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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0050443

Facility Name: Grove Of Lagrange Park

Address: 701 North Lagrange Road (Number) | Lagrange Park (City) | 60526 (Zip Code)

County: Cook

Telephone Number: (708) 354-7300 **Fax #** (708) 354-8928

HFS ID Number:

Date of Initial License for Current Owners: 04/01/09

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: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/11 to 12/31/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Cary C. Buxbaum, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	131	Skilled (SNF)	131	47,815	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	131	TOTALS	131	47,815	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	4,150	670	8,289	13,109	8
9	SNF/PED					9
10	ICF	21,790	2,375	710	24,875	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,940	3,045	8,999	37,984	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.44%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 04/01/2009

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/2009 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 131 and days of care provided 6,221

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	239,026	13,424	11,909	264,359		264,359		264,359			1
2	Food Purchase		192,405		192,405	(11,607)	180,798	(82)	180,716			2
3	Housekeeping	192,884	22,460	110	215,454		215,454	759	216,213			3
4	Laundry	77,610	33,808		111,418		111,418		111,418			4
5	Heat and Other Utilities			127,330	127,330		127,330	(4,694)	122,636			5
6	Maintenance	30,651		144,287	174,938		174,938	16,210	191,148			6
7	Other (specify):*											7
8	TOTAL General Services	540,171	262,097	283,636	1,085,904	(11,607)	1,074,297	12,193	1,086,490			8
	B. Health Care and Programs											
9	Medical Director			21,000	21,000		21,000		21,000			9
10	Nursing and Medical Records	2,115,005	169,017	73,334	2,357,356		2,357,356	(59,527)	2,297,829			10
10a	Therapy	81,081			81,081		81,081		81,081			10a
11	Activities	90,349	15,471		105,820		105,820		105,820			11
12	Social Services	54,997		3,170	58,167		58,167		58,167			12
13	CNA Training											13
14	Program Transportation			21,063	21,063		21,063		21,063			14
15	Other (specify):*							2,235	2,235			15
16	TOTAL Health Care and Programs	2,341,432	184,488	118,567	2,644,487		2,644,487	(57,292)	2,587,195			16
	C. General Administration											
17	Administrative	128,139		435,919	564,058		564,058	(411,919)	152,139			17
18	Directors Fees											18
19	Professional Services			347,290	347,290	(14,712)	332,579	(215,966)	116,612			19
20	Dues, Fees, Subscriptions & Promotions			174,002	174,002		174,002	(152,205)	21,797			20
21	Clerical & General Office Expenses	84,822	2,550	211,153	298,525		298,525	(57,880)	240,645			21
22	Employee Benefits & Payroll Taxes			585,540	585,540	11,607	597,147		597,147			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,690	1,690		1,690	288	1,978			24
25	Other Admin. Staff Transportation			1,547	1,547		1,547		1,547			25
26	Insurance-Prop.Liab.Malpractice			64,753	64,753		64,753	286	65,039			26
27	Other (specify):*							17,278	17,278			27
28	TOTAL General Administration	212,961	2,550	1,821,894	2,037,405	(3,105)	2,034,301	(820,118)	1,214,183			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,094,564	449,135	2,224,097	5,767,796	(14,712)	5,753,085	(865,217)	4,887,868			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grove Of Lagrange Park #0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			82,706	82,706		82,706	59,724	142,430			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			45,079	45,079		45,079	80,915	125,994			32
33	Real Estate Taxes					14,712	14,712	221,311	236,023			33
34	Rent-Facility & Grounds			524,546	524,546		524,546	(524,546)				34
35	Rent-Equipment & Vehicles			450	450		450		450			35
36	Other (specify):*											36
37	TOTAL Ownership			652,781	652,781	14,712	667,493	(162,596)	504,896			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		292,162	763,914	1,056,076		1,056,076		1,056,076			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			71,723	71,723		71,723		71,723			42
43	Other (specify):*			5,000	5,000		5,000	(5,000)				43
44	TOTAL Special Cost Centers		292,162	840,637	1,132,799		1,132,799	(5,000)	1,127,799			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,094,564	741,297	3,717,515	7,553,376		7,553,376	(1,032,813)	6,520,563			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	(6,263)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	55,015	30		9
10	Interest and Other Investment Income	(70)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(154)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,509)	21		18
19	Entertainment				19
20	Contributions	(78,868)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(122,373)	21		24
25	Fund Raising, Advertising and Promotional	(69,847)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(80,758)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (304,827)		$	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)	(727,986)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (727,986)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,032,813)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Grove Of Lagrange Park

ID# 0050443

Report Period Beginning: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	COPE Dues	$ (3,326)	20	1
2	Veterans' Pharmacy	(30,400)	10	2
3	Patient Personal Items	(401)	10	3
4	Bank Charges	(4,311)	21	4
5	Discount	(3,499)	21	5
6	Annual Report	(250)	20	6
7	Non-Allowable Legal	(8,946)	19	7
8	Building Co. - Bank Service Charges	(31)	21	8
9	Building Co. - Licenses & Fees	(250)	20	9
10	Building Co. - Legal Fees	(26,303)	19	10
11	Building Co. - Amortization	(2,048)	31	11
12	Building Co. - Acquisitions Costs	(8,551)	21	12
13	Marketing Consultant	(5,000)	43	13
14	Additional R&M	21,023	06	14
15	Capitalized R&M	(8,465)	06	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**	(80,758)		49

Grove Of Lagrange Park

ID# 0050443

Report Period Beginning: 01/01/11

Ending: 12/31/11

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

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Grove Of Lagrange Park **#** 0050443 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(154)		72									(82)	2
3	Housekeeping			759									759	3
4	Laundry													4
5	Heat and Other Utilities	(6,263)		1,569									(4,694)	5
6	Maintenance	12,558		3,652									16,210	6
7	Other (specify):*													7
8	**TOTAL General Services**	6,141		6,052									12,193	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(30,801)				(28,726)							(59,527)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					2,235							2,235	15
16	**TOTAL Health Care and Programs**	(30,801)				(26,491)							(57,292)	16
	C. General Administration													
17	Administrative			(411,919)									(411,919)	17
18	Directors Fees													18
19	Professional Services	(35,249)	26,303	(207,193)		173							(215,966)	19
20	Fees, Subscriptions & Promotions	(152,541)	250	40	20	26							(152,205)	20
21	Clerical & General Office Expenses	(140,274)	8,582	73,764		48							(57,880)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			288									288	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			286									286	26
27	Other (specify):*			17,278									17,278	27
28	**TOTAL General Administration**	(328,064)	35,135	(527,456)	20	247							(820,118)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(352,724)	35,135	(521,404)	20	(26,244)							(865,217)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Grove Of Lagrange Park** **#** **0050443** **Report Period Beginning:** **01/01/11** **Ending:** **12/31/11**

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	55,015		468	4,240								59,724	30
31	Amortization of Pre-Op. & Org.	(2,048)	2,048											31
32	Interest	(70)	76,838	5	4,142								80,915	32
33	Real Estate Taxes		217,473		3,838								221,311	33
34	Rent-Facility & Grounds		(524,546)	11,168	(11,168)								(524,546)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	52,897	(228,187)	11,641	1,053								(162,596)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(5,000)											(5,000)	43
44	**TOTAL Special Cost Centers**	(5,000)											(5,000)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(304,827)	(193,052)	(509,763)	1,073	(26,244)							(1,032,813)	45

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		
				Grove of Lagrange Healthcare Properties, LLC		Building Co.

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	34	Rental Income	$ 524,546	Grove of Lagrange Healthcare Properties, LLC		$	$ (524,546)	1
2	V	32	Interest	2	Grove of Lagrange Healthcare Properties, LLC		76,840	76,838	2
3	V	21	Bank Service Charges		Grove of Lagrange Healthcare Properties, LLC		31	31	3
4	V	20	License & Fees		Grove of Lagrange Healthcare Properties, LLC		250	250	4
5	V	19	Legal Fees		Grove of Lagrange Healthcare Properties, LLC		26,303	26,303	5
6	V	31	Amortization		Grove of Lagrange Healthcare Properties, LLC		2,048	2,048	6
7	V	33	Real Estate Taxes		Grove of Lagrange Healthcare Properties, LLC		217,473	217,473	7
8	V	21	Acquisition Fees		Grove of Lagrange Healthcare Properties, LLC		8,551	8,551	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 524,548			$ 331,496	$ * (193,052)	14

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

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	2	FOOD	$	Legacy Healthcare Financial Services	100.00%	$ 72	$ 72	15
16	V	3	HOUSEKEEPING		Legacy Healthcare Financial Services	100.00%	759	759	16
17	V	5	UTILITIES		Legacy Healthcare Financial Services	100.00%	1,569	1,569	17
18	V	6	GROUNDS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	3,652	3,652	18
19	V								19
20	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	2,807	2,807	20
21	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	40	40	21
22	V	21	CLERICAL & GENERAL		Legacy Healthcare Financial Services	100.00%	73,764	73,764	22
23	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	288	288	23
24	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	286	286	24
25	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	17,278	17,278	25
26	V	30	DEPRECIATION		Legacy Healthcare Financial Services	100.00%	468	468	26
27	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	5	5	27
28	V	34	RENT		Legacy Healthcare Financial Services	100.00%	11,168	11,168	28
29	V								29
30	V								30
31	V	17	MANAGEMENT FEES	435,919	Legacy Healthcare Financial Services	100.00%		(435,919)	31
32	V	19	BOOKKEEPING FEES	210,000	Legacy Healthcare Financial Services	100.00%		(210,000)	32
33	V								33
34	V	17	MANAGEMENT FEES- C. RAJCHENBACH		Legacy Healthcare Financial Services	100.00%	12,000	12,000	34
35	V	17	MANAGEMENT FEES- M. SHABAT		Legacy Healthcare Financial Services	100.00%	12,000	12,000	35
36	V								36
37	V								37
38	V								38
39	Total			$ 645,919			$ 136,156	$ * (509,763)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	20	DUES & SUBSCRIPTIONS		Legacy Real Properties	100.00%	20	$ 20	15
16	V	30	DEPRECIATION		Legacy Real Properties	100.00%	4,240	4,240	16
17	V	32	INTEREST EXPENSE		Legacy Real Properties	100.00%	4,142	4,142	17
18	V	33	REAL ESTATE TAXES		Legacy Real Properties	100.00%	3,838	3,838	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V	34	RENT	11,168	Legacy Real Properties	100.00%		(11,168)	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			$ 11,168			$ 12,241	$ * 1,073	39

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

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	10	RN SALARY		Progressive Healthcare Consulting	100.00%	27,274	$ 27,274	15
16	V	15	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	2,235	2,235	16
17	V	19	PROFESSIONAL FEES		Progressive Healthcare Consulting	100.00%	173	173	17
18	V	20	FEES, SUBSCRIPTIONS		Progressive Healthcare Consulting	100.00%	26	26	18
19	V	21	CLERICAL & GENERAL		Progressive Healthcare Consulting	100.00%	48	48	19
20	V								20
21	V								21
22	V	10	NURSING	56,000	Progressive Healthcare Consulting	100.00%		(56,000)	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			$ 56,000			$ 29,756	$ * (26,244)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	32.000%	ASTORIA PLACE LIVING AND REHABILITATION CENTER,LLC	CHICAGO				1
2	JACK RAJCHENBACH	15.000%	ELMBROOK NURSING,LLC	ELMHURST	LEGACY REAL PROPERTIES , L	LINCOLNWOOD	BUILDING CO	2
3	JAMIE DLATT	3.000%	THE GROVE NORTH LIVING AND REHAB CENTER,LLC	SKOKIE	LEGACY HEALTHCARE & FINA	LINCOLNWOOD	HOME OFFICE / BOOKK	3
4	MENACHEM SHABAT	32.000%	THE GROVE OF EVANSTON,LLC	EVANSTON				4
5	RONALD SHABAT	15.000%	THE GROVE AT LINCOLN PARK LIVING AND REHAB CENTER,LLC	CHICAGO				5
6	YAIR ZUCKERMAN	3.000%	LAKEFRONT NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO				6
7			PARK VILLA NURSING AND REHABILITATION CENTER,LLC	MELROSE PARK				7
8			PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO				8
9			WINDSOR PARK	CHICAGO				9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

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

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

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	Chaim Rajchenbach	Owner	Administrative	32.00%	See Attached	3	6.00%	Al Mgmt Fee	$ 12,000	17-7	1
2	Menachem Shabat	Owner	Administrative	32.00%	See Attached	3	6.00%	Al Mgmt Fee	12,000	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10	Where applicable, the amounts on this page have been adjusted from the actual costs to reflect										10
11	only those amounts anticipated to be considered allowable by the IL Dept. of HFS.										11
12											12
13								TOTAL	$ 24,000		13

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

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

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X]

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	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	AVAIL. BED DAYS	590,233	12	$ 890	$	47,815	$ 72	1
2	3	HOUSEKEEPING	AVAIL. BED DAYS	590,233	12	9,370	9,260	47,815	759	2
3	5	UTILITIES	AVAIL. BED DAYS	590,233	12	19,367		47,815	1,569	3
4	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	590,233	12	45,083	9,228	47,815	3,652	4
5										5
6	19	PROFESSIONAL FEES	AVAIL. BED DAYS	590,233	12	34,648		47,815	2,807	6
7	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	590,233	12	493		47,815	40	7
8	21	CLERICAL & GENERAL	AVAIL. BED DAYS	590,233	12	910,553	832,276	47,815	73,764	8
9	24	SEMINARS	AVAIL. BED DAYS	590,233	12	3,552		47,815	288	9
10	26	INSURANCE	AVAIL. BED DAYS	590,233	12	3,535		47,815	286	10
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	590,233	12	213,280		47,815	17,278	11
12	30	DEPRECIATION	AVAIL. BED DAYS	590,233	12	5,774		47,815	468	12
13	32	INTEREST	AVAIL. BED DAYS	590,233	12	62		47,815	5	13
14	34	RENT	AVAIL. BED DAYS	590,233	12	137,855		47,815	11,168	14
15										15
16	17	MANAGEMENT FEES- C. RAJ	AVG HOURS WKD	50	11	200,000		3	12,000	16
17	17	MANAGEMENT FEES- M. SHA	AVG HOURS WKD	50	11	200,000		3	12,000	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,784,461	$ 850,764		$ 136,156	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	1 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	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	590,233	12	250		47,815	20	1
2	30	DEPRECIATION	AVAIL. BED DAYS	590,233	12	52,340		47,815	4,240	2
3	32	INTEREST EXPENSE	AVAIL. BED DAYS	590,233	12	51,132		47,815	4,142	3
4	33	REAL ESTATE TAXES	AVAIL. BED DAYS	590,233	12	47,377		47,815	3,838	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					$ 151,099	$		$ 12,241	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	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	10	RN SALARY	AVAIL. BED DAYS	465,768	10	265,681	265,681	47,815	27,274	1
2	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	465,768	10	21,767		47,815	2,235	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	465,768	10	1,681		47,815	173	3
4	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	465,768	10	250		47,815	26	4
5	21	CLERICAL & GENERAL	AVAIL. BED DAYS	465,768	10	472		47,815	48	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					$ 289,851	$ 265,681		$ 29,756	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	Mortgage			$	$ 6,470,575			$ 76,840	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Private Bank		X	Line of Credit				1,159,195			37,677	6
7	Insurance Financing		X								1,777	7
8	See Supplemental Schedule										5,625	8
9	TOTAL Facility Related						$	$ 7,629,770			$ 121,919	9
	B. Non-Facility Related*											
10	Interest Income		X								(70)	10
11	Interest Income - Bldg. Co.		X								(2)	11
12	Alloc. From Legacy Healthcare		X								5	12
13	See Supplemental Schedule										4,142	13
14	TOTAL Non-Facility Related						$	$			$ 4,075	14
15	TOTALS (line 9+line14)						$	$ 7,629,770			$ 125,994	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** 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							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Private Bank		X	CapEx			$	$			$ 5,625	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										5,625	14
	B. Non-Facility Related*											
15	Allocated from Legacy Real Properties						$	$			$ 4,142	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related										4,142	20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grove Of Lagrange Park # 0050443 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 186,436	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.)		$ 202,808	2
3. Under or (over) accrual (line 2 minus line 1).		$ 16,372	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 204,939	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.**		$ 14,712	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 236,022	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006		8
2007		9
2008	215,952	10
2009	181,479	11
2010	198,970	12

2011 Accrual = $198,970 x 1.03 = $204,939

Allocated from Legacy Real Properties = $3,838

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grove Of Lagrange Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050443

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-33-128-010-0000	Long Term Care Property	$ 79,815.61	$ 79,815.61
2.	15-33-128-011-0000	Long Term Care Property	$ 119,154.16	$ 119,154.16
3.	10-35-104-076-0000	Home Office Allocation	$ 40,915.78	$ 3,314.60
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 239,885.55	$ 202,284.37

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grove Of Lagrange Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050443

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

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

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,000 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

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? [X] (a) Own the Equipment [ ] (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).

None

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	43,000	2011	$ 750,000	1
2	Allocated from Legacy Real Properties, LLC			6,628	2
3	TOTALS	43,000		$ 756,628	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	131		2011	1975	$ 3,282,000	$	39	$ 84,154	$ 84,154	$ 17,532	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		101,980	2,837		4,155	1,318	7,507	68
69	Financial Statement Depreciation			82,706			(82,706)		69
70	TOTAL (lines 4 thru 69)		$ 3,383,980	$ 85,543		$ 88,309	$ 2,766	$ 25,039	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 Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,383,980	$ 85,543		$ 88,309	$ 2,766	$ 25,039	1
2	Satellite And Cable	2009	27,500		20	1,375	1,375	3,667	2
3	Painting	2009	10,830		20	542	542	1,444	3
4	Updating And Painting	2009	10,200		20	510	510	1,318	4
5	Satellite And Cable	2009	2,721		20	136	136	340	5
6	Sign	2009	10,216		20	681	681	1,703	6
7	Hvac	2009	9,200		20	460	460	1,188	7
8	Smoking Shelter	2009	9,120		20	456	456	1,216	8
9	Install Backflow Preventer	2009	3,167		20	158	158	396	9
10	Nurses Stations,Corridor, Dining Room, Wall Covering	2009	34,900		20	1,745	1,745	4,072	10
11	Plumbing	2009	3,424		20	171	171	399	11
12	Irrigation System	2009	11,500		20	767	767	1,789	12
13	Hvac	2009	18,563		20	928	928	2,243	13
14	Kitchen Improvements- Tiles, Wall Base, Wall Work	2009	9,020		20	451	451	1,015	14
15	Kitchen Improvements- Electrical, Hvac, Grease Trap	2009	18,066		20	903	903	1,957	15
16	Architectual Fees	2009	3,613		20	181	181	421	16
17	Plumbing Repairs	2009	4,534		20	227	227	529	17
18	Architectual Fees	2009	7,392		20	370	370	832	18
19	Security System	2009	10,912		20	1,559	1,559	3,248	19
20	Door Repairs	2009	5,584		20	279	279	628	20
21	Fire Dampers	2009	5,115		20	256	256	490	21
22	Smoking Tent	2009	3,469		20	173	173	332	22
23	Working Drawings	2009	7,000		20	700	700	758	23
24	Nurses Station , Corridor, Dining Room, Wall Covering	2009	34,900		20	1,745	1,745	3,635	24
25	Nurses Station, Corridor, Dining Room, Wall Covering	2009	66,679		20	3,334	3,334	6,946	25
26	Landscaping	2010	11,350		20	568	568	1,135	26
27	2Nd Flr Nurses Station Cabinetry	2010	14,166		20	708	708	1,358	27
28	Reception Area - Cabinet/Desk/Granite	2010	8,500		20	1,700	1,700	3,258	28
29	Hot Water-New Valves/Motor/Pump	2010	2,666		20	133	133	244	29
30	Painting	2010	13,000		20	650	650	1,138	30
31	Plumbing	2010	5,869		20	293	293	514	31
32	Carpeting - 3Rd Flr	2010	8,806		20	440	440	660	32
33	Hot Water/Mixing Valve	2010	3,980		20	796	796	1,194	33
34	TOTAL (lines 1 thru 33)		$ 3,779,941	$ 85,543		$ 111,704	$ 26,161	$ 75,106	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,779,941	$ 85,543		$ 111,704	$ 26,161	$ 75,106	1
2	Carpeting -21 Bedrooms	2010	18,293		20	915	915	1,372	2
3	Landscaping	2010	6,500		20	325	325	460	3
4	Window Treatments	2010	5,459		20	273	273	318	4
5	Plumbing Install	2010	11,000		20	550	550	596	5
6	Alarm System	2010	2,947		20	147	147	172	6
7	Smoke And Fire Damper Repair	2010	3,100		20	155	155	310	7
8	Booster Pump System	2011	12,000		20	550	550	550	8
9	Patch & Repair Walls & Ceiling In 66 Resident Rooms	2011	2,640		20	110	110	110	9
10	Install Tiles/Sinks/Walling/Prime/Paint In Kitchen Area	2011	3,522		20	147	147	147	10
11	Install Security System On 3Rd Floor	2011	4,500		20	536	536	536	11
12	Install Wall Scones & New Switches To Control Scones	2011	15,180		20	2,530	2,530	2,530	12
13	Custom Built In Cabinets/Footboards/Headboards	2011	3,600		20	600	600	600	13
14	Metal Studs, Screws, Drywall, Metal Door, Windows	2011	5,325		20	200	200	200	14
15	Install Metal Door & New Window/ Drywall, Prime And Paint/Ne	2011	7,920		20	297	297	297	15
16	Electrical & Lighting - Outlets/Switches/Fluorescent Fixture In Ba	2011	2,830		20	94	94	94	16
17	Patch & Repair Damage Wall In 1St Fl Resident Rm. & Installed	2011	4,224		20	141	141	141	17
18	Installed 110 Cable Tv Jacks & Duplex Outlets/Reinstalled Tv Bra	2011	16,500		20	550	550	550	18
19	Installation Of Window Treatments In 2Nd Fl Dining Rm & Resid	2011	5,799		20	169	169	169	19
20	Painting - Patch, Prep, & Paint 20 Rooms On 2Nd Floor/Reinsitall	2011	10,500		20	306	306	306	20
21	Remove & Install Wall Tiles/Reinstall Plumbing Fictures/Paint W	2011	9,600		20	280	280	280	21
22	Remove & Install Wall Tiles/Reinstall Plumbing Fictures/Paint W	2011	9,600		20	280	280	280	22
23	Installed Additional 17 Duplex Outlets & Tv Jacks/Reinstalled Tv	2011	2,890		20	72	72	72	23
24	Remove Wallpaper, Patch, And Prime Walls/Paint Walls & Ceilin	2011	5,325		20	133	133	133	24
25	Painting - Patch, Prep, & Paint 20 Rooms On 3Rd Floor/Reinsitall	2011	10,500		20	44	44	44	25
26	Installation Of Acrylic Wall Mount Signs	2011	7,325		20	366	366	366	26
27	Built Partition Wall In Garage/Installed Metal Door	2011	4,750		20	238	238	238	27
28	Tv Cable Installation	2011	5,000		20	250	250	250	28
29	West Passenger Elevator Repairs	2011	3,165		20	158	158	158	29
30	Prep & Paint Walls	2011	5,300		20	265	265	265	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,985,235	$ 85,543		$ 122,385	$ 36,842	$ 86,650	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,985,235	$ 85,543		$ 122,385	$ 36,842	$ 86,650	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,985,235	$ 85,543		$ 122,385	$ 36,842	$ 86,650	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,985,235	$ 85,543		$ 122,385	$ 36,842	$ 86,650	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,985,235	$ 85,543		$ 122,385	$ 36,842	$ 86,650	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$	$		$	$	$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Legacy Real Properties	2009	51,349	1,678	30	1,712	34	4,279	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Legacy Real Properties	2009	29,161	672	20	1,458	786	2,066	9
10	Allocated from Legacy Real Properties	2010	8,867	209	20	355	146	532	10
11	Allocated from Legacy Real Properties	2011	12,603	278	20	630	352	630	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 101,980	$ 2,837		$ 4,155	$ 1,318	$ 7,507	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 499,575	$ 1,871	$ 17,275	$ 15,404	10	$ 57,237	71
72	Current Year Purchases	29,696		2,770	2,770	10	2,770	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 529,271	$ 1,871	$ 20,045	$ 18,174		$ 60,007	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,271,134	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 87,414	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 142,429	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 55,015	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 146,657	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
   If NO, see instructions.

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 450 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

   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 Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	39 - 03	hrs	$		$ 282,485	$		$ 282,485	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			113,068			113,068	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			311,704			311,704	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				277,339		277,339	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					56,657	14,823		71,480	13
14	TOTAL			$		$ 763,914	$ 292,162		$ 1,056,076	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 Of Lagrange Park # 0050443 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/11 (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	$ 32	$ 124,892	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,909,163	2,909,163	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	35,498	35,498	6
7	Other Prepaid Expenses		76,794	7
8	Accounts Receivable (owners or related parties)	47,931	47,931	8
9	Other(specify): See Attached Schedule	77,575	230,186	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,070,199	$ 3,424,464	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		750,000	13
14	Buildings, at Historical Cost		3,282,000	14
15	Leasehold Improvements, at Historical Cost	539,285	539,285	15
16	Equipment, at Historical Cost	212,160	612,160	16
17	Accumulated Depreciation (book methods)	(156,930)	(156,930)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		1,725,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 594,515	$ 6,751,515	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,664,714	$ 10,175,979	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 851,478	$ 851,478	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	253,326	253,326	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,038	18,038	31
32	Accrued Real Estate Taxes(Sch.IX-B)		204,939	32
33	Accrued Interest Payable	4,609	40,197	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	345,370	345,370	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,472,821	$ 1,713,348	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,159,195	1,159,195	39
40	Mortgage Payable		6,470,575	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,159,195	$ 7,629,770	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,632,016	$ 9,343,118	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,032,698	$ 832,861	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,664,714	$ 10,175,979	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Grove Of Lagrange Park **#** 0050443 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (95,436)	1
2	Restatements (describe):		2
3	**Late Entries - Old Payables & Allowance for Bad Debts**	47,079	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (48,357)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,081,055	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)**	$ 1,081,055	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,032,698	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 7,754,493	1
2	Discounts and Allowances for all Levels	(530,866)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,223,627	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,098,356	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,098,356	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	257,609	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	32,417	20
21	Other Medical Services	2,777	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 292,803	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	70	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 70	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	19,575	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 19,575	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,634,431	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,085,904	31
32	Health Care	2,644,487	32
33	General Administration	2,037,405	33
	B. Capital Expense		
34	Ownership	652,781	34
	C. Ancillary Expense		
35	Special Cost Centers	1,061,076	35
36	Provider Participation Fee	71,723	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,553,376	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,081,055	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,081,055	43

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

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

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

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

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	1,880	2,016	$ 82,849	$ 41.10	1
2	Assistant Director of Nursing	720	760	21,446	28.22	2
3	Registered Nurses	10,353	12,473	384,452	30.82	3
4	Licensed Practical Nurses	24,311	29,647	795,329	26.83	4
5	CNAs & Orderlies	58,483	68,803	807,010	11.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,913	4,555	81,081	17.80	8
9	Activity Director	1,792	1,913	28,610	14.96	9
10	Activity Assistants	5,725	6,405	61,739	9.64	10
11	Social Service Workers	2,112	2,152	54,997	25.56	11
12	Dietician					12
13	Food Service Supervisor	2,064	2,200	47,103	21.41	13
14	Head Cook	2,295	2,464	39,297	15.95	14
15	Cook Helpers/Assistants	13,006	14,101	152,626	10.82	15
16	Dishwashers					16
17	Maintenance Workers	2,040	2,192	30,651	13.98	17
18	Housekeepers	15,950	17,784	192,884	10.85	18
19	Laundry	5,845	6,504	77,610	11.93	19
20	Administrator	2,429	2,557	128,139	50.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,628	7,412	84,822	11.44	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	1,680	1,828	23,919	13.08	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	161,226	185,766	$ 3,094,564 *	$ 16.66	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	186	$ 11,909	01-03	35
36	Medical Director	Monthly	21,000	09-03	36
37	Medical Records Consultant	Monthly	1,928	10-03	37
38	Nurse Consultant	Monthly	56,311	10-03	38
39	Pharmacist Consultant	Monthly	6,328	10-03	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	3,170	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	186	$ 100,646		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	176	$ 8,767	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	176	$ 8,767		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Patricia Long	Administrator	0.00%	$ 128,139
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 128,139

B. Administrative - Other

Description	Amount
Legacy Healthcare	$ 435,919
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 435,919

C. Professional Services

Vendor/Payee	Type	Amount
Legacy Healthcare	Bookkeeping	$ 210,000
Frost, Ruttenberg & Rothblatt	Accounting	48,500
See Attached	Legal	52,837
LTC Consulting	Medicare Billing Consltg	1,000
Personnel Planners, Inc.	Unemployment Consulting	2,315
IIT/Sourcetech	Computer Services	885
ML Enterprises	Purchasing Consultant	2,800
Pioneer Environmental Services	Environmental Study	4,000
Margaret Chizek	Healthcare Risk Mgmt	2,460
E-Health Data Solutions	Data Processing	2,694
Health Data Systems, Inc.	Data Processing	19,800
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 347,290

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 98,653
Unemployment Compensation Insurance	95,382
FICA Taxes	235,135
Employee Health Insurance	123,311
Employee Meals	11,607
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	24,620
Other Employee Benefits	4,173
Employee Physical Exams	4,266
TOTAL (agree to Schedule V, line 22, col.8)	$ 597,147

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

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	3,597
Health Care Worker Background Check	2,795
(Indicate # of checks performed 46)	
Patient Background Checks 140	
Dues & Subscriptions	12,886
Licenses & Fees	443
Advertising & Promotions	69,847
Allocated from Legacy Healthcare	40
See Supplemental Schedule	46
Less: Public Relations Expense	( )
Non-allowable advertising	(69,847)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,797

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,690
Allocated from Legacy Healthcare	288
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,978

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove Of Lagrange Park # 0050443 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grove Of Lagrange Park # 0050443 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC - $12,886**

(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. $ **19,747** Line **10**

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

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

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

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **71,723**
This amount is to be recorded on line 42 of Schedule V.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **11,607** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

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

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

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

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