FOR BHF USE

LL1

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

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0050237

Facility Name: Grove North Living & Rehab Center

Address: 9000 North Lavergne Avenue (Number) Skokie (City) 60077 (Zip Code)

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 9/1/08

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (217) 258-8888
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/01/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey & Pullen, LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove North Living & Rehab Center # 0050237 Report Period Beginning: 1/01/2010 Ending: 12/31/2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	98	Skilled (SNF)	98	35,770	1
2		Skilled Pediatric (SNF/PED)			2
3	51	Intermediate (ICF)	51	18,615	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	149	TOTALS	149	54,385	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	26,087	1,830	7,037	34,954	8
9	SNF/PED					9
10	ICF	13,439	747	771	14,957	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,526	2,577	7,808	49,911	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.77%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

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

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

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

I. On what date did you start providing long term care at this location?
Date started 9/01/2008

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/01/2008 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 98 and days of care provided 7,037

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove North Living & Rehab Center # 0050237 Report Period Beginning: 1/01/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	278,243	29,470	30,983	338,696		338,696		338,696			1
2	Food Purchase		261,911		261,911		261,911	152	262,063			2
3	Housekeeping	129,619	20,251		149,870		149,870	1,129	150,999			3
4	Laundry	67,301	13,688		80,989		80,989		80,989			4
5	Heat and Other Utilities			138,427	138,427		138,427	3,537	141,964			5
6	Maintenance	57,922		83,602	141,524		141,524	12,430	153,954			6
7	Other (specify):*											7
8	TOTAL General Services	533,085	325,320	253,012	1,111,417		1,111,417	17,248	1,128,665			8
	B. Health Care and Programs											
9	Medical Director			55,200	55,200		55,200		55,200			9
10	Nursing and Medical Records	2,185,195	104,833	57,286	2,347,314		2,347,314	9,270	2,356,584			10
10a	Therapy			631,956	631,956		631,956		631,956			10a
11	Activities	126,402	14,511	2,830	143,743		143,743		143,743			11
12	Social Services	97,051		3,598	100,649		100,649		100,649			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,408,648	119,344	750,870	3,278,862		3,278,862	9,270	3,288,132			16
	C. General Administration											
17	Administrative	188,226		571,393	759,619		759,619	(548,773)	210,846			17
18	Directors Fees											18
19	Professional Services			141,670	141,670		141,670	6,306	147,976			19
20	Dues, Fees, Subscriptions & Promotions			21,146	21,146		21,146	2	21,148			20
21	Clerical & General Office Expenses	92,666	45,682	230,910	369,258		369,258	(83,572)	285,686			21
22	Employee Benefits & Payroll Taxes			576,658	576,658		576,658		576,658			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,735	2,735		2,735	(475)	2,260			24
25	Other Admin. Staff Transportation			12,410	12,410		12,410	49	12,459			25
26	Insurance-Prop.Liab.Malpractice			91,609	91,609		91,609	449	92,058			26
27	Other (specify):* Home Ofc- EE Benefi							21,511	21,511			27
28	TOTAL General Administration	280,892	45,682	1,648,531	1,975,105		1,975,105	(604,503)	1,370,602			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,222,625	490,346	2,652,413	6,365,384		6,365,384	(577,985)	5,787,399			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 North Living & Rehab Center #0050237 Report Period Beginning: 1/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			51,600	51,600		51,600	12,026	63,626			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,928	13,928		13,928	42,143	56,071			32
33	Real Estate Taxes			131,152	131,152		131,152	6,032	137,184			33
34	Rent-Facility & Grounds			679,812	679,812		679,812	640	680,452			34
35	Rent-Equipment & Vehicles			47,969	47,969		47,969	150	48,119			35
36	Other (specify):*											36
37	TOTAL Ownership			924,461	924,461		924,461	60,991	985,452			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		216,256		216,256		216,256		216,256			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			81,578	81,578		81,578		81,578			42
43	Other (specify):* Non-Allowable Cos			293,092	293,092		293,092	(293,092)				43
44	TOTAL Special Cost Centers		216,256	374,670	590,926		590,926	(293,092)	297,834			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,222,625	706,602	3,951,544	7,880,771		7,880,771	(810,086)	7,070,685			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 North Living & Rehab Center # 0050237 Report Period Beginning: 1/01/2010 Ending: 12/31/2010

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(505)	30		9
10	Interest and Other Investment Income	(122)	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	(64,864)	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	(104,425)	43		24
25	Fund Raising, Advertising and Promotional	(73,621)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(50,131)	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (293,668)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(516,418)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (516,418)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (810,086)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Grove North Living & Rehab Center

ID# 0050237

Report Period Beginning: 1/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	X-Rays - Part A	$ (14,661)	43	1
2	Labs - Part A	(47)	43	2
3	House	(9,752)	43	3
4	Patient Personal Items	(533)	43	4
5	Public Relations/Marketing	(4,683)	43	5
6	Cable TV	(19,979)	43	6
7	Nonallowable Travel and Seminar	(1,180)	19	7
8	Discount	1,778	43	8
9	Medicare A Pay Allow	(2,305)	43	9
10	Nonallowable Legal Fees	(1,119)	19	10
11	To expense an asset < $2,500	2,350	6	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(50,131)		49

Facility Name & ID Number Grove North Living & Rehab Center # 0050237 Report Period Beginning: 1/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	$	Legacy Healthcare Financial Services, LLC	100.00%	$ 152	$ 152	1
2	V	3	Housekeeping Salaries		Legacy Healthcare Financial Services, LLC	100.00%	1,121	1,121	2
3	V	3	Housekeeping Supplies		Legacy Healthcare Financial Services, LLC	100.00%	8	8	3
4	V	5	Utilities		Legacy Healthcare Financial Services, LLC	100.00%	3,537	3,537	4
5	V	6	Repairs & Maintenance		Legacy Healthcare Financial Services, LLC	100.00%	806	806	5
6	V	10	RN Salaries		Legacy Healthcare Financial Services, LLC	100.00%	9,270	9,270	6
7	V	17	Administrative Salary - Mgmt. Alloc.	571,393	Legacy Healthcare Financial Services, LLC	100.00%	22,089	(549,304)	7
8	V	19	Other Professional Fees		Legacy Healthcare Financial Services, LLC	100.00%	2,363	2,363	8
9	V	19	Accounting		Legacy Healthcare Financial Services, LLC	100.00%	1,157	1,157	9
10	V	19	Legal Fees		Legacy Healthcare Financial Services, LLC	100.00%	2,342	2,342	10
11	V	19	Data Processing		Legacy Healthcare Financial Services, LLC	100.00%	87	87	11
12	V	20	Dues, Licenses & Fees		Legacy Healthcare Financial Services, LLC	100.00%	2	2	12
13	V	21	Office Supplies		Legacy Healthcare Financial Services, LLC	100.00%	16,386	16,386	13
14	Total			$ 571,393			$ 59,320	$ * (512,073)	14

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

Provider Name: **Grove North Living and Rehab Center**
Provider #: **0050237**
Year End **12/31/2010**

Schedule 6A

Schedule 6A

Schedule V.A. Related Parties

Owners	Related Nursing Homes Name	City	Owners	Related Nursing Homes Name	City	Other Related Business Entities Name	City	pe of Business
Chaim Rajchenbach	Grove Lincoln Park Living & Rehab Cen	Chicago	Ronald Shabat	The Grove of LaGrange Park	LaGrange Park	Legacy Hea	Skokie	Management Company
	Pine Acres Rehab & Living Center	DeKalb		Florence Nursing Home	Marengo	Legacy Rea	Skokie	Real Estate
	Astoria Place Living & Rehab	Chicago		The Fountain's	Marion	Grove Heal	Skokie	Real Estate
	The Grove of Evanston	Evanston		Friendship Care Center - Herrin	Herrin	Shabat & A	Chicago	Management Company
	Grove North Living & Rehab Center	Chicago		City Care Center of Cobden	Cobden	JLR Manag	Chicago	Management Company
	Elmbrook Nursing	Elmbrook		Grove Lincoln Park Living & Rehab Center	Chicago			
	The Grove of LaGrange Park	LaGrange Park		Peterson Park Health Care Center	Chicago			
				Ridgeway Manor	Ridgeway			
Menachem Shabat	Lakefront Nursing & Rehab Center	Chicago		Sheridan Health Care Center	Zion			
	Grove Lincoln Park Living & Rehab Cen	Chicago		Oak Grove Rehab & Skilled Care	Carbondale			
	Astoria Place Living & Rehab	Chicago		Astoria Place Living & Rehab	Chicago			
	The Grove of Evanston	Evanston		The Grove of Evanston	Evanston			
	Grove North Living & Rehab Center	Chicago		Grove North Living & Rehab Center	Chicago			
	The Grove of LaGrange Park	LaGrange Park		Elmbrook Nursing	Elmbrook			
	Elmbrook Nursing	Elmbrook						
			Menachem Berger	The Grove of Evanston	Evanston			
Jack Rajchenback	Bridgeview Health Care Center	Bridgeview						
	The Carlton at the Lake	Chicago	Jake Weiss	The Grove of Evanston	Elmbrook			
	Clark Manor Convalescent Center	Chicago						
	Springfield Terrace	Springfield	The Rajchenbach Family Trust	Grove Lincoln Park Living & Rehab Center	Chicago			
	Tower Hill Healthcare Center	South Elgin		Grove North Living & Rehab Center	Chicago			
	Glenview Terrace Nursing Center	Glenview						
	The Imperial Grove Pavilion	Chicago	The Robert Hartman Family Trust	Grove Lincoln Park Living & Rehab Center	Chicago			
	The Arc of Jacksonville, Ltd.	Jacksonville		Grove North Living & Rehab Center	Chicago			
	Grove Lincoln Park Living & Rehab Cen	Chicago						
	Peterson Park Health Care Center	Chicago						
	Grove North Living & Rehab Center	Chicago						
	Embassy Health Care Center	Wilmington						
	Whitehall North	Deerfield						
	Harmony Nursing & Rehab Center	Chicago						

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove North Living & Rehab Center # 0050237 Report Period Beginning: 1/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Clerical Salaries	$ 215,000	Legacy Healthcare Financial Services LLC	100.00%	$ 102,406	$ (112,594)	15
16	V	24	Travel and Seminar		Legacy Healthcare Financial Services LLC	100.00%	705	705	16
17	V	25	Travel		Legacy Healthcare Financial Services LLC	100.00%	49	49	17
18	V	26	Insurance Expense		Legacy Healthcare Financial Services LLC	100.00%	449	449	18
19	V	22	Employee Benefits		Legacy Healthcare Financial Services LLC	100.00%	21,469	21,469	19
20	V	30	Depreciation		Legacy Healthcare Financial Services LLC	100.00%	703	703	20
21	V	32	Amortization		Legacy Healthcare Financial Services LLC	100.00%	299	299	21
22	V	33	Real Estate Taxes		Legacy Healthcare Financial Services LLC	100.00%	6,032	6,032	22
23	V	34	Rent Expense		Legacy Healthcare Financial Services LLC	100.00%	35,395	35,395	23
24	V	35	Equipment Rental		Legacy Healthcare Financial Services LLC	100.00%	150	150	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			$ 215,000			$ 167,657	$ * (47,343)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove North Living & Rehab Center # 0050237 Report Period Beginning: 1/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Repairs & Maintenance	$	Legacy Real Properties, LLC	100.00%	$ 4,348	$ 4,348	15
16	V	21	Office Supplies		Legacy Real Properties, LLC	100.00%	2,404	2,404	16
17	V	30	Depreciation Expense		Legacy Real Properties, LLC	100.00%	6,420	6,420	17
18	V	32	Interest Expense		Legacy Real Properties, LLC	100.00%	9,481	9,481	18
19	V	33	Taxes - Property	6,672	Legacy Real Properties, LLC	100.00%	6,672		19
20	V	34	Rent	34,755	Legacy Real Properties, LLC	100.00%		(34,755)	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			$ 41,427			$ 29,325	$ * (12,102)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove North Living & Rehab Center # 0050237 Report Period Beginning: 1/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Maintenance	$	Grove Healthcare Properties, LLC		$ 4,896	$ 4,896	15
16	V	19	Computer Services		Grove Healthcare Properties, LLC		1,476	1,476	16
17	V	21	Bank Service Charges		Grove Healthcare Properties, LLC		10,232	10,232	17
18	V	30	Depreciation		Grove Healthcare Properties, LLC		5,438	5,438	18
19	V	32	Interest Expense		Grove Healthcare Properties, LLC		32,485	32,485	19
20	V	34	Rent	679,812	Grove Healthcare Properties, LLC		679,812		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			$ 679,812			$ 734,339	$ * 54,527	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove North Living & Rehab Center # 0050237 Report Period Beginning: 1/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Administrative Salary - Mgmt. Alloc.	$	Shabat & Associates, LLC		$ 531	$ 531	15
16	V	27	Employee Benefits - Mgmt. Alloc.		Shabat & Associates, LLC		42	42	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			$			$ 573	$ * 573	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove North Living & Rehab Center # 0050237 Report Period Beginning: 1/01/2010 Ending: 12/31/2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	Chaim Rajchenbach	Owner	Administrative	29.00	285,682	8	16.40	Mgmt. Salary	31,360	17(3)	2
3	Menachem Shabat	Owner	Administrative	29.00	285,697	8	16.40	Mgmt. Salary	42,125	17(3)	3
4	Ronald Shabat	Owner	Administrative	15.50	199,469	2	5.71	Mgmt. Salary	531	17(3)	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 74,016		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 North Living & Rehab Center # 0050237 Report Period Beginning: 1/01/2010 Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Patient Days	304,581	10	$ 926	$	49,911	$ 152	1
2	3	Housekeeping Salaries	Patient Days	304,581	10	6,838	6,838	49,911	1,121	2
3	3	Housekeeping Supplies	Patient Days	304,581	10	46		49,911	8	3
4	5	Utilities	Patient Days	304,581	10	21,580		49,911	3,537	4
5	6	Repairs & Maintenance	Patient Days	304,581	10	4,917		49,911	806	5
6	10	RN Salaries	Patient Days	304,581	10	56,573		49,911	9,270	6
7	17	Administrative Salary - Mgmt. All	Patient Days	304,581	10	134,800	134,800	49,911	22,089	7
8	19	Other Professional Fees	Patient Days	304,581	10	14,420		49,911	2,363	8
9	19	Accounting	Patient Days	304,581	10	7,058		49,911	1,157	9
10	19	Legal Fees	Patient Days	304,581	10	14,289		49,911	2,342	10
11	19	Data Processing	Patient Days	304,581	10	531		49,911	87	11
12	20	Dues, Licenses & Fees	Patient Days	304,581	10	15		49,911	2	12
13	21	Office Supplies	Patient Days	304,581	10	99,999		49,911	16,387	13
14	21	Clerical Salaries	Patient Days	304,581	10	624,930	624,930	49,911	102,406	14
15	24	Travel and Seminar	Patient Days	304,581	10	4,300		49,911	705	15
16	25	Travel	Patient Days	304,581	10	300		49,911	49	16
17	26	Insurance Expense	Patient Days	304,581	10	2,741		49,911	449	17
18	22	Employee Benefits	Patient Days	304,581	10	131,010		49,911	21,468	18
19	30	Depreciation	Bed Days Available	363,747	10	4,701		54,385	703	19
20	32	Amortization	Patient Days	304,581	10	1,827		49,911	299	20
21	33	Real Estate Taxes	Patient Days	304,581	10	36,809		49,911	6,032	21
22	34	Rent Expense	Patient Days	304,581	10	216,000		49,911	35,395	22
23	35	Equipment Rental	Patient Days	304,581	10	917		49,911	150	23
24										24
25	TOTALS					$ 1,385,527	$ 766,568		$ 226,977	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove North Living & Rehab Center # 0050237 Report Period Beginning: 1/01/2010 Ending: 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Private Bank		X	Capital Expenditures	$10,186.00	10/23/08	$ 671,440	$ 368,273	10/1/13	3.7606	$ 13,928	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$10,186.00		$ 671,440	$ 368,273			$ 13,928	9
	B. Non-Facility Related*											
10								Offset Interest Income			(122)	10
11								Allocated from Management Company			299	11
12								Allocated from Legacy Real Properties, LI			9,481	12
13								Allocated from Grove Healthcare Properti			32,485	13
14	TOTAL Non-Facility Related						$	$			$ 42,143	14
15	TOTALS (line 9+line14)						$ 671,440	$ 368,273			$ 56,071	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 North Living & Rehab Center # 0050237 **Report Period Beginning:** 1/01/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 238,800	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.)	2009	$ 183,952	2
3. Under or (over) accrual (line 2 minus line 1).		$ (54,848)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 186,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **Allocation From Home Office**		6,032	
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.		$ 137,184	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005		8
2006		9
2007		10
2008	83,959	11
2009	183,952	12

Estimated accrual based on PY tax plus a 3% increase.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grove North Living & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050237

CONTACT PERSON REGARDING THIS REPORT Chaim Rajchenbach

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

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-16-411-018-0000	9000 Lavergne Ave.	$ 37,920.10	$ 37,920.10
2.	10-16-411-017-0000	9000 Gross Point Rd.	$ 146,031.51	$ 146,031.51
3.	Allocated from Home Office		$ 33,263.09	$ 6,032.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 217,214.70	$ 189,983.61

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.

Facility Name & ID Number Grove North Living & Rehab Center # 0050237 Report Period Beginning: 1/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,350 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2

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

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Allocated from Legacy Real Properties			$ 12,272	1
2					2
3	TOTALS			$ 12,272	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove North Living & Rehab Center # 0050237 Report Period Beginning: 1/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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				$ 95,079	$		$ 3,169	$ 3,169	$ 4,754	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Landscaping			2009	10,000	666	15	666		999	9
10	Landscaping			2009	32,000	2,134	15	2,134		3,201	10
11	Built-in Cabinets			2009	66,890	1,672	40	1,672		2,508	11
12	Satellite System Installation			2009	11,305	283	40	283		424	12
13	Exterior Painting			2009	44,020	1,101	40	1,101		1,651	13
14	1st Floor remodel			2009	18,589	465	40	465		697	14
15	Electrical Work			2009	11,488	287	40	287		431	15
16	Painting & Décor			2009	107,803	2,695	40	2,695		4,043	16
17	Rehab Bathrooms			2009	25,000	625	40	625		938	17
18	2nd Floor & Nurses Station Remodel			2009	131,292	3,282	40	3,282		4,923	18
19	Install Locks			2009	8,500	213	40	213		319	19
20	New Roof			2009	39,725	993	40	993		1,490	20
21	Call Light System			2009	15,988	400	40	400		600	21
22	Kitchen Remodel			2009	46,284	1,157	40	1,157		1,736	22
23	Vent System Installation			2009	15,466	387	40	387		580	23
24	Therapy Room Remodel			2009	29,544	739	40	739		1,108	24
25	Elevator Repairs			2009	16,128	403	40	403		605	25
26	Rehab DON Office			2009	5,767	144	40	144		216	26
27	Rehab 34 Resident Bathrooms			2009	14,593	365	40	365		547	27
28	Building Improvement			2009	5,767	144	40	144		216	28
29	Electrical & Lighting			2009	4,025	101	40	101		151	29
30	Fire Sprinkler System			2009	7,952	199	40	199		298	30
31	Ventilation System Installation			2009	15,466	387	40	387		580	31
32	Window Coverings & Installation			2009	29,706	743	40	743		1,114	32
33	Ceiling Fixtures			2009	4,530	113	40	113		170	33
34	Flooring			2009	51,071	1,277	40	1,277		1,915	34
35	Smoke Detectors			2009	6,174	154	40	154		231	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Grove North Living & Rehab Center # 0050237 Report Period Beginning: 1/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
37	Irrigation System	2009	$ 21,000	$ 525	40	$ 525	$	$ 788	37
38	Patch & Paint Conference Room	2009	1,860	47	40	47		70	38
39	Fire Sprinkler System	2009	2,100	53	40	53		79	39
40	Nurse Call System	2009	15,556	389	40	389		584	40
41	Tile Installation on 2nd Floor	2009	2,700	68	40	68		102	41
42	Rewire for Cable	2009	2,703	68	40	68		102	42
43	2nd Floor Office Remodel	2009	7,400	185	40	185		278	43
44	Tile installation	2010	3,908	49	40	49		49	44
45	Electrical for new sign	2010	14,447	181	40	181		181	45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54	Allocated from Legacy Real Properties		70,413			1,679	1,679	2,354	54
55	Allocated from Grove Healthcare Properties					5,438	5,438		55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,012,239	$ 22,694		$ 32,980	$ 10,286	$ 41,028	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grove North Living & Rehab Center # 0050237 Report Period Beginning: 1/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 188,053	$ 27,213	$ 26,678	$ (535)	10	$ 42,970	71
72	Current Year Purchases	16,236	1,693	1,693		10	1,693	72
73	Fully Depreciated Assets							73
74	See Schedule 13A	28,407		2,275	2,275	5	2,947	74
75	TOTALS	$ 232,696	$ 28,906	$ 30,646	$ 1,740		$ 47,610	75

D. Vehicle Depreciation (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)	$ 1,257,207	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 51,600	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 63,626	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 12,026	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 88,638	85	

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

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

G. Construction-in-Progress

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

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

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

Grove North Living & Rehab Center
FYE: 12/31/2010
Schedule 13A

	Category of Equipment	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Component Life	Accumulated Depreciation
1	Allocation from LHFS, Inc	3,649		703	703	5	1,041
2	Allocated from Legacy Real Properties	24,758		1,572	1,572	5	1,906
	Totals	28,407		2,275	2,275		2,947

See Accountants' Compilation Report

Facility Name & ID Number Grove North Living & Rehab Center # 0050237 Report Period Beginning: 1/01/2010 Ending: 12/31/2010

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:	1983	149	9/1/08	$ 679,812	2	8	3
4	Additions							4
5								5
6	Home Office Allocation				640			6
7	TOTAL		149		$ 680,452 **			7

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

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

10. Effective dates of current rental agreement:
    Beginning 9/1/08
    Ending 8/31/10

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 15,051 Description: Nursing Rental $14,901; Home Office Allocation $150
    (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	Patient Related	Lexus, GX 470	$ 915.00	$ 11,030	17
18	Patient Related	Lexus, RX 350	670.87	8,084	18
19	Patient Related	Lexus, RX 350	651.95	7,204	19
20	Patient Related	Toyota Camry	322.32	6,750	20
21	TOTAL		$ 2,560.14	$ 33,068	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 North Living & Rehab Center # 0050237 Report Period Beginning: 1/01/2010 Ending: 12/31/2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

Facility Name & ID Number Grove North Living & Rehab Center # 0050237 Report Period Beginning: 1/01/2010 Ending: 12/31/2010

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	$	3,049	$ 256,146	$	3,049	$ 256,146	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,004	84,354		1,004	84,354	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		3,470	291,456		3,470	291,456	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				201,933		201,933	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	39(2)					14,323		14,323	12
13	Other (specify):									13
14	TOTAL			$	7,523	$ 631,956	$ 216,256	7,523	$ 848,212	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

STATE OF ILLINOIS

Facility Name & ID Number Grove North Living & Rehab Center # 0050237 Report Period Beginning: 1/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2010 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 51,948)	1,223,060	1,223,060	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,446	120,619	6
7	Other Prepaid Expenses	27,046	27,046	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Sch 17A	1,606,793	1,606,793	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,876,345	$ 2,977,518	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	(4,200)	12,272	13
14	Buildings, at Historical Cost		95,079	14
15	Leasehold Improvements, at Historical Cost	837,265	917,160	15
16	Equipment, at Historical Cost	216,151	232,696	16
17	Accumulated Depreciation (book methods)	(75,088)	(88,638)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 974,128	$ 1,168,569	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,850,473	$ 4,146,087	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 24,407	$ 24,407	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	272,452	272,452	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	84,827	186,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch 17A	514,090	514,090	36
37	Federal Unemployment Tax	718	718	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 896,494	$ 997,667	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	368,273	368,273	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 368,273	$ 368,273	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,264,767	$ 1,365,940	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,585,706	$ 2,780,147	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,850,473	$ 4,146,087	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Provider Name: **Grove North Living and Rehab Center**
Provider #: **0050237**
Year End **12/31/2010** **Schedule 17A**

XV. BALANCE SHEET

Line 9: Other Current Assets (specify):

	Operating	After Consolidation
Due From Med Inter	421,571	421,571
Security Deposit	372,500	372,500
Due to Medicare	(122,539)	(122,539)
Due to Others	8,569	8,569
Due T/F Legacy Charity	3,174	3,174
Grove at Lincoln Park	787,672	787,672
Legacy Financial Services	160,825	160,825
Due to Lessor/Prior Owner	(24,979)	(24,979)
	1,606,793	1,606,793

Line 36: Other Current Liabilities (specify):

Accrued Insurance	9,204	9,204
Accrued FICA	(7,110)	(7,110)
Grove Healthcare Properties	(168,884)	(168,884)
Due to Members	(347,300)	(347,300)
	(514,090)	(514,090)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove North Living & Rehab Center # 0050237 Report Period Beginning: 1/01/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 849,243	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(201)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 849,042	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,736,664	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)**	$ 1,736,664	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)**	$ 2,585,706	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove North Living & Rehab Center # 0050237 Report Period Beginning: 1/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,102,031	1
2	Discounts and Allowances for all Levels	1,416,074	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,518,105	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	99,149	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 99,149	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	59	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 59	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	122	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 122	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)**	$ 9,617,435	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,111,417	31
32	Health Care	3,278,862	32
33	General Administration	1,975,105	33
	B. Capital Expense		
34	Ownership	924,461	34
	C. Ancillary Expense		
35	Special Cost Centers	509,348	35
36	Provider Participation Fee	81,578	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,880,771	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,736,664	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,736,664	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
****LLC members are cash basis tax payers**

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

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

Facility Name & ID Number Grove North Living & Rehab Center # 0050237 Report Period Beginning: 1/01/2010 Ending: 12/31/2010

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,037	2,166	$ 107,064	$ 49.43	1
2	Assistant Director of Nursing	1,417	1,611	58,107	36.07	2
3	Registered Nurses	26,147	27,972	818,780	29.27	3
4	Licensed Practical Nurses	7,329	7,747	190,336	24.57	4
5	CNAs & Orderlies	70,348	74,081	839,634	11.33	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,957	2,086	37,327	17.89	9
10	Activity Assistants	5,077	5,350	89,075	16.65	10
11	Social Service Workers	5,299	5,543	97,051	17.51	11
12	Dietician	2,113	2,197	35,524	16.17	12
13	Food Service Supervisor					13
14	Head Cook	1,952	2,255	40,665	18.03	14
15	Cook Helpers/Assistants	16,562	17,879	202,054	11.30	15
16	Dishwashers					16
17	Maintenance Workers	4,093	4,359	57,922	13.29	17
18	Housekeepers	13,311	13,989	129,619	9.27	18
19	Laundry	5,496	5,946	67,301	11.32	19
20	Administrator	4,041	4,246	146,281	34.45	20
21	Assistant Administrator	2,328	2,400	41,945	17.48	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,437	6,709	92,666	13.81	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)	8,108	8,853	135,155	15.27	30
31	Medical Records	3,082	3,132	36,119	11.53	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	187,134	198,521	$ 3,222,625 *	$ 16.23	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	298	$ 30,983	1(3)	35
36	Medical Director	1,104	55,200	9(3)	36
37	Medical Records Consultant	32	4,416	10(3)	37
38	Nurse Consultant	270	11,750	10(3)	38
39	Pharmacist Consultant	Monthly	6,205	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	49	2,448	11(3)	44
45	Social Service Consultant	45	3,598	12(3)	45
46	Other(specify) MDS Consultant	Monthly	13,090	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,798	$ 127,690		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	268	$ 19,864	10(3)	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	268	$ 19,864		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Grove North Living & Rehab Center # 0050237 Report Period Beginning: 1/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jamie Dlatt	Administrator	0%	$ 55,015
Mark Dubovick	Administrator	0%	91,266
Igor Rebel	Asst. Administrator	0%	41,945
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 188,226

B. Administrative - Other

Description	Amount
Management Fees "Eliminated in col. 7"	$ 571,393
TOTAL (agree to Schedule V, line 17, col. 3)	$ 571,393
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See SCH 21A		$ 141,670
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 141,670

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 64,606
Unemployment Compensation Insurance	59,585
FICA Taxes	237,326
Employee Health Insurance	160,577
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	29,685
Employee Benefits Other	24,879
TOTAL (agree to Schedule V, line 22, col.8)	$ 576,658

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	463
Health Care Worker Background Check	
(Indicate # of checks performed 68)	2,050
Patient Background Checks 342	3,420
IL Council on Long Term Care	13,468
Miscellaneous Licenses & Fees	750
Home Office Allocation	2
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,148

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,555
Home Office Allocation	705
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,260

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Provider N Grove North Living and Rehab Center
Provider #: 0050237
Year End 12/31/2010 **Schedule 21A**

XIX.C. Professional Services

American Data	Data Processing	12,482
Health Data Systems, Inc.	Data Processing	14,381
E-Health Data Solutions	Data Processing	3,994
Singer Networks LLC	Data Processing	344
National Datacare Corp	Data Processing	900
RSM McGladrey	Accounting	29,029
Law Office of Abaham Gutnicki	Legal	263
Meyer Magence	Legal	3,625
Much Shelist	Legal	649
Miriam F. Solo	Legal	850
Sandra Thiel	Legal	881
Scott & Krause	Legal	3,173
Sheryl E. Fuhr & Associates	Legal	3,128
Skidelsky & Associates	Legal	11,540
Singer Netwoeks	Computer	27,739
Chicago Hire	Recruitment	4,070
Astoria	Recruitment	4,800
CES	Data Processing	579
Citi Business Card	Data Processing	504
First Real estate Services	Appraisal	3,500
Front Liners of IL	Recruitment	3,000
IIT/Source Tech	Software Development	590
Meyer Magence	Legal	2,500
ML Enterprises	Purchasing consultant	2,625
Personnel Planners	Workers comp Consultant	695
Premier medical	Recruitment	5,000
Prospect resouces	Risk Management	800
Quality Therapy	Physical Therapy Consultant	30
	Total	141,670
	Schedule V, Line 19, Column 3	141,670

Legacy HC Finance Svcs, LLC Allocation	5,949
Legacy Real Properties Allocation	1,476
Remove non-allowable legal	(1,119)
Total	147,976
Schedule V, Line 19, Column 8	147,976

See Accountants' Compilation Report

Facility Name & ID Number Grove North Living & Rehab Center # 0050237 Report Period Beginning: 1/01/2010 Ending: 12/31/2010

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove North Living & Rehab Center # 0050237 Report Period Beginning: 1/01/2010 Ending: 12/31/2010

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ILCLTC $13,468**

(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 Yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **33,300** 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? **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. $ **81,578**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **N/A**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT