
21	Assistant Administrator	652	726	26,602	36.64	21
22	Other Administrative	6,532	5,766	166,636	28.90	22
23	Office Manager					23
24	Clerical	28,257	29,532	399,383	13.52	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	827	952	19,896	20.90	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Care Plan Coordin</u>	2,901	3,253	84,307	25.92	33
34	TOTAL (lines 1 - 33)	202,218	221,817	\$ 3,749,660 *	\$ 16.90	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 120	1(3)	35
36	Medical Director	Monthly	42,000	9(3)	36
37	Medical Records Consultant	80	4,512	10(3)	37
38	Nurse Consultant	880	24,000	10(3)	38
39	Pharmacist Consultant	Monthly	8,818	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	9,945	12(3)	45
46	Other(specify) <u>MDS Consulting</u>	6,992	56,013	10(3)	46
47	<u>Physician</u>	Monthly	12,000	10(3)	47
48					48
49	TOTAL (lines 35 - 48)	7,952	\$ 157,408		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	36	630	10(3)	52
53	TOTAL (lines 50 - 52)	36	\$ 630		53

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	
Ashleigh Henri	Administrator	0	\$ 35,615	Workers' Compensation Insurance	\$ 106,861	IDPH License Fee	\$ 1,824	
Harry Schayer	Administrator	0	82,440	Unemployment Compensation Insurance	41,158	Advertising: Employee Recruitment	633	
Cynthia Palao Suarez	Asst. Administrator	0	19,986	FICA Taxes	242,756	Health Care Worker Background Check		
Yaakov Garfinkel	Asst. Administrator	0	6,616	Employee Health Insurance	188,068	(Indicate # of checks performed <u>209</u>)	2,090	
				Employee Meals		Patient Background Checks	5	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & fees	2,829	
				Union Pension	8,783	Miscellaneous Dues & Subscriptions	1,000	
				Other Employee Benefits	26,251	IL Council on LTC	11,523	
				Chicago Head Tax	1,340	Disallow Lobbying	(4,631)	
				Unreimbursed Payroll Taxes	31,895	Allocated from Management Co.	409	
				Employee Physical Exam	270	Less: Public Relations Expense	()	
				State Income Tax	5,000	Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 144,657	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)				\$ 652,382		\$ 15,818		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees (eliminated in Col. 7)			\$ 874,218	N/A		\$	Out-of-State Travel	\$
(Eliminated in Col. 7)								
							In-State Travel	
							Seminar Expense	1,999
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 874,218	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
(Attach a copy of any management service agreement)							\$ 1,999	
C. Professional Services								
Vendor/Payee	Type		Amount					
See Schedule 21C	Various		\$ 211,414					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 211,414					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Grove at Lincoln Park Living and Rehabilitation Center, LLC
0050245
12/31/2013

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor/Payee	Type	Amount
McGladrey LLP	Accounting	22,314.25
FR&R	Accounting	1,825.00
Legacy Reimbursed Expenses	Accounting	293.78
Creative Technology Solutions	Data Processing	10,033.22
E-Health Data Solutions	Data Processing	13,044.61
Legacy Reimbursement	Data Processing	2,039.33
Accu-Med Services	Data Processing	2,999.95
Telemedicine Solutions	Data Processing	6,147.50
Woundroids Licensse Fee	Data Processing	(2,819.44)
Wescorn Solutions	Data Processing	3,712.68
Legacy Reimbursed Expenses	Legal	12,596.42
Meyer Magence	Legal	2,250.00
Michael R Jarecki	Legal	4,950.00
Much Selist	Legal	1,498.00
Ogletree Deakins	Legal	8,138.00
Scott & Kraus, LLC	Legal	820.00
Fox Law	Legal	2,942.50
Skidelsky & Associates	Legal	185.00
Stone, McGuire & Siegel	Legal	262.50
The Joint Commission	Legal	4,285.00
Corporationg Service company	Legal	177.27
ML Enterprises	Purchasing Consultant	3,850.00
Dr Dragic M Obradovic	Consulting	7,200.00
Dr Pendrag Simovic	Consulting	7,200.00
Collaborative Health Care	LTC Consulting	200.00
Harry Schayer	Consulting	58.85
Associated Physicians	Consulting	30,000.00
Personnel Planners, Inc	Unemployment Tax Consultant	785.00
Prospect Resources, Inc.	Energy Procurement Resource	750.00
IIT Sourcedtech	Data Processing	1,790.00
Illinois Rights Corp	Medicare Consultant	12,048.00
Govig & Associates	Other Professional Services	14,035.00
Achieve Accreditation	Other Professional Services	13,033.92
Professional Search Network	Other Professional Services	1,454.55
MTS Consulting LLC	Consulting	5,972.96
Zimmet Healthcare	Other Professional Services	703.50
Legacy Reimbursed Expenses	Other Professional Allocation	12,836.23
Building Consultants	Building Consultants	1,800.00
		211,413.58
TOTAL (agree to Schedule V, line 19, column 3)		211,414
Disallowed Legal		5,237
Reversal of duplicate		3,752
Plus: Allocation from Management Company		7,548
TOTAL (agree to Schedule V, line 19, column 8)		<u>213,690</u>

Facility Name & ID Number Grove Lincoln Park Lvg & Rehab# 0050245Report Period Beginning: 01/01/13Ending: 12/31/13**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC: \$11,523
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 31,695 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? X YES NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 136,465
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation. N/A
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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.