

Facility Name & ID Number Grove of Northbrook L & R

0052050 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	86	Skilled (SNF)	86	31,390	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,520	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	134	TOTALS	134	48,910	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	2,937	647	6,573	10,157	8
9	SNF/PED					9
10	ICF	29,542	1,736	746	32,024	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,479	2,383	7,319	42,181	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.24%

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

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 11/1/2012

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

YES Date 11/1/2012 NO

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

YES NO If YES, enter number of beds certified 83 and days of care provided 6,378

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: 12/31/2013 Fiscal Year: 12/31/2013

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Grove of Northbrook L & R

0052050

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 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	261,268	28,354	7,794	297,416		297,416		297,416		1
2	Food Purchase		249,375		249,375		249,375	(125)	249,250		2
3	Housekeeping	124,474	29,848	1,163	155,485		155,485	863	156,348		3
4	Laundry	74,861	5,151	6,544	86,556		86,556		86,556		4
5	Heat and Other Utilities			139,908	139,908		139,908	(15,465)	124,443		5
6	Maintenance	107,933		105,948	213,881		213,881	10,356	224,237		6
7	Other (specify):*										7
8	TOTAL General Services	568,536	312,728	261,357	1,142,621		1,142,621	(4,370)	1,138,251		8
	B. Health Care and Programs										
9	Medical Director			28,000	28,000		28,000		28,000		9
10	Nursing and Medical Records	2,157,826	176,441	43,435	2,377,702		2,377,702	(26,358)	2,351,344		10
10a	Therapy	199,469	279	1,610	201,358		201,358		201,358		10a
11	Activities	108,321	18,918	2,544	129,783		129,783		129,783		11
12	Social Services	104,174		8,575	112,749		112,749		112,749		12
13	CNA Training										13
14	Program Transportation			15,648	15,648		15,648	(112)	15,536		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,569,790	195,638	99,812	2,865,240		2,865,240	(26,470)	2,838,770		16
	C. General Administration										
17	Administrative	144,016		24,160	168,176		168,176	(0)	168,176		17
18	Directors Fees										18
19	Professional Services			336,947	336,947	(4,500)	332,447	(199,421)	133,026		19
20	Dues, Fees, Subscriptions & Promotions			168,294	168,294		168,294	(129,236)	39,058		20
21	Clerical & General Office Expenses	258,804	4,430	258,118	521,352		521,352	(101,031)	420,321		21
22	Employee Benefits & Payroll Taxes			584,248	584,248		584,248		584,248		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,431	4,431		4,431	977	5,408		24
25	Other Admin. Staff Transportation			6,801	6,801		6,801		6,801		25
26	Insurance-Prop.Liab.Malpractice			114,678	114,678		114,678	(3,115)	111,563		26
27	Other (specify):*							25,496	25,496		27
28	TOTAL General Administration	402,820	4,430	1,497,677	1,904,927	(4,500)	1,900,427	(406,329)	1,494,098		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,541,146	512,796	1,858,846	5,912,788	(4,500)	5,908,288	(437,169)	5,471,119		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.

Facility Name & ID Number Grove of Northbrook L & R

#0052050

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			12,111	12,111		12,111	180,005	192,116			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			36,062	36,062		36,062	498,151	534,213			32
33	Real Estate Taxes			173,111	173,111	4,500	177,611	2,673	180,284			33
34	Rent-Facility & Grounds			665,150	665,150		665,150	(665,150)	0			34
35	Rent-Equipment & Vehicles			16,036	16,036		16,036		16,036			35
36	Other (specify):*			210,000	210,000		210,000		210,000			36
37	TOTAL Ownership			1,112,470	1,112,470	4,500	1,116,970	15,678	1,132,648			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		324,338	1,116,840	1,441,178		1,441,178		1,441,178			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			298,635	298,635		298,635		298,635			42
43	Other (specify):*	64,026		619,144	683,170		683,170	(683,170)	0			43
44	TOTAL Special Cost Centers	64,026	324,338	2,034,619	2,422,983		2,422,983	(683,170)	1,739,813			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,605,172	837,134	5,005,935	9,448,241		9,448,241	(1,104,661)	8,343,580			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

Facility Name & ID Number Grove of Northbrook L & R

0052050

Report Period Beginning: 01/01/13

Ending: 12/31/13

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	(16,463)	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	(39,563)	30		9
10	Interest and Other Investment Income	(3,987)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(141)	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	(255)	21		18
19	Entertainment				19
20	Contributions	(91,000)	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	(151,802)	21		24
25	Fund Raising, Advertising and Promotional	(34,568)	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	(805,386)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,143,165)		\$	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)	38,504		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 38,504		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,104,661)		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.			\$		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

SEE ACCOUNTANTS' COMPILATION REPORT

Grove of Northbrook L & R

ID#	0052050
Report Period Beginning:	01/01/13
Ending:	12/31/13

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Veterans Pharmacy	\$ (24,865)	10	1
2	Sequestration	(48,000)	21	2
3	Patient Personal Items	(1,493)	10	3
4	Meals	(5,685)	21	4
5	Bank Charges	(6,770)	21	5
6	Insurance - Executive Life	(4,031)	26	6
7	Additional R&M	7,618	06	7
8	Annual Report	(500)	20	8
9	Non-Allowable Seminar	(89)	24	9
10	Non-Allowable Legal	(8,378)	19	10
11	Marketing Salary	(64,026)	43	11
12	Building Co. Legal Fees	(3,333)	19	12
13	Building Co. Professional Fees	(5,500)	19	13
14	Building Co. Amortization of Loan Fees	(15,000)	36	14
15	Building Co. Offie Supplies	(143)	21	15
16	Building Co. Penalties	(2,400)	21	16
17	Non-Allowable Expenses	(619,144)	43	17
18	COPE Dues	(3,647)	20	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	(805,386)	49

Grove of Northbrook L & R

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

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	Total		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Grove of Northbrook L & R# 0052050

Report Period Beginning:

01/01/13

Ending:

12/31/13

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(141)		16									(125)	2
3	Housekeeping			863									863	3
4	Laundry													4
5	Heat and Other Utilities	(16,463)		998									(15,465)	5
6	Maintenance	7,618		2,738									10,356	6
7	Other (specify):*													7
8	TOTAL General Services	(8,986)		4,616									(4,370)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(26,358)											(26,358)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation					(112)							(112)	14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(26,358)				(112)							(26,470)	16
	C. General Administration													
17	Administrative			(0)									(0)	17
18	Directors Fees													18
19	Professional Services	(17,211)	8,833	(191,043)									(199,421)	19
20	Fees, Subscriptions & Promotions	(129,715)		457	22								(129,236)	20
21	Clerical & General Office Expenses	(215,055)	2,543	111,481									(101,031)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(89)		1,066									977	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice	(4,031)		916									(3,115)	26
27	Other (specify):*			25,496									25,496	27
28	TOTAL General Administration	(366,101)	11,376	(51,627)	22								(406,329)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(401,445)	11,376	(47,011)	22	(112)							(437,169)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Grove of Northbrook L & R

0052050

Report Period Beginning:

01/01/13

Ending:

12/31/13

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(39,563)	214,420	2,116	3,032								180,005	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(3,987)	499,589	15	2,534								498,151	32
33	Real Estate Taxes				2,673								2,673	33
34	Rent-Facility & Grounds		(665,150)	8,001	(8,001)								(665,150)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(15,000)	15,000											36
37	TOTAL Ownership	(58,550)	63,859	10,132	237								15,678	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(683,170)											(683,170)	43
44	TOTAL Special Cost Centers	(683,170)											(683,170)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,143,165)	75,235	(36,879)	260	(112)							(1,104,661)	45

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	\$ 665,150	Brook Properties LLC	100.00%	\$	(665,150)	1
2	V	32 Interest	21	Brook Properties LLC	100.00%	499,610	499,589	2
3	V	19 Legal Fees		Brook Properties LLC	100.00%	3,333	3,333	3
4	V	19 Professional Fees		Brook Properties LLC	100.00%	5,500	5,500	4
5	V	36 Amortization of Loan Fees		Brook Properties LLC	100.00%	15,000	15,000	5
6	V	21 Office Supplies		Brook Properties LLC	100.00%	143	143	6
7	V	21 Penalties		Brook Properties LLC	100.00%	2,400	2,400	7
8	V	30 Depreciation		Brook Properties LLC	100.00%	214,420	214,420	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 665,171			\$ 740,406	\$ * 75,235	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%	\$ 16	\$	16	15
16	V	3	HOUSEKEEPING WAGES	Legacy Healthcare Financial Services	100.00%	770		770	16
17	V	3	HOUSEKEEPING SUPPLIES	Legacy Healthcare Financial Services	100.00%	93		93	17
18	V	5	UTILITIES	Legacy Healthcare Financial Services	100.00%	998		998	18
19	V	6	GROUNDS & MAINTENANCE	Legacy Healthcare Financial Services	100.00%	2,738		2,738	19
20	V	17	MANAGEMENT FEES	Legacy Healthcare Financial Services	100.00%				20
21	V	19	PROFESSIONAL FEES	Legacy Healthcare Financial Services	100.00%	6,957		6,957	21
22	V	20	FEES, SUBSCRIPTIONS	Legacy Healthcare Financial Services	100.00%	457		457	22
23	V	21	CLERICAL & GENERAL WAGES	Legacy Healthcare Financial Services	100.00%	102,728		102,728	23
24	V	21	CLERICAL & GENERAL OTHER COSTS	Legacy Healthcare Financial Services	100.00%	8,754		8,754	24
25	V	24	SEMINARS	Legacy Healthcare Financial Services	100.00%	1,066		1,066	25
26	V	26	INSURANCE	Legacy Healthcare Financial Services	100.00%	916		916	26
27	V	27	EMP. BEN.-GEN. ADMIN.	Legacy Healthcare Financial Services	100.00%	17,463		17,463	27
28	V	27	EMP BEN- OWNERS	Legacy Healthcare Financial Services	100.00%				28
29	V	30	DEPRECIATION	Legacy Healthcare Financial Services	100.00%	2,116		2,116	29
30	V	32	INTEREST	Legacy Healthcare Financial Services	100.00%	15		15	30
31	V	34	RENT	Legacy Healthcare Financial Services	100.00%	8,001		8,001	31
32	V								32
33	V	17	MANAGEMENT FEES	Legacy Healthcare Financial Services	100.00%			(24,160)	33
34	V	19	BOOKKEEPING FEES	Legacy Healthcare Financial Services	100.00%			(198,000)	34
35	V	17	MANAGEMENT FEES- C. RAJCHENBACH	Legacy Healthcare Financial Services	100.00%	12,080		12,080	35
36	V	17	MANAGEMENT FEES- M. SHABAT	Legacy Healthcare Financial Services	100.00%	12,080		12,080	36
37	V	27	HEALTH INSURANCE/BENEFITS- C. RAJCHENBACH	Legacy Healthcare Financial Services	100.00%	4,017		4,017	37
38	V	27	HEALTH INSURANCE/BENEFITS- M. SHABAT	Legacy Healthcare Financial Services	100.00%	4,017		4,017	38
39	Total		\$ 222,160			\$ 185,281	\$ *	(36,879)	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	20 DUES & SUBSCRIPTIONS		Legacy Real Properties	100.00%	22	\$	22	15
16	V	30 DEPRECIATION		Legacy Real Properties	100.00%	3,032		3,032	16
17	V	32 INTEREST EXPENSE		Legacy Real Properties	100.00%	2,534		2,534	17
18	V	33 REAL ESTATE TAXES		Legacy Real Properties	100.00%	2,673		2,673	18
19	V								19
20	V	34 RENT	8,001	Legacy Real Properties	100.00%			(8,001)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 8,001			\$ 8,261	\$ *	260	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	14 AMBULANCE	\$ 638	LIFELINE AMBULANCE	100.00%	\$ 526	\$	(112)	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		\$ 638			\$ 526	\$ *	(112)	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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

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	27.0000%	ASTORIA PLACE LIVING AND REHABILITATION CENTER,LLC	CHICAGO	LEGACY REAL PROPERTIES, I	LINCOLNWOOD	BUILDING CO	1
2	MENACHEM SHABAT	27.0000%	ELMBROOK NURSING,LLC	ELMHURST	LEGACY HEALTHCARE & FINA	LINCOLNWOOD	HOME OFFICE / BOOKKEEP	2
3	JACK RAJCHENBACH FAMILY TRUST	13.0000%	THE GROVE NORTH LIVING AND REHAB CENTER,LLC	SKOKIE	LIFELINE AMBULANCE LLC	CHICAGO	AMBULANCE	3
4	RONALD SHABAT	13.0000%	THE GROVE OF EVANSTON,LLC	EVANSTON	PROGRESSIVE HEALTHCARE	LINCOLNWOOD	NURSE CONSULTING	4
5	JAMIE DLATT	5.0000%	THE GROVE AT THE LAKE	ZION	BROOK PROPERTIES LLC		BUILDING CO	5
6	YAIR ZUCKERMAN	10.0000%	THE GROVE AT LINCOLN PARK LIVING AND REHAB CENTER,LLC	CHICAGO	REMED SERVICES LLC	LINCOLNWOOD	DME SALES	6
7	ROSS BOTTNER	5.0000%	LAKEFRONT NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO				7
8			PARK VILLA NURSING AND REHABILITATION CENTER,LLC	MELROSE PARK				8
9			PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO				9
10			WINDSOR PARK	CHICAGO				10
11			CHALET LIVING & REHAB CENTER	CHICAGO				11
12			THE GROVE OF NORTHBROOK	NORTHBROOK				12
13			THE VILLA AT EVERGREEN	EVERGREEN PARK				13
14			THE GROVE OF LAGRANGE PARK LLC	LAGRANGE PARK				14
15			WARREN BARR	CHICAGO				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

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								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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove of Northbrook L & R # 0052050 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	27.00%	See Attached	3.02	6.04%	Mgmt Fees	\$ 12,080	17-07	1
2	Menachem Shabat	Owner	Administrative	27.00%	See Attached	3.02	6.04%	Mgmt Fees	12,080	17-07	2
3	Ross Bottner	Owner	CFO	5.00%	See Attached	2.42	6.05%	Alloc. Sal.	12,080	21-07	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	\$ 36,240		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 Grove of Northbrook L & R

0052050 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 _____
 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove of Northbrook L & R

0052050

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
 Street Address 7040 N. Ridgeway
 City / State / Zip Code Lincolnwood, IL 60712
 Phone Number (847) 679-9797
 Fax Number (847) 679-1126

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	AVAIL. BED DAYS	809,780	17	\$ 271	\$ 48,910	\$ 16	1
2	3	HOUSEKEEPING WAGES	AVAIL. BED DAYS	809,780	17	12,745	48,910	770	2
3	3	HOUSEKEEPING SUPPLIES	AVAIL. BED DAYS	809,780	17	1,546	48,910	93	3
4	5	UTILITIES	AVAIL. BED DAYS	809,780	17	16,531	48,910	998	4
5	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	809,780	17	45,337	48,910	2,738	5
6	17	MANAGEMENT FEES	AVAIL. BED DAYS	809,780	17		48,910		6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	809,780	17	115,181	48,910	6,957	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	809,780	17	7,563	48,910	457	8
9	21	CLERICAL & GENERAL WAGE	AVAIL. BED DAYS	809,780	17	1,700,817	48,910	102,728	9
10	21	CLERICAL & GENERAL OTH	AVAIL. BED DAYS	809,780	17	144,929	48,910	8,754	10
11	24	SEMINARS	AVAIL. BED DAYS	809,780	17	17,652	48,910	1,066	11
12	26	INSURANCE	AVAIL. BED DAYS	809,780	17	15,170	48,910	916	12
13	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	809,780	17	289,128	48,910	17,463	13
14	27	EMP BEN- OWNERS	AVAIL. BED DAYS	809,780	17		48,910		14
15	30	DEPRECIATION	AVAIL. BED DAYS	809,780	17	35,039	48,910	2,116	15
16	32	INTEREST	AVAIL. BED DAYS	809,780	17	242	48,910	15	16
17	34	RENT	AVAIL. BED DAYS	809,780	17	132,473	48,910	8,001	17
18									18
19									19
20									20
21	17	MANAGEMENT FEES- C. RAJ	AVG HOURS WKD	50	17	200,000	3	12,080	21
22	17	MANAGEMENT FEES- M. SH	AVG HOURS WKD	50	17	200,000	3	12,080	22
23	27	HEALTH INSURANCE/BENEFI	AVG HOURS WKD	50	17	66,502	3	4,017	23
24	27	HEALTH INSURANCE/BENEFI	AVG HOURS WKD	50	17	66,502	3	4,017	24
25	TOTALS					\$ 3,067,628	\$ 1,713,563	\$ 185,281	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove of Northbrook L & R

0052050 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 Real Properties
 Street Address 7040 N. Ridgeway
 City / State / Zip Code Lincolnwood, IL 60712
 Phone Number (847) 679-9797
 Fax Number (847) 679-1126

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	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	809,780	17	368	54,385	22	1
2	30	DEPRECIATION	AVAIL. BED DAYS	809,780	17	50,196	54,385	3,032	2
3	32	INTEREST EXPENSE	AVAIL. BED DAYS	809,780	17	41,954	54,385	2,534	3
4	33	REAL ESTATE TAXES	AVAIL. BED DAYS	809,780	17	44,250	54,385	2,673	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				\$ 136,768	\$		\$ 8,261	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove of Northbrook L & R

0052050

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	14	Ambulance	Direct Allocation		\$	\$		\$ 526	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				\$	\$		\$ 526	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove of Northbrook L & R

0052050 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 _____
 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove of Northbrook L & R

0052050 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 _____
 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove of Northbrook L & R

0052050 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 _____
 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove of Northbrook L & R

0052050 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 _____
 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove of Northbrook L & R

0052050 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 _____
 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove of Northbrook L & R

0052050

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 _____
 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

SEE ACCOUNTANTS' COMPILATION REPORT

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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	G.A.F. Associates		X	Promissory Note			\$	\$ 1,500,000			\$ 105,000	1				
2	The Private Bank		X	Note Payable				6,000,000			394,517	2				
3												3				
4												4				
5												5				
Working Capital																
6	The Private Bank		X	Note Payable				1,174,313			36,062	6				
7	The Private Bank		X	Line of Credit				28,995			93	7				
8	See Supplemental Schedule										2,549	8				
9	TOTAL Facility Related						\$	\$ 8,703,308			\$ 538,221	9				
B. Non-Facility Related*																
10	Interest Income		X								(3,987)	10				
11	Interest Income - Bldg Co.		X								(21)	11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$ (4,008)	14				
15	TOTALS (line 9+line14)						\$	\$ 8,703,308			\$ 534,213	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.) SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Grove of Northbrook L & R

0052050

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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							\$	\$			\$					
2																
3																
4																
5																
6																
7	TOTAL Long-Term															
	Working Capital															
8	Allocated from Legacy Healthcare	X					\$	\$			\$ 15					
9	Allocated from Legacy Real Prop	X									2,534					
10																
11																
12																
13																
14	TOTAL Working Capital										2,549					
	B. Non-Facility Related*															
15							\$	\$			\$					
16																
17																
18																
19																
20	TOTAL Non-Facility Related															

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

		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.		\$	<u>243,615</u>		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.)		\$	<u>205,953</u>		2										
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(37,662)</u>		3										
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>213,445</u>		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.)		\$	<u>4,500</u>		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.		\$	<u>180,283</u>		7										
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2008	_____	8	<table border="1"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2012 \$ _____</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$ _____</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ _____</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2012 \$ _____	14	PLUS APPEAL COST FROM LINE 5 \$ _____	15	LESS REFUND FROM LINE 6 \$ _____	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____
FOR BHF USE ONLY															
13	FROM R. E. TAX STATEMENT FOR 2012 \$ _____														
14	PLUS APPEAL COST FROM LINE 5 \$ _____														
15	LESS REFUND FROM LINE 6 \$ _____														
16	AMOUNT TO USE FOR RATE CALCULATION \$ _____														
	2009	_____	9												
	2010	_____	10												
	2011	_____	11												
	2012	<u>203,281</u>	12												
<u>Beginning Accrual Adjusted for year end entry</u>															
<u>Allocated from Legacy Real Properties: \$2,673</u>															

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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grove of Northbrook L & R COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0052050
 CONTACT PERSON REGARDING THIS REPORT Steve Lavenda
 TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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 Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>04-02-202-040-0000</u>	<u>Long Term Care Facility</u>	\$ <u>203,280.68</u>	\$ <u>203,280.68</u>
2. <u>See Attached</u>	<u>See Attached</u>	\$ <u>44,384.14</u>	\$ <u>2,680.76</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>247,664.82</u></u>	\$ <u><u>205,961.44</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? 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.**

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.

Facility Name & ID Number Grove of Northbrook L & R

0052050 Report Period Beginning:

01/01/13 Ending:

12/31/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame Brick Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>			\$ <u>490,000</u>	1
2	<u>Allocated from Legacy Real Properties</u>			<u>4,941</u>	2
3	TOTALS			\$ <u>494,941</u>	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	134		2012	1976	\$ 4,410,000	\$ 113,077	35	\$ 126,000	\$ 12,923	\$ 126,000	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

See Page 12A, Line 70 for total

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	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			17,904	1,343		895	(448)	895
68			83,265	2,795		3,459	664	12,603
69				12,111			(12,111)	
70			\$ 4,511,169	\$ 129,326		\$ 130,354	\$ 1,028	\$ 139,498

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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,511,169	\$ 129,326		\$ 130,354	\$ 1,028	\$ 139,498	1
2	New Pump	2012	2,988		20	149	149	162	2
3	Furnished And Installed 1-New Watts 3-Way Mixing	2012	2,654		20	133	133	144	3
4	Copper Tube Hot Water Heater	2013	8,997		20	75	75	75	4
5	Wiring And Circuit Breakers In Main Switch Gears	2013	5,675		20	189	189	189	5
6	Switches, Locks System	2013	12,690		20	634	634	634	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)		\$ 4,544,173	\$ 129,326		\$ 131,535	\$ 2,209	\$ 140,702	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		\$ 4,544,173	\$ 129,326		\$ 131,535	\$ 2,209	\$ 140,702	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)		\$ 4,544,173	\$ 129,326		\$ 131,535	\$ 2,209	\$ 140,702	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	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 12C, Carried Forward		\$ 4,544,173	\$ 129,326		\$ 131,535	\$ 2,209	\$ 140,702	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)		\$ 4,544,173	\$ 129,326		\$ 131,535	\$ 2,209	\$ 140,702	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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 4,544,173	\$ 129,326		\$ 131,535	\$ 2,209	\$ 140,702	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)		\$ 4,544,173	\$ 129,326		\$ 131,535	\$ 2,209	\$ 140,702	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	Building Company Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	Boiler repair, pressure gauge, heat pump repair	2013	17,904	1,343	20	895	(448)	895	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

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		\$	\$		\$	\$	\$	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)	\$ 17,904	\$ 1,343		\$ 895	\$ (448)	\$ 895	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	38,285	1,276	20	1,276		5,743	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from Legacy Healthcare Financial Services	2012	1,722	181	20	86	(95)	172	9
10	Allocated from Legacy Healthcare Financial Services	2013	5,509	579	20	275	(304)	275	10
11									11
12	Allocated from Legacy Real Properties	2009	21,741	544	20	1,087	543	4,077	12
13	Allocated from Legacy Real Properties	2010	6,611	215	20	265	50	926	13
14	Allocated from Legacy Real Properties	2011	9,397		20	470	470	1,410	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

Facility Name & ID Number Grove of Northbrook L & R

0052050

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	
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
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)	\$ 83,265	\$ 2,795		\$ 3,459	\$ 664	\$ 12,603	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	\$ 537,933	\$ 101,685	\$ 56,262	\$ (45,423)	10	\$ 60,217	71
72	Current Year Purchases	72,633	672	4,323	3,651	10	4,323	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 610,566	\$ 102,357	\$ 60,585	\$ (41,772)		\$ 64,539	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 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)	\$ 5,649,680	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 231,683	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 192,120	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (39,563)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 205,242	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	Legal Fees - 2012	\$ 4,200	\$	\$	86
87	Legal Fees - 2012	5,036			87
88					88
89					89
90					90
91	TOTALS	\$ 9,236	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Architectural Fees	\$ 107,429	92
93			93
94			94
95		\$ 107,429	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Grove of Northbrook L & R

0052050

Report Period Beginning:

01/01/13

Ending: 12/31/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

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

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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ 11,764

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	Nissan	\$ 425.08	\$ 4,272	17
18					18
19					19
20					20
21	TOTAL		\$ 425.08	\$ 4,272	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove of Northbrook L & R # 0052050 Report Period Beginning: 01/01/13 Ending: 12/31/13
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>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		3	4
		1	2		
		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)	\$			

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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	413,935	\$		\$	413,935	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				153,984				153,984	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				527,034				527,034	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					288,839			288,839	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): <u>See Supplemental</u>						21,887	35,499			57,386	13
14	TOTAL			\$		\$	1,116,840	\$	324,338	\$	1,441,178	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

Facility Name & ID Number Grove of Northbrook L & R# 0052050Report Period Beginning: 01/01/13

Ending:

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	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 102,187	\$ 387,546	1
2	Cash-Patient Deposits	2,000	2,000	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,214,219	2,214,219	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	100,850	100,850	6
7	Other Prepaid Expenses	4,785	4,785	7
8	Accounts Receivable (owners or related parties)	19,307	19,307	8
9	Other(specify): <u>See Attached Schedule</u>	7,600	76,855	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,450,948	\$ 2,805,562	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		490,000	13
14	Buildings, at Historical Cost		4,410,000	14
15	Leasehold Improvements, at Historical Cost	44,565	62,469	15
16	Equipment, at Historical Cost	90,961	590,961	16
17	Accumulated Depreciation (book methods)	(13,117)	(258,339)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(210,000)	(210,000)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	2,222,710	2,241,050	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,135,119	\$ 7,326,141	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,586,067	\$ 10,131,703	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 915,024	\$ 915,024	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,174,313	1,203,308	29
30	Accrued Salaries Payable	369,956	369,956	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,937	16,937	31
32	Accrued Real Estate Taxes(Sch.IX-B)		213,445	32
33	Accrued Interest Payable		40,428	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	393,066	401,387	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,869,296	\$ 3,160,485	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,500,000	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)	\$	\$ 7,500,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,869,296	\$ 10,660,485	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,716,771	\$ (528,782)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,586,067	\$ 10,131,703	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,034,213	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,034,213	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(317,442)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (317,442)	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)	\$ 1,716,771	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	\$ 7,724,056	1	
2	Discounts and Allowances for all Levels	(1,021,161)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,702,895	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	2,083,590	6	
7	Oxygen		7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,083,590	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	310,202	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory	19,669	19	
20	Radiology and X-Ray	(575)	20	
21	Other Medical Services	11,031	21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 340,327	23	
D. Non-Operating Revenue				
24	Contributions		24	
25	Interest and Other Investment Income***	3,987	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,987	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)	\$ 9,130,799	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	1,142,621	31	
32	Health Care	2,865,240	32	
33	General Administration	1,904,927	33	
B. Capital Expense				
34	Ownership	1,112,470	34	
C. Ancillary Expense				
35	Special Cost Centers	2,124,348	35	
36	Provider Participation Fee	298,635	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,448,241	40	
41	Income before Income Taxes (line 30 minus line 40)**	(317,442)	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (317,442)	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,496,225	44
45	Private Pay - Net Inpatient Revenue	465,177	45
46	Medicare - Net Inpatient Revenue	1,554,805	46
47	Other-(specify) <u>Insurance</u>	63,739	47
48	Other-(specify) <u>Veterans</u>	122,949	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,702,895	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove of Northbrook L & R

0052050

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	1,957	2,210	\$ 111,367	\$ 50.39	1
2	Assistant Director of Nursing	1,358	1,628	57,091	35.07	2
3	Registered Nurses	20,437	22,214	635,002	28.59	3
4	Licensed Practical Nurses	14,753	16,004	441,582	27.59	4
5	CNAs & Orderlies	65,392	71,285	883,546	12.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,624	11,548	199,469	17.27	8
9	Activity Director	1,875	2,086	50,931	24.42	9
10	Activity Assistants	4,019	4,409	57,390	13.02	10
11	Social Service Workers	5,820	6,197	104,174	16.81	11
12	Dietician					12
13	Food Service Supervisor	1,973	2,166	59,153	27.31	13
14	Head Cook	6,181	6,625	103,411	15.61	14
15	Cook Helpers/Assistants	9,810	10,503	98,704	9.40	15
16	Dishwashers					16
17	Maintenance Workers	5,341	5,806	107,933	18.59	17
18	Housekeepers	11,190	11,814	124,474	10.54	18
19	Laundry	7,188	7,848	74,861	9.54	19
20	Administrator	2,590	3,194	144,016	45.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,997	19,562	258,804	13.23	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	1,220	1,326	29,238	22.05	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,920	2,044	64,026	31.32	33
34	TOTAL (lines 1 - 33)	191,645	208,469	\$ 3,605,172 *	\$ 17.29	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	\$ 7,794	01-03	35
36	Medical Director	Monthly	28,000	09-03	36
37	Medical Records Consultant	Monthly	4,512	10-03	37
38	Nurse Consultant		24,811	10-03	38
39	Pharmacist Consultant	Monthly	14,112	10-03	39
40	Physical Therapy Consultant	25	1,250	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	360	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,544	11-03	44
45	Social Service Consultant	Monthly	5,540	12-03	45
46	Other(specify)				46
47	<u>Clergy</u>	Monthly	3,035	12-03	47
48					48
49	TOTAL (lines 35 - 48)	25	\$ 91,958		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

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	
Shelley Martinez	Administrator	0.00%	\$ 1,079	Workers' Compensation Insurance	\$ 95,425	IDPH License Fee	\$ 1,805	
Igor Rebel	Administrator	0.00%	87,769	Unemployment Compensation Insurance	34,574	Advertising: Employee Recruitment	10,116	
Raphael Zimmerman	Administrator	0.00%	55,168	FICA Taxes	275,590	Health Care Worker Background Check	2,265	
				Employee Health Insurance	154,222	(Indicate # of checks performed <u>33</u>)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	11,798	
				Union Pension	8,495	Licenses	12,595	
				Employee Physical Exam	4,050	Allocated from Legacy Healthcare	457	
				Other Employee Benefits	11,891	Allocated from Legacy Real Prop	22	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 144,016					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount					
Chaim Rajchenbach - Management Fees			\$ 12,080				Less: Public Relations Expense ()	
Menachem Shabat - Management Fees			12,080				Non-allowable advertising ()	
							Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 24,160					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
See Attached	Legal		\$ 34,850				Out-of-State Travel	\$
Frost, Ruttenberg, Rothblatt	Accounting		13,532					
McGladrey LLP	Accounting		69					
Legacy Healthcare	Bookkeeping Fees		198,000				In-State Travel	
Creative Technology Solutions	Data Processing		10,188					
Emdeon Business	Data Processing		96					
Health Data Systems Inc.	Data Processing		6,259					
IIT SourceTech	Data Processing		1,535				Seminar Expense	4,342
Wescom Solutions	Data Processing		17,267				Allocated from Legacy Healthcare	1,066
Lexis Nexis	Data Processing		869					
Point Click Care	Data Processing		115					
See Supplemental Schedule			54,167				Entertainment Expense ()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 336,947				TOTAL \$ 5,408	

* 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	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

Facility Name & ID Number Grove of Northbrook L & R

0052050

Report Period Beginning:

01/01/13

Ending:

12/31/13

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council on Long Term Care \$13,628
- (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. \$ 37,002 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 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. \$ 298,635
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 - c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
 - d. Have vehicle usage logs been maintained? N/A
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
 - 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.