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: 0033548

Facility Name: West Grove

Address: Rural Route #1, Box 417 (Number) Lawrenceville (City) 62439 (Zip Code)

County: Lawrence

Telephone Number: (618) 943-7597 **Fax #** (618) 945-9030

HFS ID Number:

Date of Initial License for Current Owners: 05/24/1988

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: John Knoblett **Telephone Number:** (217) 351-2073
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2012 to 12/31/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) William R. Gillis
(Title) President

Paid Preparer

(Signed) (Date)
(Print Name and Title) John Knoblett, CPA, Partner
(Firm Name & Address) Kemper CPA Group LLP, 1701 Broadmoor Drive, Suite 120
(Telephone) (217) 351-2073 Fax # (217) 351-3487

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 West Grove # 0033548 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	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					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,466			4,466	13
14	TOTALS	4,466			4,466	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.47%

D. How many bed-hold days during this year were paid by the Department?
52 (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 05/26/1988

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date Built 05/26/1988 NO [ ]

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

Medicare Intermediary N/A

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 West Grove # 0033548 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	14,401	1,382	1,310	17,093	(2,401)	14,692		14,692			1
2	Food Purchase		34,996		34,996	(4,917)	30,079		30,079			2
3	Housekeeping	3,220	2,712		5,932		5,932		5,932			3
4	Laundry		303		303		303		303			4
5	Heat and Other Utilities			8,427	8,427		8,427		8,427			5
6	Maintenance		60	9,996	10,056		10,056		10,056			6
7	Other (specify):*											7
8	**TOTAL General Services**	17,621	39,453	19,733	76,807	(7,318)	69,489		69,489			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	149,451	3,064		152,515		152,515	(874)	151,641			10
10a	Therapy			678	678		678		678			10a
11	Activities	10,045	153	562	10,760		10,760		10,760			11
12	Social Services	9,138		1,727	10,865		10,865		10,865			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	168,634	3,217	4,167	176,018		176,018	(874)	175,144			16
	C. General Administration											
17	Administrative	15,600		82,500	98,100	(43,231)	54,869	(13,095)	41,774			17
18	Directors Fees											18
19	Professional Services			9,709	9,709	917	10,626		10,626			19
20	Dues, Fees, Subscriptions & Promotions			986	986		986		986			20
21	Clerical & General Office Expenses		1,049	3,962	5,011	34,654	39,665	(127)	39,538			21
22	Employee Benefits & Payroll Taxes			32,372	32,372	11,748	44,120		44,120			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,937	5,937	403	6,340	(212)	6,128			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			9,064	9,064	186	9,250		9,250			26
27	Other (specify):*											27
28	**TOTAL General Administration**	15,600	1,049	144,530	161,179	4,677	165,856	(13,434)	152,422			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	201,855	43,719	168,430	414,004	(2,641)	411,363	(14,308)	397,055			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 West Grove #0033548 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			26,988	26,988		26,988	(13,417)	13,571			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,533	12,533	2,564	15,097	(11,828)	3,269			32
33	Real Estate Taxes			8,191	8,191		8,191		8,191			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			882	882		882		882			35
36	Other (specify):*											36
37	**TOTAL Ownership**			48,594	48,594	2,564	51,158	(25,245)	25,913			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			948	948		948		948			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			29,128	29,128		29,128		29,128			42
43	Other (specify):*					77	77	(77)				43
44	**TOTAL Special Cost Centers**			30,076	30,076	77	30,153	(77)	30,076			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	201,855	43,719	247,100	492,674		492,674	(39,630)	453,044			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 West Grove # 0033548 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(871)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(127)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(212)	24		19
20	Contributions	(77)	43		20
21	Owner or Key-Man Insurance	(874)	10		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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	(24,374)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (26,535)		$	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)	(13,095)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (13,095)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (39,630)		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

West Grove

ID# 0033548

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Interest on Mortgage in excess of original debt	$ (10,957)	32	1
2	Depreciation on Stepped-Up Basis	(13,417)	30	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(24,374)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number West Grove # 0033548 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	PAGES 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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(874)	0	0	0	0	0	0	0	0	0	0	(874)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(874)	0	0	0	0	0	0	0	0	0	0	(874)	16
	C. General Administration													
17	Administrative	0	(13,095)	0	0	0	0	0	0	0	0	0	(13,095)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(127)	0	0	0	0	0	0	0	0	0	0	(127)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(212)	0	0	0	0	0	0	0	0	0	0	(212)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(339)	(13,095)	0	0	0	0	0	0	0	0	0	(13,434)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,213)	(13,095)	0	0	0	0	0	0	0	0	0	(14,308)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number West Grove # 0033548 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(13,417)	0	0	0	0	0	0	0	0	0	0	(13,417)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,828)	0	0	0	0	0	0	0	0	0	0	(11,828)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(25,245)	0	0	0	0	0	0	0	0	0	0	(25,245)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(77)	0	0	0	0	0	0	0	0	0	0	(77)	43
44	**TOTAL Special Cost Centers**	(77)	0	0	0	0	0	0	0	0	0	0	(77)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(26,535)	(13,095)	0	0	0	0	0	0	0	0	0	(39,630)	45

Facility Name & ID Number West Grove # 0033548 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See next page						

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	17	Management Fees	$ 82,500	Rincker Healthcare Corporation	100.00%	$ 69,405	$ (13,095)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 82,500			$ 69,405	$ * (13,095)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number West Grove # 0033548 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Angela West Trust	20%	Lawrence Community Healthcare Corporation	Bridgeport				1
2	Angela West Trust	25%	Rincker Healthcare Corporation	Bridgeport				2
3	Angela West Trust	25%	Friendship Manor	St. Elmo				3
4	Mary Jane Rincker Trust	20%	Lawrence Community Healthcare Corporation	Bridgeport				4
5	Mary Jane Rincker Trust	25%	Rincker Healthcare Corporation	Bridgeport				5
6	Mary Jane Rincker Trust	25%	Friendship Manor	St. Elmo				6
7	Deanna Gillis Trust	20%	Lawrence Community Healthcare Corporation	Bridgeport				7
8	Deanna Gillis Trust	25%	Rincker Healthcare Corporation	Bridgeport				8
9	Deanna Gillis Trust	25%	Friendship Manor	St. Elmo				9
10	William J. Rincker Trust	20%	Lawrence Community Healthcare Corporation	Bridgeport				10
11	William J. Rincker Trust	25%	Rincker Healthcare Corporation	Bridgeport				11
12	William J. Rincker Trust	25%	Friendship Manor	St. Elmo				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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number West Grove # 0033548 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	William Rincker		Administrative	0.25	28,374	9	0.25	Wages	$ 4,626	17-1	1
2	Angela West		Administrative	0.25	28,374	9	0.25	Wages	4,626	17-1	2
3	Deanna Gillis	Administrator	Administrative	0.25	34,399	7	0.70	Wages	21,209	17-1	3
4	Jane Rincker	Accounting Supv.	Bookkeeping	0.25	165,920	10	0.25	Wages	27,052	21-1	4
5	Rob Gillis	Administrator	Administrative		171,000	1	0.03	Wages	9,981	17-1	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 67,494		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number West Grove # 0033548 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Rincker Healthcare Corporation
Street Address: 900 East Corporation
City / State / Zip Code: Bridgeport, IL 62417
Phone Number: (618) 945-2091
Fax Number: (618) 945-9030

	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		See Attached Schedule Pg 25				$	$		$	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 West Grove # 0033548 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	First Financial Bank NA		X	Real Estate Mortgage	$5,391.00	09/25/02	$ 619,778	$ 244,135	09/15/17	4.6000	$ 12,533	1
2	First Financial Bank NA		X	Rincker Healthcare - Auto	$1,170.00	03/10/10	62,000	13,586	03/10/15	5.0000	119	2
3												3
4												4
5												5
	Working Capital											
6	First Financial Bank NA		X	Rincker Healthcare - LOC	n/a	12/21/12	2,000,000	169,000	11/01/13	3.2500	2,446	6
7												7
8												8
9	TOTAL Facility Related				$6,561.00		$ 2,681,778	$ 426,721			$ 15,098	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,681,778	$ 426,721			$ 15,098	15

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

* 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 West Grove # 0033548 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	7,930	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.)	$	8,060	2
3. Under or (over) accrual (line 2 minus line 1).	$	130	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)	$	8,060	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	8,190	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2007	8,099	8
2008	8,162	9
2009	8,633	10
2010	7,930	11
2011	8,060	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME West Grove COUNTY Lawrence

FACILITY IDPH LICENSE NUMBER 0033548

CONTACT PERSON REGARDING THIS REPORT John Knoblett, CPA

TELEPHONE (217) 351-2073 FAX #: (217) 351-3487

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.	06-000-486-20	Building & Land	$ 8,060.48	$ 8,060.48
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 8,060.48	$ 8,060.48

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

Facility Name & ID Number West Grove # 0033548 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,000 Main Floor B. General Construction Type: Exterior Brick/Vinyl Frame Wood/Masonry Number of Stories 1w/1,000 sq ft basement

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

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

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

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

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

N/A

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

1. Total Amount Incurred: 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	Ground for Facility	34,200	1987	$ 7,531	1
2					2
3	TOTALS	34,200		$ 7,531	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number West Grove # 0033548 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16			1988	$ 289,571	$ 11,583	25	$ 11,583	$	$ 283,779	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvements			1988	4,365					4,365	9
10	Land Improvements			1990	600					600	10
11	Building Improvements			2000	3,800	152	25	152		1,837	11
12	Exit Light			2001	1,077					1,077	12
13	Building Roof			2004	10,000	400	25	400		3,267	13
14	Bathroom Flooring			2007	2,255	226	10	226		1,184	14
15	Wood Flooring			2007	5,407	541	10	541		2,793	15
16	Vinyl Flooring			2008	1,564	156	7	156		756	16
17	Vinyl Flooring			2008	1,572	157	7	157		655	17
18	Fixtures, Counter Tops, Etc.			2008	2,699	180	7	180		735	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number West Grove # 0033548 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 322,910	$ 13,395		$ 13,395	$	$ 301,048	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number West Grove # 0033548 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,950	$ 163	$ 163	$	12 Yrs	$ 190	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	38,784				5-10 Yrs	38,784	73
74								74
75	TOTALS	$ 40,734	$ 163	$ 163	$		$ 38,974	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	Client Medical, Social	2000 Ford E250 Van	1999	$ 36,009	$	$	$	4	$ 36,009	76
77										77
78										78
79										79
80	TOTALS			$ 36,009	$	$	$		$ 36,009	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)	$ 407,184	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 13,558	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 13,558	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 376,031	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number West Grove # 0033548 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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: $ Description:
(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 West Grove # 0033548 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

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

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

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	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 West Grove # 0033548 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2012 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 10,964	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	324,222		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	416		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	5,060		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 340,662	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	27,320		13
14	Buildings, at Historical Cost	655,324		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	142,481		16
17	Accumulated Depreciation (book methods)	(567,474)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **Goodwill**	63,333		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 320,984	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 661,646	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 12,888	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	169,000		29
30	Accrued Salaries Payable	3,230		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	8,060		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Management Fees	122,200		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 315,378	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	244,135		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Owner Advances	33,000		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 277,135	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 592,513	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 69,133	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 661,646	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number West Grove # 0033548 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 67,106	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 67,106	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	5,027	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	(3,000)	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)**	$ 2,027	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)**	$ 69,133	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number West Grove # 0033548 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 489,605	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 489,605	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education	6,966	9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 6,966	23
	D. Non-Operating Revenue		
24	Contributions	259	24
25	Interest and Other Investment Income***	871	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,130	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 497,701	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	76,807	31
32	Health Care	176,018	32
33	General Administration	161,179	33
	B. Capital Expense		
34	Ownership	48,594	34
	C. Ancillary Expense		
35	Special Cost Centers	948	35
36	Provider Participation Fee	29,128	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 492,674	40
41	**Income before Income Taxes (line 30 minus line 40)****	5,027	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 5,027	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? See Pg 26 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 West Grove # 0033548 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	260	259	5,977	23.08	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	12,856	13,220	110,661	8.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	992	951	10,045	10.56	9
10	Activity Assistants					10
11	Social Service Workers	976	970	8,503	8.77	11
12	Dietician					12
13	Food Service Supervisor	1,569	1,842	14,401	7.82	13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	380	320	3,220	10.06	18
19	Laundry					19
20	Administrator	520	457	15,540	34.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,080	2,112	33,508	15.87	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	19,633	20,131	$ 201,855 *	$ 10.03	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	28	$ 1,310	1-3	35
36	Medical Director	24	1,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	24	948	39-3	39
40	Physical Therapy Consultant	7	302	10A-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	22	562	11-3	44
45	Social Service Consultant	12	297	12-3	45
46	Other(specify)				46
47	Psychology Consultant	13	1,430	12-3	47
48					48
49	TOTAL (lines 35 - 48)	129	$ 6,049		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number West Grove # 0033548 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Deanna Gillis	Administrator	25%	$ 15,600
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 15,600

B. Administrative - Other

Description	Amount
Management Fees - Rincker Healthcare Corporation	$ 82,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 82,500
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Kemper CPA Group LLP	Accounting	$ 9,709
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 9,709

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 6,169
Unemployment Compensation Insurance	10,621
FICA Taxes	18,945
Employee Health Insurance	868
Employee Meals	7,318
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	199
TOTAL (agree to Schedule V, line 22, col.8)	$ 44,120

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	$ 252
Advertising: Employee Recruitment	194
Health Care Worker Background Check	280
(Indicate # of checks performed 6)	
Patient Background Checks	
Dues and Subscriptions	260
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 986

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Program Administration - Gas, Oil, Etc.	3,807
Gas - Owner	2,321
Entertainment	212
Seminar Expense	
Entertainment Expense	(212)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,128

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number West Grove # 0033548 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number West Grove # 0033548 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **N/A**

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

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

(9) Are you presently operating under a sublease agreement? YES **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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **29,128**
This amount is to be recorded on line 42 of Schedule V.

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

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. $ **7,318** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
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?
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. $

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

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

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

Page 15
There are no training fees because West Grove only hires fully-trained employees.

SEE ACCOUNTANTS' COMPILATION REPORT.

Page 8 - Allocation of costs of Related Party - Rincker Healthcare, Inc.

Line Description	Amount	Line Ref
Administrative	$ 26,174	17
Professional Services	917	19
Clerical & General Office Expenses	34,654	21
Employee Benefits & Payroll Taxes	4,430	22
Travel and Seminar	403	24
Insurance - Prop.Liab.Malpractice	186	26
Interest	2,564	32
Rent - Equipment & Vehicles	-	35
Donations	77	43
Administrative	69,405	17
Grand Total of allocated costs	$ 69,405	

SEE ACCOUNTANTS' COMPILATION REPORT.

Page 19 - Reconciliation of taxable income to book net income

Book Net income (loss)	$	5,027
Rounding Difference		5
Difference book vs. tax depreciation		9,127
Accrual to Cash Conversion		(68,800)
Taxable Income	$	(54,641)

SEE ACCOUNTANTS' COMPILATION REPORT.

Breakdown of owner salaries from other nursing homes.

	William J. Rincker	Angie West	Deanna Gillis	Jane Rincker	William Gillis
Friendship Manor	$ 7,402.00	$ 7,402.00	$ 8,974.00	$ 43,284.00	$ 15,970.00
West Grove	4,626.00	4,626.00	21,209.00	27,052.00	9,981.00
Lawrence Comm. Healthcare Center	13,570.00	13,570.00	16,451.00	79,352.00	139,060.00
Rincker Residential	7,402.00	7,402.00	8,974.00	43,284.00	15,970.00
	33,000.00	33,000.00	55,608.00	192,972.00	180,981.00
Salaries reported on this cost report	4,626.00	4,626.00	21,209.00	27,052.00	9,981.00
Salaries reported by other homes	$ 28,374.00	$ 28,374.00	$ 34,399.00	$ 165,920.00	$ 171,000.00

SEE ACCOUNTANTS' COMPILATION REPORT.

Fixed Assets Reconciliation

	Land	Building & Improvements	Equipment & Vehicles	Total
Schedule XV Balance Sheet	$ 27,320	$ 655,324	$ 142,481	$ 825,125
Non-Care Assets	-	-	-	-
Schedule XI Ownership Costs	7,531	322,910	76,743	407,184
Difference	$ 19,789	$ 332,414	$ 65,738	$ 417,941

The difference arises from July 15, 1996 sale of all assets of the corporation to William F. Rincker who also purchased the corporate stock. After the former shareholders distributed all cash from the corporation, Mr. Rincker contributed the property and the equipment to the corporation.

SEE ACCOUNTANTS' COMPILATION REPORT.

West Grove - Detail for Schedule V, Line 24 - Travel Costs

Account Number	Description	Amount
9169	Gas & Maintenance - Facility Vehicle, Employee Mileage Reimbursements	$ 3,616
9155	Gas - Owner	2,321
		5,937
	Allocation of Related Party (Rincker Healthcare Inc.) Employee Reimbursements, Facility Errands	191
	Allocation of Related Party (Rincker Healthcare Inc.) Business Meals/Outings	212
	Adjustments - Meals/Entertainment	(212)
	Total Schedule V, Line 24 Travel Expense	$ 6,128

SEE ACCOUNTANTS' COMPILATION REPORT.