



Facility Name & ID Number Grove Lincoln Park Lvg & Reh

# 0050245 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	<u>109</u>	Skilled (SNF)	<u>109</u>	<u>39,785</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>109</u>	TOTALS	<u>109</u>	<u>39,785</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>9,580</u>	<u>3,116</u>	<u>16,274</u>	<u>28,970</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,580</u>	<u>3,116</u>	<u>16,274</u>	<u>28,970</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.82%

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

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

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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

YES  NO

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

Date started 09/01/08

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

YES  Date 09/01/08 NO

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

YES  NO  If YES, enter number

of beds certified 109 and days of care provided 14,861

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: 12/31/14 Fiscal Year: 12/31/14

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	257,592	17,458		275,050		275,050		275,050		1
2	Food Purchase		221,801		221,801		221,801	5	221,806		2
3	Housekeeping	130,586	28,990		159,576		159,576	505	160,081		3
4	Laundry		1,499	125,410	126,909		126,909		126,909		4
5	Heat and Other Utilities			117,289	117,289		117,289	1,005	118,294		5
6	Maintenance	46,065		99,777	145,842		145,842	1,210	147,052		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>434,243</b>	<b>269,748</b>	<b>342,476</b>	<b>1,046,467</b>		<b>1,046,467</b>	<b>2,725</b>	<b>1,049,192</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			39,058	39,058		39,058		39,058		9
10	Nursing and Medical Records	2,431,114	147,823	139,231	2,718,168		2,718,168	(47,532)	2,670,636		10
10a	Therapy										10a
11	Activities	93,883	18,823		112,706		112,706	206	112,912		11
12	Social Services	9,973		9,821	19,794		19,794	2,370	22,164		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,534,970</b>	<b>166,646</b>	<b>188,110</b>	<b>2,889,726</b>		<b>2,889,726</b>	<b>(44,956)</b>	<b>2,844,770</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	91,063		14,593	105,656		105,656	3,949	109,605		17
18	Directors Fees										18
19	Professional Services			229,826	229,826		229,826	(23,794)	206,032		19
20	Dues, Fees, Subscriptions & Promotions			18,003	18,003		18,003	(3,382)	14,621		20
21	Clerical & General Office Expenses	233,385	25,106	312,436	570,927		570,927	(268,927)	302,000		21
22	Employee Benefits & Payroll Taxes			650,948	650,948		650,948		650,948		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,674	2,674		2,674	295	2,969		24
25	Other Admin. Staff Transportation			30,457	30,457		30,457		30,457		25
26	Insurance-Prop.Liab.Malpractice			126,642	126,642		126,642	480	127,122		26
27	Other (specify):* <b>Mgmt Alloc of Benefit</b>							19,961	19,961		27
28	<b>TOTAL General Administration</b>	<b>324,448</b>	<b>25,106</b>	<b>1,385,579</b>	<b>1,735,133</b>		<b>1,735,133</b>	<b>(271,418)</b>	<b>1,463,715</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,293,660</b>	<b>461,500</b>	<b>1,916,165</b>	<b>5,671,325</b>		<b>5,671,325</b>	<b>(313,649)</b>	<b>5,357,676</b>		<b>29</b>

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

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

Facility Name &amp; ID Number

Grove Lincoln Park Lvg &amp; Reh

#0050245

Report Period Beginning:

01/01/14

Ending:

12/31/14

## 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	
	<b>D. Ownership</b>											
30	Depreciation			65,853	65,853		65,853	6,853	72,706			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,837	1,837		1,837	(709)	1,128			32
33	Real Estate Taxes			135,510	135,510		135,510	1,614	137,124			33
34	Rent-Facility & Grounds			583,513	583,513		583,513		583,513			34
35	Rent-Equipment & Vehicles			79,589	79,589		79,589	315	79,904			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			866,302	866,302		866,302	8,073	874,375			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		769,745	1,727,240	2,496,985		2,496,985	(2,363)	2,494,622			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			142,128	142,128		142,128		142,128			42
43	Other (specify):* <b>Non-Allowable Cos</b>	152,452		1,515,838	1,668,290		1,668,290	(1,668,290)				43
44	<b>TOTAL Special Cost Centers</b>	152,452	769,745	3,385,206	4,307,403		4,307,403	(1,670,653)	2,636,750			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,446,112	1,231,245	6,167,673	10,845,030		10,845,030	(1,976,229)	8,868,801			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(8,656)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,868	30		9
10	Interest and Other Investment Income	4,063	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(104,634)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(317,925)	43		24
25	Fund Raising, Advertising and Promotional	(59,572)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(1,259,777)	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (1,744,633)</b>		<b>\$</b>	<b>30</b>

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)	(231,596)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (231,596)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (1,976,229)</b>		<b>37</b>

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

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

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

Grove Lincoln Park Lvg & Reh

Report Period Beginning: 01/01/14  
 Ending: 12/31/14

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Adj Prior Year Expenses	\$ (68,366)	43	1
2	Labs - Part A	(128,401)	43	2
3	Pharm House stock	(4,793)	43	3
4	Charity Discounts	(10,090)	43	4
5	Discount	32,577	43	5
6	Personal Items	(10,315)	43	6
7	Admitting	(152,452)	43	7
8	Out of Period Legal	(12,159)	19	8
9	Lobbying Expense	(3,669)	20	9
10	Valet Services	(9,568)	43	10
11	Offset Marketing Salaries	(66,446)	21	11
12	Non Allowable Expenses	(826,095)	43	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35

36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	(1,259,777)	49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Pg 6-Supp		See Pg 6-Supp		See Pg6-Supp		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	2 Food	\$ 1	Legacy Healthcare Financial Services, LLC	100.00%	\$	(1)	1
2	V	3 Housekeeping		Legacy Healthcare Financial Services, LLC	100.00%	505	505	2
3	V	5 Utilities		Legacy Healthcare Financial Services, LLC	100.00%	1,005	1,005	3
4	V	6 Grounds & Maintenance		Legacy Healthcare Financial Services, LLC	100.00%	1,171	1,171	4
5	V	11 Activities Program		Legacy Healthcare Financial Services, LLC	100.00%	206	206	5
6	V	17 Management Fees	14,593	Legacy Healthcare Financial Services, LLC	100.00%	14,593		6
7	V	19 Professional Fees		Legacy Healthcare Financial Services, LLC	100.00%	3,382	3,382	7
8	V	20 Fees, Subscriptions		Legacy Healthcare Financial Services, LLC	100.00%	277	277	8
9	V	21 Clerical & General Office	278,400	Legacy Healthcare Financial Services, LLC	100.00%	74,887	(203,513)	9
10	V	24 Seminars		Legacy Healthcare Financial Services, LLC	100.00%	287	287	10
11	V	26 Insurance		Legacy Healthcare Financial Services, LLC	100.00%	480	480	11
12	V	27 Employee Benefits		Legacy Healthcare Financial Services, LLC	100.00%	19,867	19,867	12
13	V	30 Depreciation		Legacy Healthcare Financial Services, LLC	100.00%	1,278	1,278	13
14	Total		\$ 292,994			\$ 117,938	\$ *	(175,056) 14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	32 Interest	\$	Legacy Healthcare Financial Services, LLC	100.00%	\$ 7	\$	7	15
16	V	33 Real Estate Taxes		Legacy Healthcare Financial Services, LLC	100.00%	1,614		1,614	16
17	V	34 Rent Expense		Legacy Healthcare Financial Services, LLC	100.00%	5,781		5,781	17
18	V	30 Depreciation		Legacy Healthcare Financial Services, LLC	100.00%	(356)		(356)	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		\$			\$ 7,046	\$ *	7,046	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	19 Professional Fees	\$	Legacy Real Properties, LLC	100.00%	\$ 57	\$	57	15
16	V	30 Depreciation		Legacy Real Properties, LLC	100.00%	1,831		1,831	16
17	V	32 Interest		Legacy Real Properties, LLC	100.00%	1,121		1,121	17
18	V	34 Rent	5,781	Legacy Real Properties, LLC	100.00%			(5,781)	18
19	V	30 Depreciation		Legacy Real Properties, LLC	100.00%	642		642	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 5,781			\$ 3,651	\$ *	(2,130)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19 Professional Fees	\$	Grove Healthcare Properties, LLC	100.00%	\$ 296	\$ 296	15
16	V	30 Depreciation		Grove Healthcare Properties, LLC	100.00%	1,590	1,590	16
17	V	32 Interest Expense	5,901	Grove Healthcare Properties, LLC	100.00%		(5,901)	17
18	V	34 Real Estate Taxes	135,510	Grove Healthcare Properties, LLC	100.00%	135,510		18
19	V	34 Rent	583,513	Grove Healthcare Properties, LLC	100.00%	583,513		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		\$ 724,924			\$ 720,909	\$ * (4,015)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	2 Food	\$	Progressive Healthcare Consulting	100.00%	\$ 6	\$	6	15
16	V	6 Maintenance		Progressive Healthcare Consulting	100.00%	39		39	16
17	V	10 RN Salary	48,000	Progressive Healthcare Consulting	100.00%	2,323		(45,677)	17
18	V	12 Clergy Salary	1,855	Progressive Healthcare Consulting	100.00%	2,370		515	18
19	V	15 Emp. Ben - Nursing		Progressive Healthcare Consulting	100.00%	94		94	19
20	V	17 Admissions Salary		Progressive Healthcare Consulting	100.00%	3,949		3,949	20
21	V	19 Professional Fees		Progressive Healthcare Consulting	100.00%	273		273	21
22	V	20 Fees and Subscriptions		Progressive Healthcare Consulting	100.00%	10		10	22
23	V	21 Clerical & General		Progressive Healthcare Consulting	100.00%	1,032		1,032	23
24	V	24 Seminars		Progressive Healthcare Consulting	100.00%	8		8	24
25	V	27 Auto & Travel		Progressive Healthcare Consulting	100.00%	298		298	25
26	V	35 Auto Rental		Progressive Healthcare Consulting	100.00%	17		17	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		\$ 49,855			\$ 10,419	\$ *	(39,436)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	39 Ambulance	\$ 10,180	Lifeline Ambulance	100.00%	\$ 7,817	\$	(2,363)	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		\$ 10,180			\$ 7,817	\$ *	(2,363)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 Maintenance	\$ 6,256	ReMED Services, LLC	100.00%	\$ 6,256	\$	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		\$ 6,256			\$ 6,256	\$ *	0	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	19 Professional Fees	\$ 17,343	ProPay	100.00%	\$ 13,701	\$	(3,642)	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		\$ 17,343			\$ 13,701	\$ *	(3,642)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Professional Fees	\$ 12,000	ML Group Design	100.00%	\$	\$ (12,000)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 12,000			\$ 0	\$ * (12,000)

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

Facility Name &amp; ID Number

Grove Lincoln Park Lvg &amp; Reh

# 0050245

Report Period Beginning:

01/01/14

Ending:

12/31/14

## VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Chaim Rajchenbach	29.00	Astoria Place Living & Rehab	Chicago	Legacy Healthcare	Lincolnwood	Management Co.	1
2	Menachem Shabat	29.00	Bethany Terrace	Morton Grove	Financial Svcs, LLC			2
3	Jack Rajchenback	6.10	Chalet Living & Rehab Center	Chicago				3
4	Ronald Shabat	15.50	Elmbrook Nursing	Elmhurst	Legacy Real	Lincolnwood	Real Estate	4
5	The Rajchenbach Family Trust	15.50	The Grove of Evanston, LLC	Evanston	Properties, LLC			5
6	The Robert Hartman Family Trust	4.90	The Villa at Evergreen	Evergreen Park				6
7			The Grove of Fox Valley	Aurora	Grove Healthcare	Lincolnwood	Real Estate	7
8			The Grove of LaGrange Park LLC	LaGrange Park	Properties, LLC			8
9			The Grove at the Lake	Zion				9
10			Lakefront Nursing & Rehab Center, LLC	Chicago	Remed Services,	Lincolnwood	Medical	10
11			The Grove at Lincoln Park Living & Rehab	Chicago	LLC		Equipment Sales	11
12			Avantara Long-Grove	Long Grove				12
13			The Grove North Living & Rehab Center	Skokie	Progressive	Lincolnwood	Consulting	13
14			The Grove of Northbrook	Northbrook	Healthcare			14
15			Warren Barr North Shore	Highland Park	Consulting			15
16			Avantara Park Ridge	Park Ridge				16
17			Peterson Park Associates Ltd. Partnetship	Chicago	Astoria Real	Lincolnwood	Real Estate	17
18			Warren Barr South Loop	Chicago	Property, LLC			18
19			Warren Barr	Chicago				19
20			Aurora Supportive Living	Aurora	Lifeline Ambulance	Chicago	Ambulance Svcs.	20
21								21
22					ProPay	Evanston	Payroll Services	22
23								23
24					ML Group Design	Lincolnwood	Asset Mgmt Fees	24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Grove Lincoln Park Lvg & Reh # 0050245 Report Period Beginning: 01/01/14 Ending: 12/31/14

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Chaim Rajchenbach	Owner	Administrative	29.00	See Attached	See Att.	See Att.	Mgmt. Salary	\$ 7,297	17(3)	1
2	Menachem Shabat	Owner	Administrative	29.00	See Attached	See Att.	See Att.	Mgmt. Salary	7,297	17(3)	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 14,594		13

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

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

Facility Name & ID Number Grove Lincoln Park Lvg & Reh # 0050245 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Bed Days Available	1,090,513	21	\$ (38)	\$ 39,785	\$ (1)	1
2	3	Housekeeping	Bed Days Available	1,090,513	21	13,826	12,349	39,785	504
3	5	Utilities	Bed Days Available	1,090,513	21	27,544	39,785	39,785	1,005
4	6	Grounds & Maintenance	Bed Days Available	1,090,513	21	32,093	39,785	39,785	1,171
5	11	Management Fees	Bed Days Available	1,090,513	21	5,642	39,785	39,785	206
6	17	Management Fees	Hours	1,090,513	21	400,000	400,000	39,785	14,593
7	19	Professional Fees	Bed Days Available	1,090,513	21	92,690	39,785	39,785	3,382
8	20	Fees, Subscriptions	Bed Days Available	1,090,513	21	7,596	39,785	39,785	277
9	21	Clerical	Bed Days Available	1,090,513	21	2,052,680	1,925,545	39,785	74,888
10	24	Seminars	Bed Days Available	1,090,513	21	7,856	39,785	39,785	287
11	26	Insurance	Bed Days Available	1,090,513	21	13,167	39,785	39,785	480
12	27	Employee Benefits	Bed Days Available	1,090,513	21	544,583	39,785	39,785	19,868
13	30	Depreciation	Bed Days Available	1,090,513	21	35,040	39,785	39,785	1,278
14	32	Interest	Bed Days Available	1,090,513	21	199	39,785	39,785	7
15	33	Real Estate Taxes	Bed Days Available	1,090,513	21	44,250	39,785	39,785	1,614
16	34	Rent Expense	Bed Days Available	1,090,513	21	158,445	39,785	39,785	5,781
17	30	Depreciation	Direct Allocation						(356)
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,435,570	\$ 2,337,894	\$	124,984

Facility Name & ID Number Grove Lincoln Park Lvg & Reh # 0050245 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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	951,147	18	\$ 149	\$	39,785	\$ 6	1
2	6	Maintenance	951,147	18	943		39,785	39	2
3	10	RN Salary	951,147	18	55,528	55,528	39,785	2,323	3
4	12	Clergy Salary	951,147	18	56,656	56,656	39,785	2,370	4
5	15	Emp. Ben - Nursing	951,147	18	2,247		39,785	94	5
6	17	Admissions Salary	951,147	18	94,409	94,409	39,785	3,949	6
7	19	Professional Fees	951,147	18	6,532		39,785	273	7
8	20	Fees and Subscriptions	951,147	18	250		39,785	10	8
9	21	Clerical & General	951,147	18	24,680		39,785	1,032	9
10	24	Seminars	951,147	18	199		39,785	8	10
11	27	Auto & Travel	951,147	18	7,129		39,785	298	11
12	35	Auto Rental	951,147	18	413		39,785	17	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				\$ 249,135	\$ 206,593		\$ 10,419	25

Facility Name & ID Number Grove Lincoln Park Lvg & Reh # 0050245 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Ambulance	Direct Cost		\$	\$		7,817	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				\$	\$		7,817	25

Facility Name & ID Number Grove Lincoln Park Lvg & Reh # 0050245 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 ReMED Services, LLC  
 Street Address 7040 N. Ridgeway Avenue  
 City / State / Zip Code Lincolndwood, IL 60712  
 Phone Number ( 855) 501-5500  
 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	6	Maintenance	Direct Cost		\$	\$		6,256	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				\$	\$		6,256	25

Facility Name & ID Number Grove Lincoln Park Lvg & Reh # 0050245 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 ProPay HR, LLC  
 Street Address 2201 W. Main  
 City / State / Zip Code Evanston, IL 60202  
 Phone Number ( 847) 905-32658  
 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	19	Professional Fees	Direct Cost		\$	\$		\$ 13,701	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				\$	\$		\$ 13,701	25

Facility Name & ID Number Grove Lincoln Park Lvg & Reh # 0050245 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 ML Group Design  
 Street Address 7040 N. Ridgeway Avenue  
 City / State / Zip Code Lincolnwood, IL 60712  
 Phone Number ( 773) 415-3071  
 Fax Number ( 312) 949-9262

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	19	Professional Fees	Direct Cost		\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

	1	Name of Lender	2		3	4	5	6		7	8	9	10	
			Related**	YES				NO	Purpose of Loan					Monthly Payment Required
		<b>A. Directly Facility Related</b>												
		<b>Long-Term</b>												
1		The Private Bank		X	Capital Expenditures	\$10,247.56	12/16/13	\$	20,000	\$	12/16/14	Varies	\$ 1,837	1
2														2
3														3
4														4
5														5
		<b>Working Capital</b>												
6														6
7														7
8														8
9		<b>TOTAL Facility Related</b>				\$10,247.56		\$	20,000	\$			\$ 1,837	9
		<b>B. Non-Facility Related*</b>												
10									Interest Income Offset				(1,837)	10
11									Allocated from Management Company				7	11
12									Allocated from Real Properties				1,121	12
13														13
14		<b>TOTAL Non-Facility Related</b>						\$		\$			(709)	14
15		<b>TOTALS (line 9+line14)</b>						\$	20,000	\$			\$ 1,128	15

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

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

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

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

**B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2013 report.		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>		\$	<b>145,438</b>	<b>1</b>
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.)		<b>2013</b>		\$	<b>135,199</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).				\$	<b>(10,239)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	<b>145,749</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>				\$		<b>5</b>
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.			<b>Allocated from Management Co.</b>		<b>1,614</b>	
<b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>				\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	<b>137,124</b>	<b>7</b>
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		<b>2009</b>	<b>97,732</b>	<b>8</b>	<b>FOR BHF USE ONLY</b>	
		<b>2010</b>	<b>101,987</b>	<b>9</b>	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2013 \$ <b>13</b>
		<b>2011</b>	<b>147,032</b>	<b>10</b>	<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$ <b>14</b>
		<b>2012</b>	<b>136,539</b>	<b>11</b>	<b>15</b>	LESS REFUND FROM LINE 6 \$ <b>15</b>
		<b>2013</b>	<b>135,199</b>	<b>12</b>	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$ <b>16</b>
<b>2014 Accrual of \$145,749</b>						

**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.**

## 2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grove Lincoln Park Lvg & Reh COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050245

CONTACT PERSON REGARDING THIS REPORT Chaim Rajchenbach

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

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2013 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 2013.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-28-308-008-0000</u>	<u>Nursing Home</u>	\$ <u>138,386.46</u>	\$ <u>138,386.00</u>
2. <u>Home Office Allocation</u>	<u>Home Office Allocation</u>	\$ <u>38,392.03</u>	\$ <u>1,614.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>176,778.49</u></u>	\$ <u><u>140,000.00</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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

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

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

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

None

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

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

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Allocated from Legacy Real Properties</u>			<u>\$ 2,985</u>	1
2					2
3	<b>TOTALS</b>			<b>\$ 2,985</b>	3

Facility Name &amp; ID Number Grove Lincoln Park Lvg &amp; Reh

# 0050245

Report Period Beginning:

01/01/14

Ending:

12/31/14

## XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4		Allocated from Legacy Real Properties			\$ 23,125	\$		\$ 771	\$ 771	\$ 4,240	4
5											5
6											6
7											7
8											8
		<b>Improvement Type**</b>									
9		Office Remodel - carpeting & built in cabinets	2009		54,635	1,366	40	1,366		7,513	9
10		Satellite system purchase & installation	2009		11,600	290	40	290		1,595	10
11		New Roof	2009		34,325	858	40	858		4,719	11
12		1st Floor Remodel									12
13		- Flooring, wallpaper & paint, carpeting, permits, update	2009		32,473	812	40	812		4,466	13
14		survey & architectural drawings									14
15		Electrical work	2009		8,645	216	40	216		1,188	15
16		Painting, Decor & Wallcoverings	2009		104,931	2,623	40	2,623		14,427	16
17		2nd Floor Remodel	2009		108,080	2,722	40	2,722		15,059	17
18		- Built in resident room furniture, handrails & baseboards									18
19		Outdoor Improvements - Awnings, Red Stucco	2009		42,033	1,051	40	1,051		5,780	19
20		Landscaping	2009		36,271	907	40	907		4,988	20
21		- install new flower bed, remove existing cement sidewalk,									21
22		remove gravel base, install new gravel base, brick pavers,									22
23		tuckpointing, remove/repair and transplant existing									23
24		landscaping, install new landscaping and plants									24
25		Install new phone system	2009		21,675	542	40	542		2,981	25
26		Sprinkler system	2009		3,047	76	40	76		418	26
27		Lock installation	2009		10,773	269	40	269		1,480	27
28		Patient Room Update - built in resident room furniture	2009		65,040	1,626	40	1,626		8,941	28
29		Chandeliers	2009		2,542	64	40	64		352	29
30											30
31		Landscaping	2009		26,271	1,751	15	1,751		9,631	31
32		- install new flower bed, remove existing cement sidewalk,									32
33		remove gravel base, install new gravel base, brick pavers,									33
34		tuckpointing, remove/repair and transplant existing									34
35		landscaping, install new landscaping and plants									35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Grove Lincoln Park Lvg &amp; Reh

# 0050245

Report Period Beginning:

01/01/14

Ending:

12/31/14

## 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	2009	\$ 16,042	\$ 401	40	\$ 401	\$	\$ 2,206	37
38	2009	2,564	64	40	64		352	38
39	2009	15,995	400	40	400		2,200	39
40	2009	18,149	454	40	454		2,496	40
41	2009	3,500	88	40	88		483	41
42	2009	3,985	100	40	100		549	42
43	2009	10,120	253	40	253		1,392	43
44	2009	3,844	96	40	96		528	44
45	2009	7,751	194	40	194		1,066	45
46	2009	10,000	250	40	250		1,375	46
47								47
48	2010	2,578	64	40	64		288	48
49	2010	28,831	721	40	721		3,244	49
50	2010	4,800	120	40	120		540	50
51	2010	14,135	353	40	353		1,589	51
52	2011	2,671	67	40	67		512	52
53	2011	2,640	66	40	66		506	53
54	2011	2,860	72	40	72		787	54
55	2011	9,535	238	40	238		1,827	55
56	2011	3,200	80	40	80		614	56
57	2011	2,765	69	40	69		760	57
58	2011	5,000	125	40	125		959	58
59	2011	2,690	67	40	67		516	59
60	2011	42,763	1,069	40	1,069		16,341	60
61	2011	45,095	1,127	40	1,127		17,232	61
62	2011	7,400	185	40	185		1,419	62
63								63
64	2012	3,275	82	40	82		205	64
65	2012	6,025	151	40	151		377	65
66	2012	3,975	99	40	99		248	66
67	2012	9,775	244	40	244		611	67
68	2012	3,575	89	40	89		223	68
69								69
70		\$ 881,001	\$ 22,561		\$ 23,332	\$ 771	\$ 149,224	70

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

Facility Name &amp; ID Number Grove Lincoln Park Lvg &amp; Reh

# 0050245

Report Period Beginning:

01/01/14

Ending:

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## 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		\$ 881,001	\$ 22,561		\$ 23,332	\$ 771	\$ 149,224	1
2								2
3	2012	4,975	124	40	124		311	3
4	2012	32,895	822	40	822		2,056	4
5	2012	6,900	173	40	173		431	5
6								6
7	2013	2,685	67	40	67		101	7
8	2013	4,347	109	40	109		163	8
9	2013	5,701	143	40	143		214	9
10	2013	3,280	82	40	82		123	10
11	2013	8,349	209	40	209		313	11
12	2013	20,949	524	40	524		786	12
13	2013	2,520	63	40	63		95	13
14	2013	8,705	218	40	218		327	14
15	2013	24,380	610	40	610		915	15
16								16
17	2014	85,999	1,075	40	1,075		1,075	17
18	2014	5,750	72	40	72		72	18
19				40				19
20	2014	4,353	54	40	54		54	20
21	2014	14,700	184	40	184		184	21
22	2014	9,315	116	40	116		116	22
23	2014	8,891	111	40	111		111	23
24	2014	9,411	118	40	118		118	24
25	2014	74,084	926	40	926		926	25
26	2014	28,833	360	40	360		360	26
27								27
28								28
29			3			(3)		29
30								30
31								31
32								32
33								33
34		\$ 1,248,023	\$ 28,722		\$ 29,490	\$ 768	\$ 158,073	34

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

Facility Name &amp; ID Number Grove Lincoln Park Lvg &amp; Reh

# 0050245

Report Period Beginning:

01/01/14

Ending:

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## 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		\$ 1,248,023	\$ 28,722		\$ 29,490	\$ 768	\$ 158,073	1
2								2
3	2008	22,660		30	1,510	1,510	9,527	3
4	2010	6,050		30	80	80	688	4
5								5
6								6
7								7
8								8
9								9
10	2009	13,132			657	657	3,119	10
11	2010	3,993			160	160	719	11
12	2011	5,676			284	284	1,135	12
13								13
14								14
15								15
16	2012	1,040			52	52	156	16
17	2013	3,327			166	166	333	17
18	2014	325			16	16	16	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		\$ 1,304,226	\$ 28,722		\$ 32,415	\$ 3,693	\$ 173,766	34

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

Facility Name & ID Number Grove Lincoln Park Lyg & Reh

# 0050245

Report Period Beginning:

01/01/14

Ending:

12/31/14

**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	\$ 340,551	\$ 30,326	\$ 32,197	\$ 1,871	3 to 10	\$ 106,127	71
72	Current Year Purchases	132,716	6,805	6,805		7 to 10	6,805	72
73	Fully Depreciated Assets							73
74	See Sch 13A	18,689		1,289	1,289	10	9,977	74
75	TOTALS	\$ 491,956	\$ 37,131	\$ 40,291	\$ 3,160		\$ 122,909	75

**D. Vehicle Costs. (See instructions.)\***

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

**E. Summary of Care-Related Assets**

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,799,167	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 65,853	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 72,706	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,853	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 296,675	85

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

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

**G. Construction-in-Progress**

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

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

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

**Facility Name:** Grove Lincoln Park Lvg & Reh  
**IDPH License ID Number:** 0050245  
**Fiscal Year End:** 12/31/14

**Schedule 13A**

**XI. Ownership Costs**

**Line 74 - Equipment Costs - Excluding Transportation**

Category of Equipment	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Component Life	Accumulated Depreciation
Allocation from LHFS, Inc	6,867		687	687	10	1,305
Allocated from Grove HC Properties	5,800			-	5	5,800
Allocated from Legacy Real Properties	6,022		602	602	10	2,872
<b>TOTAL</b>	18,689	-	1,289	1,289	25	9,977

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

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

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		109	Sep-08	\$ 583,513			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		109		\$ 583,513			7

10. Effective dates of current rental agreement:

Beginning 09/01/2008

Ending 08/31/2018

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

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. 2015 \$ 603,406

13. 2016 \$ 616,668

14. 2017 \$ \_\_\_\_\_

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 N/A 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: \$ 69,756 Description: Bed Equip:\$59,522; Dietary Equip.\$10,234

(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	Business	Business Car-Ally 8042	\$ 749.00	\$ 10,486	17
18	Business	Infiniti 3087	619.00	6,431	18
19	Reimbursement			(7,084)	19
20	Allocation from Management			315	20
21	<b>TOTAL</b>		\$ 1,368	\$ 10,148	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.

**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides.</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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**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**

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

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

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

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

	Service	Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or) Allocated	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	10,448	\$ 647,792	\$	10,448	\$ 647,792	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		3,532	218,976		3,532	218,976	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		11,986	743,159		11,986	743,159	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				760,048		760,048	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	39(2)					9,697		9,697	12
13	Other (specify): <u>Ambulance</u>	39(3)				114,950			114,950	13
14	TOTAL			\$	25,966	\$ 1,724,877	\$ 769,745	25,966	\$ 2,494,622	14

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

Facility Name & ID Number Grove Lincoln Park Lvg & Reh

# 0050245

Report Period Beginning: 01/01/14

Ending:

12/31/14

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of 12/31/14

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>604,790</u> )	2,163,528	2,163,528	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	16,075	16,075	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Sch17A</u>	1,182,101	1,182,101	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,361,704	\$ 3,361,704	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		2,985	13
14	Buildings, at Historical Cost		23,125	14
15	Leasehold Improvements, at Historical Cost	1,235,090	1,281,101	15
16	Equipment, at Historical Cost	470,457	491,956	16
17	Accumulated Depreciation (book methods)	(236,386)	(296,675)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe			22
23	Other(specify): <u>Deposits</u>	481,500	481,500	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,950,661	\$ 1,983,992	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,312,365	\$ 5,345,696	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 627,312	\$ 627,312	26
27	Officer's Accounts Payable	(22,334)	(22,334)	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	359,771	359,771	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	145,749	145,749	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Sch17A</u>	89,388	89,388	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,199,886	\$ 1,199,886	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,199,886	\$ 1,199,886	46
47	<b>TOTAL EQUITY (page 18, line 24)</b>	\$ 4,112,479	\$ 4,145,810	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,312,365	\$ 5,345,696	48

\*(See instructions.)

Facility Name: Grove Lincoln Park Lvg & Reh  
 IDPH License ID Number: 0050245  
 Fiscal Year End: 12/31/14

**Schedule 17A**

**XV. Balance Sheet**

**Line 9 Current Assets Other (specify):**

Description	Operating	After Consolidation
EMP LOAN, ADV, W/A	30,513	30,513
DUE TO MEDICARE	(8,965)	(8,965)
IL B L F	1	1
LEG CHARITY	(24,067)	(24,067)
LEGACY	(98,073)	(98,073)
GHCP	1,240,744	1,240,744
T/F CHALET REALTY	100,000	100,000
DUE TO/FROM ML ENTERPRISES	(861)	(861)
DUE T/F PROGRESSIVE	(57,191)	(57,191)
<b>Total - Line 9</b>	<b>1,182,101</b>	<b>1,182,101</b>

**XV. Balance Sheet**

**Line 36 Other Current Liabilities (specify):**

Description	Operating	After Consolidation
TRUST CLEARING ACCT	(8,192)	(8,192)
PREPAID INS - LIAB	(95,118)	(95,118)
DUE TO IDPA	148,666	148,666
ADMIN BONUS	10,000	10,000
ACC MGMT FEE	10,437	10,437
ACCRUED F I C A	6,939	6,939
GN	(81,617)	(81,617)
DUE TO MEMBERS	(5,028)	(5,028)
RELATED LESSOR	100,000	100,000
DUE T/F AP	3,301	3,301

**Total - Line 36**

<u>89,388</u>	<u>89,388</u>
---------------	---------------

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>4,315,532</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Adjustment</b>	<b>(173,345)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>4,142,187</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>970,292</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(1,000,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(29,708)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>4,112,479</b>	<b>24</b> *

\* This must agree with page 17, line 47.

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 11,459,084	1
2	Discounts and Allowances for all Levels	(719,552)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 10,739,532</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	904,250	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 904,250</b>	8
<b>C. Other Operating Revenue</b>			
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	49,287	17
18	Sale of Supplies to Non-Patients	30,986	18
19	Laboratory	88,098	19
20	Radiology and X-Ray	280	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 168,651</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2,889	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 2,889</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>		29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 11,815,322</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,046,467	31
32	Health Care	2,889,726	32
33	General Administration	1,735,133	33
<b>B. Capital Expense</b>			
34	Ownership	866,302	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	4,165,275	35
36	Provider Participation Fee	142,128	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 10,845,030</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>970,292</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 970,292</b>	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,595,104	44
45	Private Pay - Net Inpatient Revenue	744,437	45
46	Medicare - Net Inpatient Revenue	8,399,991	46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 10,739,532</b>	49

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

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.  
 ^ - This entity is a cash basis taxpayer

Facility Name & ID Number Grove Lincoln Park Lvg & Reh

# 0050245

Report Period Beginning:

01/01/14

Ending:

12/31/14

**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	2,143	2,443	\$ 119,302	\$ 48.83	1
2	Assistant Director of Nursing	1,669	1,984	71,695	36.13	2
3	Registered Nurses	16,728	18,431	613,439	33.28	3
4	Licensed Practical Nurses	17,306	18,177	471,245	25.92	4
5	CNAs & Orderlies	80,059	89,280	1,108,469	12.42	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,905	2,110	27,749	13.15	9
10	Activity Assistants	6,751	7,034	66,134	9.40	10
11	Social Service Workers	475	496	9,973	20.11	11
12	Dietician					12
13	Food Service Supervisor	1,312	1,389	30,154	21.70	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,385	18,678	227,438	12.18	15
16	Dishwashers					16
17	Maintenance Workers	2,270	2,391	46,065	19.26	17
18	Housekeepers	11,136	12,272	130,586	10.64	18
19	Laundry					19
20	Administrator	1,810	1,855	87,044	46.92	20
21	Assistant Administrator	154	171	4,019	23.50	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	24,533	26,606	385,837	14.50	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	1,956	2,126	30,469	14.33	31
32	Other Health Care MDS Coordinator	556	635	16,494	25.97	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	188,148	206,081	\$ 3,446,112 *	\$ 16.72	34

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	39,058	9(3)	36
37	Medical Records Consultant	Monthly	4,616	10(3)	37
38	Nurse Consultant	Monthly	24,000	10(3)	38
39	Pharmacist Consultant	Monthly	7,373	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	9,821	12(3)	45
46	Other(specify) <u>MDS Consulting</u>	Monthly	54,600	10(3)	46
47	<u>Physician Consultant</u>	Monthly	24,500	10(3)	47
48	<u>Clergy</u>	Monthly	1,855	10(3)	48
49	TOTAL (lines 35 - 48)		\$ 165,823		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	1,351	22,287	10(3)	52
53	TOTAL (lines 50 - 52)	1,351	\$ 22,287		53

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

\*\* See instructions.



**Facility Name:** Grove Lincoln Park Lvg & Reh  
**IDPH License ID Number:** 0050245  
**Fiscal Year End:** 12/31/14

**Schedule 21C**

**XIX. SUPPORT SCHEDULES**

**C. Professional Services**

<b>Vendor</b>	<b>Type</b>	<b>Amount</b>
McGladrey LLP	Accounting	26,555
FR&R	Accounting	1,194
Legacy Reimbursed Expenses (Add'l Accounting Fees)	Accounting	14,000
Creative Technology Solutions	Data Processing	12,730
E-Health Data Solutions	Data Processing	11,063
Legacy Reimbursement	Data Processing	9,667
Telemedicine Solutions	Data Processing	2,250
Wescom Solutions	Data Processing	11,759
Meyer Magence	Legal	2,063
Much Selist	Legal	1,587
Ogletree Deakins	Legal	10,300
Scott & Kraus, LLC	Legal	12,499
Sheryl E Fuhr	Legal	2,582
Stone, McGuire & Siegel	Legal	796
Alliance of Healthcare Counsel	Legal	172
Ashman & Stein	Legal	292
Ashman & Stein	Legal	162
Ashman & Stein	Legal	103
Ashman & Stein	Legal	462
Ashman & Stein	Legal	16
Ashman & Stein	Legal	251
Ashman & Stein	Legal	392
Ashman & Stein	Legal	97
Ashman & Stein	Legal	617
Ashman & Stein	Legal	359
Ashman & Stein	Legal	2,121
Ashman & Stein	Legal	75
Frost, Ruttenberg & Rothblatt, P.C.	Legal	124
McGladrey	Legal	157

McGladrey	Legal	22
McGuire's II, L.L.C.	Legal	79
Meyer Magence	Legal	72
Much Shelist	Legal	222
Much Shelist	Legal	92
Ober Kaler	Legal	345
Ober Kaler	Legal	85
Ober Kaler	Legal	219
Ober Kaler	Legal	1,406
Ober Kaler	Legal	195
Ober Kaler	Legal	1,894
Ogletree Deakins	Legal	936
Ogletree Deakins	Legal	264
Ogletree Deakins	Legal	651
Ogletree Deakins	Legal	1,080
Ogletree Deakins	Legal	628
Ogletree Deakins	Legal	282
Ogletree Deakins	Legal	183
Ogletree Deakins	Legal	624
Ogletree Deakins	Legal	146
Ogletree Deakins	Legal	127
Ogletree Deakins	Legal	10
Ogletree Deakins	Legal	60
Ogletree Deakins	Legal	8
Ogletree Deakins	Legal	40
Ogletree Deakins	Legal	7
Ogletree Deakins	Legal	106
Ogletree Deakins	Legal	108
Stone, McGuire & Siegel	Legal	366
Stone, McGuire & Siegel	Legal	488
Stone, McGuire & Siegel	Legal	375
Stone, McGuire & Siegel	Legal	226
Stone, McGuire & Siegel	Legal	65
Stone, McGuire & Siegel	Legal	254
Stone, McGuire & Siegel	Legal	650
Stone, McGuire & Siegel	Legal	1,194
Stone, McGuire & Siegel	Legal	161
Stone, McGuire & Siegel	Legal	130
Stone, McGuire & Siegel	Legal	120
Wang Kobayashi Austin LLC	Legal	122
ML Enterprises	Purchasing Consultant	3,850
Dr Dragic M Obradovic	Consulting	7,200

Dr Pendrag Simovic	Consulting	2,400
Group Design & Development	Asset Management Fees	12,000
Stone, McGuire & Siegel	Compliance Audits	912
Ogletree Deakins	Compliance Audits	10,702
Documentation Solutions Inc.	Compliance Audits	975
Personnel Planners	Other Professional Services	2,021
IIT Sourcetechn	Data Processing	1,790
Illinois Rights Corp	Medicare Consultant	12,000
Paycor	Other Professional Services	17,343
Achieve Accreditation	Other Professional Services	9,999
The Joint Commission	Other Professional Services	2,350
MTS Consulting LLC	Consulting	1,039
David Etzman	Other Professional Services	4,761
Pathway	Other Professional Services	1,996

**Total (agree to Schedule V, line 19, column 3)** 229,826

Allocated from Management Company Professional Services (11,634)

Less: Non-Allowable Legal Fees (12,160)

**Total (agree to Schedule V, line 19, column 8)** 206,032

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

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. ICLTC: \$7,449
- (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. \$ 29,710 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? X YES NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 142,128  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
  - a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
  - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
  - c. What percent of all travel expense relates to transportation of nurses and patients? 0
  - d. Have vehicle usage logs been maintained? Adequate records have been maintained.
  - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
  - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
  - g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees.