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: 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 01/01/12 to 12/31/12 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) Kimberley A. Waite, 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: 01/01/12 Ending: 12/31/12

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	47,946	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	47,946	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	4,207	682	10,077	14,967	8
9	SNF/PED					9
10	ICF	22,091	2,417	485	24,992	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,298	3,099	10,562	39,959	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.34%

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 8,666

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

* 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: 01/01/12 Ending: 12/31/12

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	235,900	15,645	17,687	269,232		269,232		269,232			1
2	Food Purchase		219,368		219,368	(12,590)	206,778	(15,911)	190,866			2
3	Housekeeping	173,823	27,695	376	201,894		201,894	810	202,704			3
4	Laundry	102,147	19,669		121,816		121,816		121,816			4
5	Heat and Other Utilities			116,057	116,057		116,057	(4,011)	112,046			5
6	Maintenance	45,987		125,064	171,051		171,051	18,599	189,650			6
7	Other (specify):*											7
8	TOTAL General Services	557,857	282,377	259,184	1,099,418	(12,590)	1,086,828	(514)	1,086,314			8
	B. Health Care and Programs											
9	Medical Director			23,000	23,000		23,000		23,000			9
10	Nursing and Medical Records	2,262,558	184,641	71,681	2,518,880		2,518,880	(84,060)	2,434,820			10
10a	Therapy	99,165			99,165		99,165		99,165			10a
11	Activities	108,393	8,995		117,388		117,388		117,388			11
12	Social Services	55,224			55,224		55,224	1,755	56,979			12
13	CNA Training											13
14	Program Transportation			21,435	21,435		21,435		21,435			14
15	Other (specify):*							1,149	1,149			15
16	TOTAL Health Care and Programs	2,525,340	193,636	116,116	2,835,092		2,835,092	(81,156)	2,753,936			16
	C. General Administration											
17	Administrative	131,782		24,000	155,782		155,782	17,897	173,679			17
18	Directors Fees											18
19	Professional Services			341,037	341,037	(14,515)	326,522	(216,391)	110,131			19
20	Dues, Fees, Subscriptions & Promotions			183,025	183,025		183,025	(159,948)	23,077			20
21	Clerical & General Office Expenses	108,581	3,019	231,480	343,080		343,080	(56,978)	286,102			21
22	Employee Benefits & Payroll Taxes			637,377	637,377	12,590	649,967		649,967			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,179	2,179		2,179	(317)	1,862			24
25	Other Admin. Staff Transportation			4,196	4,196		4,196		4,196			25
26	Insurance-Prop.Liab.Malpractice			86,136	86,136		86,136	515	86,651			26
27	Other (specify):*							22,108	22,108			27
28	TOTAL General Administration	240,363	3,019	1,509,430	1,752,812	(1,925)	1,750,887	(393,115)	1,357,773			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,323,560	479,032	1,884,730	5,687,322	(14,515)	5,672,807	(474,784)	5,198,023			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: 01/01/12 Ending: 12/31/12

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			180,530	180,530		180,530	11,521	192,051			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			28,761	28,761		28,761	396,531	425,292			32
33	Real Estate Taxes					14,515	14,515	267,879	282,394			33
34	Rent-Facility & Grounds			900,000	900,000		900,000	(900,000)				34
35	Rent-Equipment & Vehicles			6,639	6,639		6,639	96	6,735			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,115,930	1,115,930	14,515	1,130,445	(223,972)	906,473			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		347,300	873,803	1,221,103		1,221,103		1,221,103			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			268,268	268,268		268,268		268,268			42
43	Other (specify):*			587,584	587,584		587,584	(587,584)				43
44	**TOTAL Special Cost Centers**		347,300	1,729,655	2,076,955		2,076,955	(587,584)	1,489,371			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,323,560	826,332	4,730,315	8,880,207		8,880,207	(1,286,340)	7,593,867			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: 01/01/12 Ending: 12/31/12

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	(5,185)	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	(75,150)	30		9
10	Interest and Other Investment Income	(98)	32		10
11	Discounts, Allowances, Rebates & Refunds	(15,759)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(170)	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	(508)	21		18
19	Entertainment				19
20	Contributions	(99,400)	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	(150,030)	21		24
25	Fund Raising, Advertising and Promotional	(53,866)	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	(714,095)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,114,260)		$	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)	(172,080)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (172,080)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,286,340)		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: 01/01/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	COPE Dues	$ (6,724)	20	1
2	Veterans' Pharmacy	(47,816)	10	2
3	Patient Personal Items	(2,727)	10	3
4	Bank Charges	(8,053)	21	4
5	Other Refunds	(3,300)	21	5
6	Non-Allowable Legal	(6,899)	19	6
7	Building Co. - Bank Service Charges	(50,533)	21	7
8	Building Co. - Processing Fee - RE Tax Online	(4)	19	8
9	Building Co. - Licenses & Fees	(309)	20	9
10	Building Co. - Amortization	(12,286)	36	10
11	Building Co. - Accounting Fees	(2,000)	19	11
12	Building Co. - Legal Fees	(1,430)	19	12
13	Building Co. - State Income Taxes	(650)	21	13
14	Non-Allowable Seminar	(464)	24	14
15	Additional R&M	16,684	06	15
16	Non-Allowable Expense	(587,584)	43	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**	(714,095)		49

Grove Of Lagrange Park

ID# 0050443

Report Period Beginning: 01/01/12

Ending: 12/31/12

	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:** 01/01/12 **Ending:** 12/31/12

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	(15,929)		18									(15,911)	2
3	Housekeeping			810									810	3
4	Laundry													4
5	Heat and Other Utilities	(5,185)		1,174									(4,011)	5
6	Maintenance	16,684		1,915									18,599	6
7	Other (specify):*													7
8	**TOTAL General Services**	(4,430)		3,917									(514)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(50,543)				(33,517)							(84,060)	10
10a	Therapy													10a
11	Activities													11
12	Social Services					1,755							1,755	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					1,149							1,149	15
16	**TOTAL Health Care and Programs**	(50,543)				(30,613)							(81,156)	16
	C. General Administration													
17	Administrative					17,897							17,897	17
18	Directors Fees													18
19	Professional Services	(10,333)	3,434	(209,610)		117							(216,391)	19
20	Fees, Subscriptions & Promotions	(160,299)	309	42									(159,948)	20
21	Clerical & General Office Expenses	(213,074)	51,183	104,715		198							(56,978)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(464)		147									(317)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			515									515	26
27	Other (specify):*			22,108									22,108	27
28	**TOTAL General Administration**	(384,170)	54,926	(82,083)		18,212							(393,115)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(439,143)	54,926	(78,166)		(12,401)							(474,784)	29

STATE OF ILLINOIS

Summary B

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

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	(75,150)	84,154	836	1,681								11,521	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(98)	393,580	3	3,046								396,531	32
33	Real Estate Taxes		264,916		2,963								267,879	33
34	Rent-Facility & Grounds		(900,000)	8,936	(8,936)								(900,000)	34
35	Rent-Equipment & Vehicles					96							96	35
36	Other (specify):*	(12,286)	12,286											36
37	**TOTAL Ownership**	(87,534)	(145,064)	9,775	(1,246)	96							(223,972)	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):*	(587,584)											(587,584)	43
44	**TOTAL Special Cost Centers**	(587,584)											(587,584)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,114,260)	(90,138)	(68,391)	(1,246)	(12,305)							(1,286,340)	45

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

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	$ 900,000	Grove of Lagrange Healthcare Properties, LLC		$	$ (900,000)	1
2	V	32	Interest	47	Grove of Lagrange Healthcare Properties, LLC		393,627	393,580	2
3	V	21	Bank Service Charges		Grove of Lagrange Healthcare Properties, LLC		50,533	50,533	3
4	V	19	Processing Fee - RE Tax Online		Grove of Lagrange Healthcare Properties, LLC		4	4	4
5	V	20	Licenses and Permits		Grove of Lagrange Healthcare Properties, LLC		309	309	5
6	V	36	Amortization		Grove of Lagrange Healthcare Properties, LLC		12,286	12,286	6
7	V	19	Accounting Fees		Grove of Lagrange Healthcare Properties, LLC		2,000	2,000	7
8	V	19	Legal Fees		Grove of Lagrange Healthcare Properties, LLC		1,430	1,430	8
9	V	30	Depreciation		Grove of Lagrange Healthcare Properties, LLC		84,154	84,154	9
10	V	33	Real Estate Expense		Grove of Lagrange Healthcare Properties, LLC		264,916	264,916	10
11	V	21	State Income Tax		Grove of Lagrange Healthcare Properties, LLC		650	650	11
12	V								12
13	V								13
14	Total			$ 900,047			$ 809,909	$ * (90,138)	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: 01/01/12 Ending: 12/31/12

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%	$ 18	$ 18	15
16	V	3	HOUSEKEEPING		Legacy Healthcare Financial Services	100.00%	810	810	16
17	V	5	UTILITIES		Legacy Healthcare Financial Services	100.00%	1,174	1,174	17
18	V	6	GROUNDS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	1,915	1,915	18
19	V	17	MANAGEMENT FEES		Legacy Healthcare Financial Services	100.00%			19
20	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	4,488	4,488	20
21	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	42	42	21
22	V	21	CLERICAL & GENERAL		Legacy Healthcare Financial Services	100.00%	104,715	104,715	22
23	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	147	147	23
24	V	25	AUTO AND TRAVEL		Legacy Healthcare Financial Services	100.00%			24
25	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	515	515	25
26	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	15,328	15,328	26
27	V	30	DEPRECIATION		Legacy Healthcare Financial Services	100.00%	836	836	27
28	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	3	3	28
29	V	33	REAL ESTATE TAX		Legacy Healthcare Financial Services	100.00%			29
30	V	34	RENT		Legacy Healthcare Financial Services	100.00%	8,936	8,936	30
31	V	35	AUTO RENTAL		Legacy Healthcare Financial Services	100.00%			31
32	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services	100.00%			32
33	V	17	MANAGEMENT FEES	24,000	Legacy Healthcare Financial Services	100.00%		(24,000)	33
34	V	19	BOOKKEEPING FEES	214,098	Legacy Healthcare Financial Services	100.00%		(214,098)	34
35	V	17	MANAGEMENT FEES- C. RAJCHENBACH		Legacy Healthcare Financial Services	100.00%	12,000	12,000	35
36	V	17	MANAGEMENT FEES- M. SHABAT		Legacy Healthcare Financial Services	100.00%	12,000	12,000	36
37	V	27	HEALTH INSURANCE/BENEFITS- C. RAJCHENBACH		Legacy Healthcare Financial Services	100.00%	3,390	3,390	37
38	V	27	HEALTH INSURANCE/BENEFITS- M. SHABAT		Legacy Healthcare Financial Services	100.00%	3,390	3,390	38
39	Total			$ 238,098			$ 169,707	$ * (68,391)	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: 01/01/12 Ending: 12/31/12

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	30	DEPRECIATION		Legacy Real Properties	100.00%	1,681	$ 1,681	15
16	V	32	INTEREST EXPENSE		Legacy Real Properties	100.00%	3,046	3,046	16
17	V	33	REAL ESTATE TAXES		Legacy Real Properties	100.00%	2,963	2,963	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V	34	RENT	8,936	Legacy Real Properties	100.00%		(8,936)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 8,936			$ 7,690	$ * (1,246)	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: 01/01/12 Ending: 12/31/12

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	5	UTILITIES	$	Progressive Healthcare Consulting	100.00%	$	$	15
16	V	6	REPAIRS & MAINTENANCE		Progressive Healthcare Consulting	100.00%			16
17	V	10	RN SALARY		Progressive Healthcare Consulting	100.00%	8,483	8,483	17
18	V	12	CELRGY SALARY		Progressive Healthcare Consulting	100.00%	1,755	1,755	18
19	V	15	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	1,149	1,149	19
20	V	17	ADMIN		Progressive Healthcare Consulting	100.00%	17,897	17,897	20
21	V	19	PROFESSIONAL FEES		Progressive Healthcare Consulting	100.00%	117	117	21
22	V	20	FEES, SUBSCRIPTIONS		Progressive Healthcare Consulting	100.00%			22
23	V	21	CLERICAL & GENERAL		Progressive Healthcare Consulting	100.00%	198	198	23
24	V	24	SEMINARS		Progressive Healthcare Consulting	100.00%			24
25	V	25	AUTO AND TRAVEL		Progressive Healthcare Consulting	100.00%			25
26	V	26	INSURANCE		Progressive Healthcare Consulting	100.00%			26
27	V	27	EMP. BEN.-GEN. ADMIN.		Progressive Healthcare Consulting	100.00%			27
28	V	30	DEPRECIATION		Progressive Healthcare Consulting	100.00%			28
29	V	32	INTEREST		Progressive Healthcare Consulting	100.00%			29
30	V	33	REAL ESTATE TAX		Progressive Healthcare Consulting	100.00%			30
31	V	34	RENT		Progressive Healthcare Consulting	100.00%			31
32	V	35	AUTO RENTAL		Progressive Healthcare Consulting	100.00%	96	96	32
33	V								33
34	V	10	NURSING	42,000	Progressive Healthcare Consulting	100.00%		(42,000)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 42,000			$ 29,695	$ * (12,305)	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: 01/01/12 Ending: 12/31/12

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: 01/01/12 Ending: 12/31/12

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: 01/01/12 Ending: 12/31/12

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.**

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

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: 01/01/12 Ending: 12/31/12

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: 01/01/12 Ending: 12/31/12

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: 01/01/12 Ending: 12/31/12

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	SHABAT & ASSOCIATES	SKOKIE	MANAGEMENT CO	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	LIFELINE AMBULANCE, LLC	CHICAGO	AMBULANCE	4
5	RONALD SHABAT	15.000%	THE GROVE AT THE LAKE	ZION	PROGRESSIVE HEALTHCARE	LINCOLNWOOD	NURSE CONSULTING	5
6	YAIR ZUCKERMAN	3.000%	THE GROVE AT LINCOLN PARK LIVING AND REHAB CENTER,LLC	CHICAGO				6
7			LAKEFRONT NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO				7
8			PARK VILLA NURSING AND REHABILITATION CENTER,LLC	MELROSE PARK				8
9			PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO				9
10			WINDSOR PARK	CHICAGO				10
11			CHALET LIVING & REHAB CENTER	CHICAGO				11
12			THE GROVE OF NORTHBROOK	NORTHBROOK				12
13								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: 01/01/12 Ending: 12/31/12

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: 01/01/12 Ending: 12/31/12

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	3.00	6.00%	Alloc Mgt Fee	$ 12,000	17-7	1
2	Menachem Shabat	Owner	Administrative	32.00%	See Attached	3.00	6.00%	Alloc Mgt Fee	12,000	17-7	2
3	Yair Zuckerman	Owner	Administrative	3.00%	See Attached	3.84	9.60%	Alloc. Sal.	3,745	17-7	3
4	Jamie Dlatt	Owner	Administrative	3.00%	See Attached	3.84	9.60%				4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 27,745		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: 01/01/12 Ending: 12/31/12

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: 01/01/12 Ending: 12/31/12

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	716,018	13	$ 270	$	47,946	$ 18	1
2	3	HOUSEKEEPING	AVAIL. BED DAYS	716,018	13	12,097	11,779	47,946	810	2
3	5	UTILITIES	AVAIL. BED DAYS	716,018	13	17,526		47,946	1,174	3
4	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	716,018	13	28,596		47,946	1,915	4
5	17	MANAGEMENT FEES	AVAIL. BED DAYS	716,018	13			47,946		5
6	19	PROFESSIONAL FEES	AVAIL. BED DAYS	716,018	13	67,029		47,946	4,488	6
7	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	716,018	13	625		47,946	42	7
8	21	CLERICAL & GENERAL	AVAIL. BED DAYS	716,018	13	1,563,793	1,447,779	47,946	104,715	8
9	24	SEMINARS	AVAIL. BED DAYS	716,018	13	2,200		47,946	147	9
10	25	AUTO AND TRAVEL	AVAIL. BED DAYS	716,018	13			47,946		10
11	26	INSURANCE	AVAIL. BED DAYS	716,018	13	7,687		47,946	515	11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	716,018	13	228,907		47,946	15,328	12
13	30	DEPRECIATION	AVAIL. BED DAYS	716,018	13	12,480		47,946	836	13
14	32	INTEREST	AVAIL. BED DAYS	716,018	13	51		47,946	3	14
15	33	REAL ESTATE TAX	AVAIL. BED DAYS	716,018	13			47,946		15
16	34	RENT	AVAIL. BED DAYS	716,018	13	133,442		47,946	8,936	16
17	35	AUTO RENTAL	AVAIL. BED DAYS	716,018	13			47,946		17
18	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	716,018	13			47,946		18
19										19
20	17	MANAGEMENT FEES- C. RAJ	AVG HOURS WKD	50	12	200,000		3	12,000	20
21	17	MANAGEMENT FEES- M. SHA	AVG HOURS WKD	50	12	200,000		3	12,000	21
22	27	HEALTH INSURANCE/BENEF	AVG HOURS WKD	50	12	56,500		3	3,390	22
23	27	HEALTH INSURANCE/BENEF	AVG HOURS WKD	50	12	56,500		3	3,390	23
24										24
25	TOTALS					$ 2,587,703	$ 1,459,558		$ 169,707	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	30	DEPRECIATION	AVAIL. BED DAYS	716,018	13	25,098		47,946	1,681	1
2	32	INTEREST EXPENSE	AVAIL. BED DAYS	716,018	13	45,486		47,946	3,046	2
3	33	REAL ESTATE TAXES	AVAIL. BED DAYS	716,018	13	44,250		47,946	2,963	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	$		$ 7,690	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	5	UTILITIES	AVAIL. BED DAYS	498,858	9	$	$	47,946	$	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	498,858	9			47,946		2
3	10	RN SALARY	AVAIL. BED DAYS	498,858	9	88,262	88,262	47,946	8,483	3
4	12	CELRGY SALARY	AVAIL. BED DAYS	498,858	9	18,263	18,263	47,946	1,755	4
5	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	498,858	9	11,955		47,946	1,149	5
6	17	ADMIN	AVAIL. BED DAYS	498,858	9	186,212	186,212	47,946	17,897	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	498,858	9	1,215		47,946	117	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	498,858	9			47,946		8
9	21	CLERICAL & GENERAL	AVAIL. BED DAYS	498,858	9	2,058		47,946	198	9
10	24	SEMINARS	AVAIL. BED DAYS	498,858	9			47,946		10
11	25	AUTO AND TRAVEL	AVAIL. BED DAYS	498,858	9			47,946		11
12	26	INSURANCE	AVAIL. BED DAYS	498,858	9			47,946		12
13	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	498,858	9			47,946		13
14	30	DEPRECIATION	AVAIL. BED DAYS	498,858	9			47,946		14
15	32	INTEREST	AVAIL. BED DAYS	498,858	9			47,946		15
16	33	REAL ESTATE TAX	AVAIL. BED DAYS	498,858	9			47,946		16
17	34	RENT	AVAIL. BED DAYS	498,858	9			47,946		17
18	35	AUTO RENTAL	AVAIL. BED DAYS	498,858	9	999		47,946	96	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 308,964	$ 292,737		$ 29,695	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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: 01/01/12 Ending: 12/31/12

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: 01/01/12 Ending: 12/31/12

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: 01/01/12 Ending: 12/31/12

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: 01/01/12 Ending: 12/31/12

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: 01/01/12 Ending: 12/31/12

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: 01/01/12 Ending: 12/31/12

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			$ 393,627	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Private Bank		X	Line of Credit				488,000			26,885	6
7	Insurance Financing		X								1,876	7
8	See Supplemental Schedule										3,049	8
9	TOTAL Facility Related						$	$ 6,958,575			$ 425,437	9
	B. Non-Facility Related*											
10	Interest Income		X								(98)	10
11	Interest Income - Bldg Co.		X								(47)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (145)	14
15	TOTALS (line 9+line14)						$	$ 6,958,575			$ 425,292	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: 01/01/12 Ending: 12/31/12

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	Allocated from Legacy Real Prop		X				$	$			$ 3,046	8
9	Allocated from Legacy Healthcare		X								3	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										3,049	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											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:** 01/01/12 **Ending:** 12/31/12

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.**	$ 204,939	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.)		$ 232,161	2
3. Under or (over) accrual (line 2 minus line 1).		$ 27,222	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 240,658	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.**		$ 14,515	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.		$ 282,395	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2007		8
2008	215,952	9
2009	181,479	10
2010	198,970	11
2011	229,198	12

2012 Accrual = $229,198 x 1.05 = $240,658

Allocated from Legacy Real Properties = $2,963

	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 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 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.	15-33-128-010-0000	Long Term Care Property	$ 91,936.35	$ 91,936.35
2.	15-33-128-011-0000	Long Term Care Property	$ 137,261.24	$ 137,261.24
3.	10-35-104-076-0000	Home Office Allocation	$ 42,154.05	$ 2,822.72
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 271,351.64	$ 232,020.31

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 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

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: 01/01/12 Ending: 12/31/12

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	Alloc from Legacy Real Properties LLC			5,478	2
3	TOTALS	43,000		$ 755,478	3

SEE ACCOUNTANTS' COMPILATION REPORT

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

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			2011	1975	$ 3,282,000	$ 84,154	39	$ 84,154	$	$ 101,686	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: 01/01/12 Ending: 12/31/12

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
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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)		86,206	1,271		3,529	2,258	10,137	68
69	Financial Statement Depreciation			180,530			(180,530)		69
70	TOTAL (lines 4 thru 69)		$ 3,368,206	$ 265,955		$ 87,683	$ (178,272)	$ 111,823	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: 01/01/12 Ending: 12/31/12

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		$ 3,368,206	$ 265,955		$ 87,683	$ (178,272)	$ 111,823	1
2	Satellite And Cable	2009	27,500		20	1,375	1,375	5,042	2
3	Painting	2009	10,830		20	542	542	1,986	3
4	Updating And Painting	2009	10,200		20	510	510	1,828	4
5	Satellite And Cable	2009	2,721		20	136	136	476	5
6	Sign	2009	10,216		20	681	681	2,384	6
7	Hvac	2009	9,200		20	460	460	1,648	7
8	Smoking Shelter	2009	9,120		20	456	456	1,672	8
9	Install Backflow Preventer	2009	3,167		20	158	158	554	9
10	Nurses Stations,Corridor, Dining Room, Wall Covering	2009	34,900		20	1,745	1,745	5,817	10
11	Plumbing	2009	3,424		20	171	171	571	11
12	Irrigation System	2009	11,500		20	767	767	2,556	12
13	Hvac	2009	18,563		20	928	928	3,171	13
14	Kitchen Improvements- Tiles, Wall Base, Wall Work	2009	9,020		20	451	451	1,466	14
15	Kitchen Improvements- Electrical, Hvac, Grease Trap	2009	18,066		20	903	903	2,860	15
16	Architectual Fees	2009	3,613		20	181	181	602	16
17	Plumbing Repairs	2009	4,534		20	227	227	756	17
18	Architectual Fees	2009	7,392		20	370	370	1,201	18
19	Security System	2009	10,912		20	1,559	1,559	4,806	19
20	Door Repairs	2009	5,584		20	279	279	907	20
21	Nurses Station , Corridor, Dining Room, Wall Covering	2009	34,900		20	1,745	1,745	5,380	21
22	Nurses Station, Corridor, Dining Room, Wall Covering	2009	66,679		20	3,334	3,334	10,280	22
23	Working Drawings	2009	7,000		20	700	700	2,158	23
24	Fire Dampers	2009	5,115		20	256	256	789	24
25	Smoking Tent	2009	3,469		20	173	173	535	25
26	Landscaping	2010	11,350		20	568	568	1,703	26
27	2Nd Flr Nurses Station Cabinetry	2010	14,166		20	708	708	2,066	27
28	Reception Area - Cabinet/Desk/Granite	2010	8,500		20	1,700	1,700	4,958	28
29	Hot Water-New Valves/Motor/Pump	2010	2,666		20	133	133	378	29
30	Painting	2010	13,000		20	650	650	1,788	30
31	Plumbing	2010	5,869		20	293	293	807	31
32	Carpeting - 3Rd Flr	2010	8,806		20	440	440	1,101	32
33	Hot Water/Mixing Valve	2010	3,980		20	796	796	1,990	33
34	TOTAL (lines 1 thru 33)		$ 3,764,167	$ 265,955		$ 111,078	$ (154,877)	$ 186,057	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: 01/01/12 Ending: 12/31/12

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		$ 3,764,167	$ 265,955		$ 111,078	$ (154,877)	$ 186,057	1
2	Carpeting -21 Bedrooms	2010	18,293		20	915	915	2,287	2
3	Landscaping	2010	6,500		20	325	325	785	3
4	Window Treatments	2010	5,459		20	273	273	591	4
5	Plumbing Install	2010	11,000		20	550	550	1,146	5
6	Alarm System	2010	2,947		20	147	147	319	6
7	Smoke And Fire Damper Repair	2010	3,100		20	310	310	646	7
8	Booster Pump System	2011	12,000		20	600	600	1,150	8
9	Qfive 180 - Patch & Repair Walls & Ceiling In Resident Rooms	2011	2,640		20	132	132	242	9
10	All N One Remodeling - Install Tiles/Sinks/Walling/Prime/Paint In	2011	3,522		20	176	176	323	10
11	Installation Of Acrylic Wall Mount Signs	2011	7,325		20	733	733	1,343	11
12	Healthcare Security Systems On 3Rd Floor	2011	4,500		20	643	643	1,179	12
13	Adig Construction - Install Wall Sconces (81), Install New Switche	2011	15,180		20	3,036	3,036	5,566	13
14	Pegasus - Cabinets/Footboards/Headboards	2011	3,600		20	720	720	1,320	14
15	Metal Studs, Screws, Drywall, Metal Door, Windows	2011	5,325		20	266	266	466	15
16	Metal Door, New Window, Drywall, Prime, Paint, Cove Base - Act	2011	7,920		20	396	396	693	16
17	Basement - Electrical/Lighting - Outlet, Switches, Fluorescent Fixt	2011	2,830		20	142	142	236	17
18	Patch & Repair Wall In 1St Floor Resedent Room, New Tile In 1S	2011	4,224		20	282	282	458	18
19	110 Cable Tv Jacks & Duplex Outlets / Reinstall Tv Brackets	2011	16,500		20	825	825	1,375	19
20	Window Treatments - 2Nd Floor Dining & Resident Rooms	2011	5,799		20	290	290	459	20
21	Patch, Prime, Prep & Paint 20 Rooms On 2Nd Floor / Reinstall Tv	2011	10,500		20	525	525	831	21
22	New Wall Tiles, Reimstall Plumbing Fixtures, Paint Wall & Ceilin	2011	9,600		20	480	480	760	22
23	New Wall Tiles, Reinstall Plumbing Fixtures, Paint Wall & Ceiling	2011	9,600		20	480	480	760	23
24	Installed 17 Duplex Outlets & Tv Jacks, Reinstalled Tv Brackets	2011	2,890		20	145	145	217	24
25	Remove Wallpaper, Patch, Prime, Paint Walls / Install New Tv Lin	2011	5,325		20	266	266	399	25
26	Prep, Patch, Paint 20 Rooms On 3Rd Floor / Reinstall All Tv'S & I	2011	10,500		20	525	525	569	26
27	Partition Wall In Garage / Installed Metal Door	2011	4,750		20	238	238	277	27
28	Tv Cable Installation	2011	5,000		20	250	250	271	28
29	West Passenger Elevator Repairs	2011	3,165		20	158	158	237	29
30	Prep And Paint Walls	2011	5,300		20	265	265	442	30
31	Kitchen-Cutting Floors To Replace Approx 8 Feet Of Pipes To Gr	2012	4,000		20	67	67	67	31
32	New Sealer, New Concrete, Replace Hot Water Valve, Light Fixtur	2012	4,850		20	243	243	243	32
33	Install New Granite Countertop, Install Countertop Legs, Cabinet	2012	4,672		20	195	195	195	33
34	TOTAL (lines 1 thru 33)		$ 3,982,984	$ 265,955		$ 125,673	$ (140,282)	$ 211,907	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: 01/01/12 Ending: 12/31/12

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		$ 3,982,984	$ 265,955		$ 125,673	$ (140,282)	$ 211,907	1
2	Install Power Line In New Stove In Activity Room, Install New Fu	2012	2,550		20	106	106	106	2
3	Material, Electric & Ac Unit, Service Calls, Internet & Phone Wir	2012	5,175		20	194	194	194	3
4	Railing Bars For The Existing Stairways. Additional Bars Are Ma	2012	7,450		20	186	186	186	4
5	New Granite Countertop, Demolish Outside Wall By The Window	2012	5,000		20	63	63	63	5
6	Install New Sink And Faucet, Patch And Paint Wall, Install Panels	2012	3,790		20	47	47	47	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,006,949	$ 265,955		$ 126,270	$ (139,685)	$ 212,503	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: 01/01/12 Ending: 12/31/12

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		$ 4,006,949	$ 265,955		$ 126,270	$ (139,685)	$ 212,503	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,006,949	$ 265,955		$ 126,270	$ (139,685)	$ 212,503	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: 01/01/12 Ending: 12/31/12

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
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$	$		$	$	$	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: 01/01/12 Ending: 12/31/12

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	42,445	788	30	1,415	627	4,952	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Legacy Real Properties	2009	24,104	195	20	1,205	1,010	3,314	9
10	Allocated from Legacy Real Properties	2010	7,330	59	20	293	234	734	10
11	Allocated from Legacy Real Properties	2011	10,418	84	20	521	437	1,042	11
12									12
13	Allocated from Legacy Healthcare Financial Services	2012	1,909	145	20	95	(50)	95	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 86,206	$ 1,271		$ 3,529	$ 2,258	$ 10,137	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: 01/01/12 Ending: 12/31/12

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	$ 526,609	$ 942	$ 62,930	$ 61,988	10	$ 102,442	71
72	Current Year Purchases	22,324	304	2,851	2,547	10	2,851	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 548,933	$ 1,246	$ 65,782	$ 64,536		$ 105,293	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)	$ 5,311,359	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 267,201	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 192,051	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (75,150)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 317,797	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: 01/01/12 Ending: 12/31/12

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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.	/2013	$
13.	/2014	$
14.	/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: $ 6,735 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: 01/01/12 Ending: 12/31/12

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: 01/01/12 Ending: 12/31/12

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 - 03	hrs	$		$ 292,004	$		$ 292,004	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			250,072			250,072	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			286,736			286,736	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				295,974		295,974	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					44,991	51,326		96,317	13
14	TOTAL			$		$ 873,803	$ 347,300		$ 1,221,103	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:** 01/01/12 **Ending:** 12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/12 **(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	$	$ 390,753	1
2	Cash-Patient Deposits	29,007	29,007	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,721,109	2,721,109	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	95,260	95,260	6
7	Other Prepaid Expenses	107,157	109,075	7
8	Accounts Receivable (owners or related parties)	13,958	13,958	8
9	Other(specify): See Attached Schedule	183,771	183,771	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,150,262	$ 3,542,933	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	579,122	579,122	15
16	Equipment, at Historical Cost	646,823	646,823	16
17	Accumulated Depreciation (book methods)	(358,770)	(460,456)	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	1,729,760	1,776,857	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,596,935	$ 6,574,346	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,747,197	$ 10,117,279	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 738,668	$ 738,668	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	488,000	488,000	29
30	Accrued Salaries Payable	251,389	251,389	30
31	Accrued Taxes Payable (excluding real estate taxes)	39,034	39,034	31
32	Accrued Real Estate Taxes(Sch.IX-B)	126,059	240,658	32
33	Accrued Interest Payable	49,707	82,060	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	2,102,767	(17,447)	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,795,624	$ 1,822,362	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)**	$	$ 6,470,575	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,795,624	$ 8,292,937	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,951,573	$ 1,824,342	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,747,197	$ 10,117,279	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,032,698	1
2	Restatements (describe):		2
3	**Late Entries**	204,093	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,236,791	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	889,782	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	(175,000)	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)**	$ 714,782	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)**	$ 1,951,573	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: 01/01/12 Ending: 12/31/12

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	$ 8,008,270	1
2	Discounts and Allowances for all Levels	(387,880)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,620,390	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,803,235	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,803,235	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	286,099	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	39,518	20
21	Other Medical Services	1,590	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 327,207	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	98	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 98	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	19,059	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 19,059	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,769,989	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,099,418	31
32	Health Care	2,835,092	32
33	General Administration	1,752,812	33
	B. Capital Expense		
34	Ownership	1,115,930	34
	C. Ancillary Expense		
35	Special Cost Centers	1,808,687	35
36	Provider Participation Fee	268,268	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,880,207	40
41	**Income before Income Taxes (line 30 minus line 40)****	889,782	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 889,782	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,213,755	44
45	Private Pay - Net Inpatient Revenue	521,898	45
46	Medicare - Net Inpatient Revenue	2,491,940	46
47	Other-(specify) Veteran	239,838	47
48	Other-(specify) Insurance	152,959	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,620,390	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	1,897	2,091	$ 86,412	$ 41.33	1
2	Assistant Director of Nursing	1,881	2,059	61,592	29.91	2
3	Registered Nurses	14,075	16,957	520,550	30.70	3
4	Licensed Practical Nurses	25,882	27,924	680,533	24.37	4
5	CNAs & Orderlies	64,364	75,722	884,697	11.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,805	5,593	99,165	17.73	8
9	Activity Director	1,988	2,089	31,504	15.08	9
10	Activity Assistants	7,534	7,915	76,889	9.71	10
11	Social Service Workers	2,429	2,169	55,224	25.46	11
12	Dietician					12
13	Food Service Supervisor	1,372	1,486	32,162	21.64	13
14	Head Cook	4,247	4,594	69,652	15.16	14
15	Cook Helpers/Assistants	10,771	12,118	134,086	11.07	15
16	Dishwashers					16
17	Maintenance Workers	2,870	3,084	45,987	14.91	17
18	Housekeepers	14,243	15,486	173,823	11.22	18
19	Laundry	6,863	7,687	102,147	13.29	19
20	Administrator	2,049	2,157	107,653	49.91	20
21	Assistant Administrator	904	960	24,129	25.13	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,746	9,002	108,581	12.06	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	2,030	2,209	28,774	13.03	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	177,950	201,302	$ 3,323,560 *	$ 16.51	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	276	$ 17,687	01-03	35
36	Medical Director	Monthly	23,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	57,135	10-03	38
39	Pharmacist Consultant	Monthly	7,664	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				45
46	Other(specify)				46
47	Transitional Care Consult	Monthly	4,950	10-03	47
48	Dental Consultant	Per Visit	1,260	10-03	48
49	TOTAL (lines 35 - 48)	276	$ 111,696		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	13	$ 672	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	13	$ 672		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: 01/01/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Patricia Long	Administrator	0.00%	$ 107,653
Igor Rebel	Assist. Admin	0.00%	24,129
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 131,782

B. Administrative - Other

Description	Amount
Chaim Rajchenbach - Management Fees	$ 12,000
Menachem Shabat - Management Fees	12,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 24,000

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 41,618
Frost, Ruttenberg, Rothblatt	Accounting	27,706
Krupnik Bokor Kagda, Brooks	Accounting	750
E-Health Data Solutions	Data Processing	1,347
Health Data System	Data Processing	13,244
Westcom Solutions	Data Processing	4,763
National Datacare Corp	Data Processing	4
RG Enterprise	Data Processing	696
LTC Solutions	Data Processing	1,600
TikTek IT Solutions	Data Processing	1,825
Legacy Healthcare	Bookkeeping	214,098
See Supplemetal Schedule		33,386
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 341,038

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 90,704
Unemployment Compensation Insurance	108,514
FICA Taxes	252,775
Employee Health Insurance	
Employee Meals	12,590
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	159,479
Other Employee Benefits	9,778
Employee Physical Exams	16,127
TOTAL (agree to Schedule V, line 22, col.8)	$ 649,968

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	$ 3,980
Advertising: Employee Recruitment	1,104
Health Care Worker Background Check (Indicate # of checks performed 283)	2,830
Patient Background Checks	
Dues and Subscriptions	13,031
License and Permits	2,090
See Supplemental Schedule	42
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,077

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,715
Allocated from Legacy Healthcare	147
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,862

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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:** 01/01/12 **Ending:** 12/31/12

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Il Council on Long Term Care $8,279**

(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. $ **25,438** 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. $ **268,268**
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. $ **12,590** 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% Line 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.