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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0051615

Facility Name: CHALET LIVING & REHAB CTR

Address: 7350 N SHERIDAN RD (Number) CHICAGO (City) 60626 (Zip Code)

County: COOK

Telephone Number: (773) 274-1000 **Fax #** (773) 274-0153

HFS ID Number:

Date of Initial License for Current Owners: 10/01/11

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: SANFORD BOKOR **Telephone Number:** (847) 675-3585
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 01/01/2012 to 12/31/2012 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) MENACHEM SHABAT
(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) SANFORD BOKOR, PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 _____

	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	219	Skilled (SNF)	219	80,154	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	219	TOTALS	219	80,154	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	48,220	1,903	6,430	56,553	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,220	1,903	6,430	56,553	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.56%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
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 10 / 01 / 11

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/11/11 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 219 and days of care provided 6,110

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	367,955	25,881	11,536	405,372		405,372		405,372			1
2	Food Purchase		334,252		334,252	(36,509)	297,743	30	297,773			2
3	Housekeeping	166,756	67,840		234,596		234,596	1,354	235,950			3
4	Laundry	61,746	23,846		85,592		85,592		85,592			4
5	Heat and Other Utilities			184,098	184,098		184,098	1,962	186,060			5
6	Maintenance	154,777	64,265	191,681	410,723		410,723	3,201	413,924			6
7	Other (specify):*			29,212	29,212		29,212		29,212			7
8	TOTAL General Services	751,234	516,084	416,527	1,683,845	(36,509)	1,647,336	6,547	1,653,883			8
	B. Health Care and Programs											
9	Medical Director			39,600	39,600		39,600		39,600			9
10	Nursing and Medical Records	2,403,035	193,304	55,949	2,652,288		2,652,288	8,181	2,660,469			10
10a	Therapy	153,557	1,069		154,626		154,626		154,626			10a
11	Activities	97,877	8,215	7,410	113,502		113,502		113,502			11
12	Social Services	62,721		5,435	68,156		68,156	2,934	71,090			12
13	CNA Training											13
14	Program Transportation			14,870	14,870		14,870		14,870			14
15	Other (specify):*							1,921	1,921			15
16	TOTAL Health Care and Programs	2,717,190	202,588	123,264	3,043,042		3,043,042	13,036	3,056,078			16
	C. General Administration											
17	Administrative	222,132		690,857	912,989		912,989	(590,817)	322,172			17
18	Directors Fees											18
19	Professional Services			186,998	186,998		186,998	16,577	203,575			19
20	Dues, Fees, Subscriptions & Promotions			174,572	174,572		174,572	(160,099)	14,473			20
21	Clerical & General Office Expenses	183,175	39,912	258,451	481,538		481,538	(25,586)	455,952			21
22	Employee Benefits & Payroll Taxes			674,219	674,219	36,509	710,728		710,728			22
23	Inservice Training & Education			2,809	2,809		2,809		2,809			23
24	Travel and Seminar							246	246			24
25	Other Admin. Staff Transportation			1,950	1,950		1,950		1,950			25
26	Insurance-Prop.Liab.Malpractice			81,529	81,529		81,529	861	82,390			26
27	Other (specify):*			195,616	195,616		195,616	(163,211)	32,405			27
28	TOTAL General Administration	405,307	39,912	2,267,001	2,712,220	36,509	2,748,729	(922,029)	1,826,700			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,873,731	758,584	2,806,792	7,439,107		7,439,107	(902,446)	6,536,661			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: CHALET LIVING & REHAB CTR **#0051615** **Report Period Beginning: 01/01/2012** **Ending: 12/31/2012**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	11,536	
	REPAIRS & MAINTENANCE		0	
			0	11,536
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		57,530	
	ELECTRICITY		78,460	
	WATER		39,297	
	CABLE TV - LOBBY		8,811	
			0	184,098
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		21,528	
	PAINTING & DECORATING		4,109	
	BUILDING REPAIRS		15,653	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		47,459	
	ELEVATOR MAINTENANCE & REPAIR		16,475	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		5,708	
	FIRE SERVICE		10,147	
	PROPERTY SPECIALIST - LEGACY		70,602	
			0	
			0	
			0	191,681
7	**OTHER**			
	SCAVENGER		25,428	
	SECURITY SERVICE		3,784	
			0	
			0	29,212
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	39,600	39,600

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		15,377	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,512	
	PHARMACY CONSULTANT	XVIII B 39-2	8,060	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	NURSING	XVIII B 38-2	3,000	
	WOUND DIRECTOR		1,000	
	NURSING PROGRAM CONSULTANT		24,000	55,949
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	7,410	
			0	7,410
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	5,435	
				5,435
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number CHALET LIVING & REHAB CTR **#0051615** **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		14,870	14,870
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES & OTHER ADMIN FEES	XIX B	690,857	690,857
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	43,564	
	ADMINISTRATIVE CONSULTANTS	XIX C		
	PROFESSIONAL FEES	XIX C	143,434	
			0	186,998
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	61,923	
	EMPLOYEE WANT ADS	XIX F	932	
	CONTRIBUTIONS	VI 20 XIX F	97,496	
	DUES & SUBSCRIPTIONS	XIX F	6,523	
	LICENSES & PERMITS	XIX F	375	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,000	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,520	
	PATIENT BACKGROUND CHECKS	XIX F	4,803	
				174,572
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		12,907	
	AR FIELD COORDINATOR - LEGACY		15,626	
	OUTSIDE CLERICAL SERVICES		188,512	
	PENALTIES / OVERDRAFT CHARGES	VI 18	962	
	IN HOUSE COUNCIL		6,701	
	PURCHASE DIRECTOR		5,736	
	TELEPHONE		22,069	
	MESSENGER SERVICE		1,115	
	CORP IT DIRECTOR		4,823	258,451

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	289,704	
	UNEMPLOYMENT COMPENSATION	XIX D	104,527	
	WORKERS COMPENSATION INSURANC	XIX D	70,822	
	HOSPITALIZATION INSURANCE	XIX D	135,336	
	EMPLOYEE BENEFITS - OTHER	XIX D	23,097	
	EMPLOYEE PHYSICAL EXAMS	XIX D	8,460	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	26,209	
	CHICAGO HEAD TAX	XIX D	1,292	
	LEGACY'S PAYROLL TAXES		14,772	674,219
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,809	
				2,809
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		1,950	
				1,950
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		81,529	
				81,529
27	**OTHER**			
	BAD DEBTS	VI 24	195,616	
				195,616

GRAND TOTAL COLUMN 3 OTHER **2,806,792**

CHALET LIVING & REHAB CTR
SCHEDULES
12/31/2012

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	334,252
LESS SALES TAX	0
NET FOOD	334,252
TOTAL PATIENT CENSUS	56,553
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	169,659
ADD # EMPLOYEE MEALS/DAY	57
TIMES # DAYS	366
TOTAL EMPLOYEE MEALS	20,862
PATIENT MEALS	169,659
ADD EMPLOYEE MEALS	20,862
TOTAL MEALS/YEAR	190,521
NET FOOD	334,252
DIVIDE TOTAL MEALS/YEAR	190,521
COST PER MEAL	1.75
TIMES EMPLOYEE MEALS	20,862
EMPLOYEE MEAL RECLASSIFICATION	**36,509**

HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??

Facility Name & ID Number CHALET LIVING & REHAB CTR #0051615 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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			4,426	4,426		4,426	182,791	187,217			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			62,237	62,237		62,237	61,497	123,734			32
33	Real Estate Taxes					188,512	188,512	4,954	193,466			33
34	Rent-Facility & Grounds			1,475,702	1,475,702	(188,512)	1,287,190	73,512	1,360,702			34
35	Rent-Equipment & Vehicles			49,187	49,187		49,187	161	49,348			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,591,552	1,591,552		1,591,552	322,915	1,914,467			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		254,369	798,808	1,053,177		1,053,177		1,053,177			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			393,645	393,645		393,645		393,645			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		254,369	1,192,453	1,446,822		1,446,822		1,446,822			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,873,731	1,012,953	5,590,797	10,477,481		10,477,481	(579,531)	9,897,950			45

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(33,984)	30		9
10	Interest and Other Investment Income	(537)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(962)	21		18
19	Entertainment		20		19
20	Contributions	(98,496)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(195,616)	27		24
25	Fund Raising, Advertising and Promotional	(61,923)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(11,500)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (403,018)		$	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)	(176,513)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (176,513)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (579,531)		37

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

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

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

CHALET LIVING & REHAB CTR

ID# 0051615

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ (11,500)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				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**	(11,500)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CHALET LIVING & REHAB CTR **#** 0051615 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	30	0	0	0	0	0	0	0	0	30	2
3	Housekeeping	0	0	1,354	0	0	0	0	0	0	0	0	1,354	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,962	0	0	0	0	0	0	0	0	1,962	5
6	Maintenance	0	0	3,201	0	0	0	0	0	0	0	0	3,201	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	6,547	0	0	0	0	0	0	0	0	6,547	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	8,181	0	0	0	0	0	0	8,181	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	2,934	0	0	0	0	0	0	2,934	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	1,921	0	0	0	0	0	0	1,921	15
16	**TOTAL Health Care and Programs**	0	0	0	0	13,036	0	0	0	0	0	0	13,036	16
	C. General Administration													
17	Administrative	0	0	(620,737)	0	29,920	0	0	0	0	0	0	(590,817)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,878	7,504	0	195	0	0	0	0	0	0	16,577	19
20	Fees, Subscriptions & Promotions	(160,419)	250	70	0	0	0	0	0	0	0	0	(160,099)	20
21	Clerical & General Office Expenses	(12,462)	0	(13,455)	0	331	0	0	0	0	0	0	(25,586)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	246	0	0	0	0	0	0	0	0	246	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	861	0	0	0	0	0	0	0	0	861	26
27	Other (specify):*	(195,616)	0	32,405	0	0	0	0	0	0	0	0	(163,211)	27
28	**TOTAL General Administration**	(368,497)	9,128	(593,106)	0	30,446	0	0	0	0	0	0	(922,029)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(368,497)	9,128	(586,559)	0	43,482	0	0	0	0	0	0	(902,446)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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	(33,984)	212,568	1,397	2,810	0	0	0	0	0	0	0	182,791	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(537)	56,936	6	5,092	0	0	0	0	0	0	0	61,497	32
33	Real Estate Taxes	0	0	0	4,954	0	0	0	0	0	0	0	4,954	33
34	Rent-Facility & Grounds	0	73,512	14,938	(14,938)	0	0	0	0	0	0	0	73,512	34
35	Rent-Equipment & Vehicles	0	0	0	0	161	0	0	0	0	0	0	161	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(34,521)	343,016	16,341	(2,082)	161	0	0	0	0	0	0	322,915	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(403,018)	352,144	(570,218)	(2,082)	43,643	0	0	0	0	0	0	(579,531)	45

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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
CHAIM RAJCHENBACH	28.60	THE GROVE AT LINCOLN PARK	CHICAGO	GROVE HC PROP	CHICAGO	REAL ESTATE
MENCAHEM SHABAT	28.60	THE GROVE OF NORTHBROOK	CHICAGO	LEGACY HC		
JACK RAJCHENBACH FAMILY TRST	14.00	ASTORIA PLACE LIVING & REHAB CENTER	CHICAGO	FINANCIAL SERV	LINCOLNWOOD	MGMT
RONALD SHABAT	14.00	THE GROVE OF EVANSTON	EVANSTON	LEGACY REAL PRO	LINCOLNWOOD	REAL ESTATE
JAIME DLATT	5.00	ELMBROOK NURSING	ELMHURST	ASTORIA HEALTH		
YAIR ZUCKERMAN	5.00	PETERSON PARK	CHICAGO	CARE PROP	CHICAGO	REAL ESTATE
NATHAN DAVID	4.80	LAKEFRONT NURSING	CHICAGO	EVANSTON HC RLT	EVANSTON	REAL ESTATE

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	RENT	$ 1,287,190	THE CHALET REAL PROPERTY,LLC		$	$ (1,287,190)	1
2	V	19	PROFESSIONAL FEES		THE CHALET REAL PROPERTY,LLC		8,878	8,878	2
3	V	20	LICENSES AND FEES		THE CHALET REAL PROPERTY,LLC		250	250	3
4	V	30	DEPRECIATION		THE CHALET REAL PROPERTY,LLC		212,568	212,568	4
5	V	32	INTEREST		THE CHALET REAL PROPERTY,LLC		56,936	56,936	5
6	V	34	RENT		THE CHALET REAL PROPERTY,LLC		1,360,702	1,360,702	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,287,190			$ 1,639,334	$ * 352,144	14

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	$ 644,737	LEGACY HEALTHCARE FINANCIAL SERVICES LLC		$	$ (644,737)	15
16	V	21	OUTSIDE CLERICAL	188,512	LEGACY HEALTHCARE FINANCIAL SERVICES LLC			(188,512)	16
17	V	2	FOOD		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		30	30	17
18	V	3	HOUSEKEEPING		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		1,354	1,354	18
19	V	5	UTILITIES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		1,962	1,962	19
20	V	6	GROUNDS & MAINTENANCE		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		3,201	3,201	20
21	V	17	MANAGEMENT FEES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		24,000	24,000	21
22	V	19	PROFESSIONAL FEES		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		7,504	7,504	22
23	V	20	FEES,SUBSCRIPTIONS		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		70	70	23
24	V	21	CLERICAL & GENERAL		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		175,057	175,057	24
25	V	24	SEMINARS		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		246	246	25
26	V	26	INSURANCE		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		861	861	26
27	V	27	EMPL BENEFITS-GEN ADMIN		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		25,625	25,625	27
28	V	27	EMPL BENEFITS-OWNERS		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		6,780	6,780	28
29	V	30	DEPRECIATION		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		1,397	1,397	29
30	V	32	INTEREST		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		6	6	30
31	V	34	RENT		LEGACY HEALTHCARE FINANCIAL SERVICES LLC		14,938	14,938	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 833,249			$ 263,031	$ * (570,218)	39

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	34	RENT	$ 14,938	LEGACY REAL PROPERTIES LLC		$	$ (14,938)	15
16	V	30	DEPRECIATION		LEGACY REAL PROPERTIES LLC		2,810	2,810	16
17	V	32	INTEREST EXPENSE		LEGACY REAL PROPERTIES LLC		5,092	5,092	17
18	V	33	REAL ESTATE TAXES		LEGACY REAL PROPERTIES LLC		4,954	4,954	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			$ 14,938			$ 12,856	$ * (2,082)	39

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	NURSE CONSULTANT	$ 6,000	PROGRESSIVE HEALTHCARE CONSULTING		$	$ (6,000)	15
16	V	10	RN SALARIES		PROGRESSIVE HEALTHCARE CONSULTING		14,181	14,181	16
17	V	12	CLERGY SALARY		PROGRESSIVE HEALTHCARE CONSULTING		2,934	2,934	17
18	V	15	EMPLOYEE BENEFITS		PROGRESSIVE HEALTHCARE CONSULTING		1,921	1,921	18
19	V	17	ADMIN		PROGRESSIVE HEALTHCARE CONSULTING		29,920	29,920	19
20	V	19	PROFESSIONAL FEES		PROGRESSIVE HEALTHCARE CONSULTING		195	195	20
21	V	21	CLERICAL AND GENERAL		PROGRESSIVE HEALTHCARE CONSULTING		331	331	21
22	V	35	AUTO RENTAL		PROGRESSIVE HEALTHCARE CONSULTING		161	161	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 6,000			$ 49,643	$ * 43,643	39

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	PROPERTY SPECIALIST	$ 70,602	LEGACY HEALTHCARE FINANCIAL SERVICES		$ 70,602	$	15
16	V	21	AR FIELD COORDINATOR	15,626	LEGACY HEALTHCARE FINANCIAL SERVICES		15,626		16
17	V	21	IN-HOUSE CONSEL	6,701	LEGACY HEALTHCARE FINANCIAL SERVICES		6,701		17
18	V	21	PURCHASING DIRECTOR	5,736	LEGACY HEALTHCARE FINANCIAL SERVICES		5,736		18
19	V	21	CORPORATE IT DIRECTOR	4,823	LEGACY HEALTHCARE FINANCIAL SERVICES		4,823		19
20	V	22	PAYROLL TAXES	10,340	LEGACY HEALTHCARE FINANCIAL SERVICES		10,340		20
21	V	17	ADMINISTRATOR	46,120	PROGRESSIVE HEALTHCARE CONSULTING		46,120		21
22	V	22	PAYROLL TAXES	4,432	PROGRESSIVE HEALTHCARE CONSULTING		4,432		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			$ 164,380			$ 164,380	$ *	39

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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			THE GROVE OF LAGRANGE	LAGRANGE PARK	ELMBROOK			1
2			THE GROVE AT THE LAKE	ZION	HEALTHCARE RLT	ELMHURST	REAL ESTATE	2
3			THE GROVE OF SKOKIE	SKOKIE	PETERSON PK RLTY	CHICAGO	REAL ESTATE	3
4			PARK VILLA NURSING & REHAB	PALOS HEIGHTS	GROVE LAGRANGE			4
5			THE VILLA AT WINDSOR PARK	CHICAGO	REALTY	LAGRANGE PK	REAL ESTATE	5
6					GROVE AT THE			6
7					LAKE REALTY	ZION	REAL ESTATE	7
8					CHALET REAL			8
9					PROPERTY	CHICAGO	REAL ESTATE	9
10					PARK VILLA RLTY	PALOS HGTS	REAL ESTATE	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 CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	RELATIVE	Administrative	28.60	SEE ATTACHED			SALARY	$ 12,000	17-7	1
2								HEALTH INS	3,390	27-7	2
3											3
4	MENACHEM SHABAT	OWNER	Administrative	28.60	SEE ATTACHED			SALARY	12,000	17-7	4
5								HEALTH INS	3,390	27-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 30,780		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 CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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 FINANCIALS
Street Address: 7040 RIDGEWAY
City / State / Zip Code: LINCOLNWOOD ILL 60712
Phone Number: (847) 679-9797
Fax Number: (847) 679-3676

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	FOOD	Bed Days Available	716,018	13	$ 270	$	80,154	$ 30	1
2	3	HOUSEKEEPING	Bed Days Available	716,018	13	12,097		80,154	1,354	2
3	5	UTILITIES	Bed Days Available	716,018	13	17,526		80,154	1,962	3
4	6	GROUNDS & MAINTENANCE	Bed Days Available	716,018	13	28,596		80,154	3,201	4
5	17	MANAGEMENT FEES	WEIGHTED AVERAGE	100	13	400,000	400,000	6	24,000	5
6	19	PROFESSIONAL FEES	Bed Days Available	716,018	13	67,029		80,154	7,504	6
7	20	FEES,SUBSCRIPTIONS	Bed Days Available	716,018	13	625		80,154	70	7
8	21	CLERICAL & GENERAL	Bed Days Available	716,018	13	1,563,793		80,154	175,057	8
9	24	SEMINARS	Bed Days Available	716,018	13	2,200		80,154	246	9
10	26	INSURANCE	Bed Days Available	716,018	13	7,687		80,154	861	10
11	27	EMPL BENEFITS-GEN ADMIN	Bed Days Available	716,018	13	228,907		80,154	25,625	11
12	27	EMPL BENEFITS-OWNERS	Bed Days Available	100	13	113,000		6	6,780	12
13	30	DEPRECIATION	Bed Days Available	716,018	13	12,480		80,154	1,397	13
14	32	INTEREST	Bed Days Available	716,018	13	51		80,154	6	14
15	34	RENT	Bed Days Available	716,018	13	133,442		80,154	14,938	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,587,703	$ 400,000		$ 263,031	25

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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 LLC
Street Address: 7040 RIDGEWAY
City / State / Zip Code: LINCOLNWOOD ILL 60712
Phone Number: (847) 679-9797
Fax Number: (847) 679-3676

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	Bed Days Available	716,018	13	$ 25,098	$	80,154	$ 2,810	1
2	32	INTEREST EXPENSE	Bed Days Available	716,018	13	45,486		80,154	5,092	2
3	33	REAL ESTATE TAXES	Bed Days Available	716,018	13	44,250		80,154	4,954	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					$ 114,834	$		$ 12,856	25

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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: Prosgressive Healthcare Consulting
Street Address: 7040 RIDGEWAY
City / State / Zip Code: LINCOLNWOOD ILL 60712
Phone Number: (847) 679-9797
Fax Number: (847) 679-3676

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	RN SALARIES	Bed Days Available	498,858	9	$ 88,262	$ 88,262	80,154	$ 14,181	1
2	12	CLERGY SALARY	Bed Days Available	498,858	9	18,263	18,263	80,154	2,934	2
3	15	EMPLOYEE BENEFITS	Bed Days Available	498,858	9	11,955		80,154	1,921	3
4	17	ADMIN	Bed Days Available	498,858	9	186,212		80,154	29,920	4
5	19	PROFESSIONAL FEES	Bed Days Available	498,858	9	1,215		80,154	195	5
6	21	CLERICAL AND GENERAL	Bed Days Available	498,858	9	2,058		80,154	331	6
7	35	AUTO RENTAL	Bed Days Available	498,858	9	999		80,154	161	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					$ 308,964	$ 106,525		$ 49,643	25

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	PRIVATE BANK		X	LINE OF CREDIT	INT		2,000,000	620,000	9/29/2013		60,761	6
7	INSURANCE POLICY FIN		X	INS POLICY FINANCE							1,476	7
8												8
9	TOTAL Facility Related						$ 2,000,000	$ 620,000			$ 62,237	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,000,000	$ 620,000			$ 62,237	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # 36

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

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	RELATED PARTY:						$	$			$	1
2	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN							5,000	2
3	PRIVATE BANK		X	CAPITAL EXPENDITURES	INT ONLY			976,554	9/30/2013		51,936	3
4												4
5											5,098	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 976,554			$ 62,034	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 976,554			$ 62,034	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # 36

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

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007		8
	2008		9
	2009		10
	2010		11
	2011	193,231	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CHALET LIVING & REHAB CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0051615

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-29-314-026-0000	NURSING HOME	$ 6,030.72	$ 6,030.72
2.	11-29-314-027-0000	NURSING HOME	$ 5,095.68	$ 5,095.68
3.	11-29-314-028-0000	NURSING HOME	$ 88,812.53	$ 88,812.53
4.	11-29-314-029-0000	NURSING HOME	$ 88,572.84	$ 88,572.84
5.			$	$
6.	10-35-104-076-0000	HOME OFFICE ALLOCATION	$ 42,154.05	$ 4,718.90
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 230,665.82	$ 193,230.67

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 ___X___ 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 76,920 B. General Construction Type: Exterior MASONRY Frame _____ Number of Stories 4 WITH BASEMENT

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

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

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

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] 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				$	1
2	ALLOC FR LEGACY RP		2009	9,158	2
3	TOTALS			$ 9,158	3

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2ND FLOOR BUILT IN NURSES STATION			2012	10,000	139	39	139		139	9
10	2nd floor built in cabinets for med room / nutrition room			2012	9,675	134	39	134		134	10
11	2ND FLOOR PAINTING			2012	84,566	8,457	5	8,457		8,457	11
12	2ND FLOOR LIGHTING			2012	15,030	209	39	209		209	12
13	2nd floor drop ceiling & cove lighting, crown molding			2012	24,600	342	39	342		342	13
14	2ND FLOOR RESILIENT FLOORING			2012	46,620	648	39	648		648	14
15	2ND FLOOR PANELS, ROOM DIVIDERS, LIGHT COVERS			2012	37,350	519	39	519		519	15
16	3RD FLOOR BUILT IN NURSES STATION			2012	10,000	139	39	139		139	16
17	3rd floor built in cabinets for med room / nutrition room			2012	9,675	134	39	134		134	17
18	3RD FLOOR PAINTING			2012	83,712	8,371	5	8,371		8,371	18
19	3RD FLOOR LIGHTING			2012	2,500	35	39	35		35	19
20	3RD FLOOR BATHROOM REMODELING			2012	19,500	271	39	271		271	20
21	3RD FLOOR RESILIENT FLOORING			2012	46,620	647	39	647		647	21
22	INSTALL 76 OUTLETS ON THE 3RD FLOOR			2012	5,490	76	39	76		76	22
23	3RD FLOOR ELECTRICAL WORK			2012	3,235	45	39	45		45	23
24	3RD FLOOR DROP CEILING / CROWN MOLDING			2012	8,282	115	39	115		115	24
25	3RD FLOOR CABLE AND WIRING			2012	8,325	116	39	116		116	25
26	SECURITY WIRING			2012	6,150	85	39	85		85	26
27	CUBICLE TRACKS AND CURTAINS			2012	24,687	14,108	7	1,763	(12,345)	1,763	27
28	WALLCOVERINGS			2012	19,527	1,953	5	1,953		1,953	28
29	18 ELECTRICAL OUTLETS			2012	1,950	27	39	27		27	29
30	EXTERIOR SIGNAGE			2012	11,303	157	39	157		157	30
31	SPRINKLERS ELEVATOR ROOM & SHAFT			2012	5,625	78	39	78		78	31
32	2ND & 3RD FLOOR DESIGNER FEE			2012	25,000	347	39	347		347	32
33	WANDER GUARD SECURITY SYSTEM			2012	32,619	453	39	453		453	33
34	3RD FLOOR RENOVATIONS			2012	6,565	91	39	91		91	34
35	Wiring & installation material for communication system			2012	8,345	116	39	116		116	35
36	2ND FLOOR RENOVATION			2012	22,730	316	39	316		316	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 CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	CABLE INSTALLATION	2012	$ 4,750	$ 15	39	$ 15	$	$ 15	37
38	ARCHITECT FEES	2012	8,944	29	39	29		29	38
39	1ST FLOOR ELECTRICAL & MECHANICAL ENGINEERING	2012	5,000	16	39	16		16	39
40	PLUMBING FOR SPRINKLER SYSTEM, CLEAN UP DRAIN	2012			39				40
41	LINE IN ROOM 220 AND 221, INSTALL CERAMIC TILES	2012			39				41
42	IN THREE HALLWAY BATHROOMS, REPAIR VINYL TILE	2012			39				42
43	IN THE ROOMS ON SECOND FLLOR, INSTALL DROP	2012			39				43
44	CEILING LIGHT FIXTURES ON THIRD FLOOR, REPAIR	2012			39				44
45	DROP CEILING ON THIRD FLOOR, INSTALL NEW ELEC-	2012			39				45
46	TRICAL OUTLETS FOR AIR FRESHENERS ON 2TH AND	2012			39				46
47	3RD FLOORS, REPLACE CONTROL BOX FOR EXHAUST	2012			39				47
48	ROOF FAN	2012	13,570	43	39	43		43	48
49	WOODWORK FOR FRONT DESK, COLUMNS, LIBRARY.	2012			39				49
50	AND TABLES	2012	5,000	16	39	16		16	50
51	SIGNAGE	2012	11,527	37	39	37		37	51
52	TILING FOR FIRST FLOOR LOBBY	2012	14,045	45	39	45		45	52
53	TILING IN THE SECOND FLOOR SHOWER ROOM	2012	5,046	16	39	16		16	53
54	walk in bath tub with plumbing in 2nd floor shower room	2012	4,477	14	39	14		14	54
55	elec work for dishwasher, light fixt for drop ceil(kitch + 4th floor)	2012	4,525	15	39	15		15	55
56	install toilets and sinks, tiles,electrical work and woodwork	2012	16,358	52	39	52		52	56
57	FIRE SPRINKLER SYSTEM AND DESIGN FEE	2012	10,500	34	39	34		34	57
58	flooring in 4th floor dining room and in shower room	2012	8912	29	39	29		29	58
59	WATER HEATER	2012	15290	49	39	49		49	59
60	FIRST FLOOR ELECTRIC (BARBER-SHOP, LIBRARY,								60
61	DOCTORS LUNCH ROOM, ADMINISTRATOR OFFICE,								61
62	OFFICE, 3 BATHROOMS. FOURTH FLOOR ELECTRIC-								62
63	ELECTRICAL OUTLETS, FIRE RATED DISCONNECT AND								63
64	TRASH 8 OLD LIGHT FIXTURES, PROVIDE AND INSTALL								64
65	1 ELECTRICAL OUTLETS AND LEVITON 20AMP 125V								65
66	DUPLEX RECEPTACLE, PROVIDE AND INSTALL 1 TV								66
67	OUTLETS. FOURTH FLOOR ELECTRIC- PROVIDE AND								67
68	INSTALL NEW 150 WATT LED LIGHTS FIXTURES. PROVIDE								68
69	AND INSTALL NEW LIGHTS COVER.	2012	14,350	46	39	46		46	69
70	TOTAL (lines 4 thru 69)		$ 731,975	$ 38,584		$ 26,239	$ (12,345)	$ 26,239	70

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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		$ 731,975	$ 38,584		$ 26,239	$ (12,345)	$ 26,239	1
2	4TH FLOOR NURSE STATION	2012	10,000	32	39	32		32	2
3	3rd floor bathroom mirrors, lights, and toilet paper holders	2012	3,124	10	39	10		10	3
4	WALK IN FREEZER	2012	8,349	27	39	27		27	4
5	SMOKE DETECTOR	2012	3,020	10	39	10		10	5
6	RAMP WALK AND LANDSCAPE WORK	2012	24,120	804	15	804		804	6
7	IRRIGATION SYSTEM	2012	20,900	697	15	697		697	7
8	3rd floor dining room drapes, rods,blinds,cornice boards,								8
9	and shades	2012	33,803	19,317	7	1,380	(17,937)	1,380	9
10	1st floor carpeting for conference room and dining room	2012	11,656	6,661	7	833	(5,828)	833	10
11	WALLCOVERINGS FOR FIRST FLOOR	2012	11,856	593	5	593		593	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 858,803	$ 66,735		$ 30,625	$ (36,110)	$ 30,625	34

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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		$ 858,803	$ 66,735		$ 30,625	$ (36,110)	$ 30,625	1
2									2
3									3
4	RELATED PARTY INFORMATION								4
5	BUILDINGS:								5
6	ALLOCATED FROM LEGACY RP	2009	70,957		30	1,317	1,317		6
7									7
8									8
9									9
10	LEASEDHOLD IMPROVEMENTS:								10
11	ALLOCATED FROM LEGACY RP	2009	40,296		20	326	326		11
12	ALLOCATED FROM LEGACY RP	2010	12,253		20	99	99		12
13	ALLOCATED FROM LEGACY RP	2011	17,416		20	141	141		13
14									14
15									15
16									16
17									17
18									18
19									19
20	ALLOCATED FROM LEGACY HEALTHCARE FINANCIAL	2012	3,192		20	243	243		20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,002,917	$ 66,735		$ 32,751	$ (33,984)	$ 30,625	34

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$ 29,631	$ 4,426	$ 4,426	$	5-10 YRS	$ 5,533	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	REL PARTY		147,915	147,915				74
75	TOTALS	$ 29,631	$ 152,341	$ 152,341	$		$ 5,533	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)	$ 1,041,706	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 219,076	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 185,092	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (33,984)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 36,158	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 CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		219	10/01/11	$ 1,475,702	7		3
4	Additions							4
5								5
6								6
7	TOTAL		219		$ 1,475,702 **			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: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning 10/1/11
    Ending 9/30/18

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

	Fiscal Year Ending	Annual Rent
12.	9/30/2013	$ ########
13.	9/30/2014	$ ########
14.	9/30/2015	$ ########

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: $ 49,187 Description: SEE SCHEDULE ATTACHED
    (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.

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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.

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 291,604	$		$ 291,604	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			164,313			164,313	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			342,891			342,891	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				254,369		254,369	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$ 798,808	$ 254,369		$ 1,053,177	14

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 (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	$ 188,517	$ 257,912	1
2	Cash-Patient Deposits	4,898	4,898	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (166,772))	3,688,562	3,688,562	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	96,532	96,532	6
7	Other Prepaid Expenses	96,861	96,861	7
8	Accounts Receivable (owners or related parties)	447,367		8
9	Other(specify): REPLACEMENT RESERVE		143,750	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,522,737	$ 4,288,515	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost		858,803	15
16	Equipment, at Historical Cost	29,631	277,682	16
17	Accumulated Depreciation (book methods)	(5,533)	(218,101)	17
18	Deferred Charges		8,750	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe opt dep/dep on asset		839,498	22
23	Other(specify): Security Deposit/lease costs	121,350	121,350	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 145,448	$ 1,887,982	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,668,185	$ 6,176,497	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,728,710	$ 1,890,657	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	620,000	1,596,554	29
30	Accrued Salaries Payable	194,591	194,591	30
31	Accrued Taxes Payable (excluding real estate taxes)	67,479	67,479	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO RELATED PARTY		98,647	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,610,780	$ 3,847,928	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,610,780	$ 3,847,928	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,057,405	$ 2,328,569	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,668,185	$ 6,176,497	48

*(See instructions.)

Facility Name & ID Number CHALET LIVING & REHAB CTR **#** 0051615 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 402,474	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 402,474	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,654,931	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)**	$ 1,654,931	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,057,405	24	*

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,760,748	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,760,748	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	344,342	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 344,342	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	537	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 537	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	PARKING INCOME	3,625	28
28a	DISCOUNTS EARNED	15,818	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 19,443	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,125,070	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,683,845	31
32	Health Care	3,043,042	32
33	General Administration	2,712,220	33
	B. Capital Expense		
34	Ownership	1,591,552	34
	C. Ancillary Expense		
35	Special Cost Centers	1,053,177	35
36	Provider Participation Fee	393,645	36
	D. Other Expenses (specify):		
37	OTHER EXPENSE ADJUSTMENTS	(7,342)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,470,139	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,654,931	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,654,931	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,118,362	44
45	Private Pay - Net Inpatient Revenue	341,043	45
46	Medicare - Net Inpatient Revenue	3,235,038	46
47	Other-(specify) INSURANCE	66,305	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,760,748	49

****TAX RETURN PREPARED ON CASH BASIS**

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO** If not, please attach a reconciliation.**

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

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	1,928	1,988	$ 103,024	$ 51.82	1
2	Assistant Director of Nursing	1,714	1,799	68,595	38.13	2
3	Registered Nurses	32,199	32,870	955,771	29.08	3
4	Licensed Practical Nurses	17,834	18,490	457,181	24.73	4
5	CNAs & Orderlies	68,275	71,298	704,176	9.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,752	11,069	153,557	13.87	8
9	Activity Director	1,646	1,825	26,540	14.54	9
10	Activity Assistants	6,180	6,531	71,337	10.92	10
11	Social Service Workers	5,639	5,762	62,721	10.89	11
12	Dietician	3,437	3,543	76,464	21.58	12
13	Food Service Supervisor	5,733	5,963	72,091	12.09	13
14	Head Cook	5,722	5,918	68,835	11.63	14
15	Cook Helpers/Assistants	8,027	8,657	88,484	10.22	15
16	Dishwashers	6,064	6,597	62,081	9.41	16
17	Maintenance Workers	13,257	14,082	154,777	10.99	17
18	Housekeepers	16,613	17,534	166,756	9.51	18
19	Laundry	5,862	6,334	61,746	9.75	19
20	Administrator	2,492	2,549	112,958	44.31	20
21	Assistant Administrator	2,866	2,971	109,174	36.75	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,507	9,899	132,137	13.35	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	2,297	2,392	55,037	23.01	31
32	Other Health C: Care Plan,Ward cl	2,473	2,576	59,251	23.00	32
33	Other(specify) Admitting	2,042	2,091	51,038	24.41	33
34	TOTAL (lines 1 - 33)	232,559	242,738	$ 3,873,731 *	$ 15.96	34

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

** See instructions.

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	206	$ 11,536	1-3	35
36	Medical Director	MONTHLY	39,600	9-3	36
37	Medical Records Consultant	MONTHLY	4,512	10-3	37
38	Nurse Consultant	MONTHLY	3,000	10-3	38
39	Pharmacist Consultant	MONTHLY	8,060	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		7,410	11-3	44
45	Social Service Consultant	90	5,435	12-3	45
46	Other(specify) Nursing Program con	MONTHLY	24,000	10-3	46
47	Wound director		1,000	10-3	47
48					48
49	TOTAL (lines 35 - 48)	296	$ 104,553		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
WILLIAM PFEIFFER	ADMINISTRATOR		$ 111,958
AMBREEN QURESHI	ADMINISTRATOR		1,000
JAMES DLATT	ASST ADMIN	5	8,157
MORDECHAI POLSTEIN	ASST ADMIN		80,237
ARMAND STERN	ASST ADMIN		12,623
YAIR ZUCKERMAN	ASST ADMIN	5	8,157
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 222,132

B. Administrative - Other

Description	Amount
LEGACY HEALTHCARE	$ 690,857
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 690,857

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		186,998
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 186,998

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,822
Unemployment Compensation Insurance	104,527
FICA Taxes	289,704
Employee Health Insurance	135,336
Employee Meals	36,509
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	23,097
EMPLOYEE PHYSICAL EXAMS	8,460
PENSION/PROFIT SHARING PLANS	26,209
CHICAGO HEAD TAX	1,292
INSURANCE - EXECUTIVE LIFE	0
LEGACY PAYROLL - TAX	14,772
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 710,728

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	$
Advertising: Employee Recruitment	932
Health Care Worker Background Check	1,520
(Indicate # of checks performed 152)	
Patient Background Checks 101	4,803
TRUST/FRANCHISE/CONTRIB/ETC	98,496
MARKETING/ADV/PROMO	61,923
LICENSES/DUES/SUBSCRIPTIONS	6,898
RELATED PARTY	320
TRUST/FRANCHISE/CONTRIB/ETC	(98,496)
Less: Public Relations Expense	(0)
Non-allowable advertising	(61,923)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,473

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
REL PARTY	246
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 246

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

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

Facility Name & ID Number CHALET LIVING & REHAB CTR # 0051615 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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. **ill council long term care $300**

(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?

(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 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **6,921** Line **10-2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **393,645**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **36,509** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(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. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

(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.