FOR BHF USE

LL1

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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.

I. IDPH License ID Number: 0050237

Facility Name: Grove of Skokie L & R

Address: 9000 N Lavergne Ave (Number) Skokie (City) 60077 (Zip Code)

County: Cook

Telephone Number: (847) 679-2322 **Fax #** (847) 679-9325

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
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 01/01/13 to 12/31/13 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)
(Firm Name & Address) McGladrey LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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

Facility Name & ID Number Grove of Skokie L & R # 0050237 Report Period Beginning: 01/01/13 Ending: 12/31/13

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	25,322	1,994	8,454	35,770	8
9	SNF/PED					9
10	ICF	14,710	835	119	15,664	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,032	2,829	8,573	51,434	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.57%

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)
N/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location?
Date started 09/01/2008

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 98 and days of care provided 8,454

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

Facility Name & ID Number Grove of Skokie L & R # 0050237 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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	342,737	24,152	18,799	385,688		385,688		385,688			1
2	Food Purchase		304,749		304,749		304,749	18	304,767			2
3	Housekeeping	149,229	31,799	1,037	182,065		182,065	960	183,025			3
4	Laundry	58,556	10,246	11,756	80,558		80,558		80,558			4
5	Heat and Other Utilities			111,121	111,121		111,121	1,110	112,231			5
6	Maintenance	103,219	720	143,652	247,591		247,591	6,860	254,451			6
7	Other (specify):*											7
8	**TOTAL General Services**	653,741	371,666	286,365	1,311,772		1,311,772	8,948	1,320,720			8
	B. Health Care and Programs											
9	Medical Director			99,600	99,600		99,600		99,600			9
10	Nursing and Medical Records	2,628,614	159,416	175,919	2,963,949		2,963,949	(44,767)	2,919,182			10
10a	Therapy											10a
11	Activities	161,686	12,209	2,288	176,183		176,183	4,367	180,550			11
12	Social Services	118,816		8,781	127,597		127,597	610	128,207			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,909,116	171,625	286,588	3,367,329		3,367,329	(39,790)	3,327,539			16
	C. General Administration											
17	Administrative	127,696		702,121	829,817		829,817	(662,212)	167,605			17
18	Directors Fees											18
19	Professional Services			152,261	152,261		152,261	7,423	159,684			19
20	Dues, Fees, Subscriptions & Promotions			29,977	29,977		29,977	558	30,535			20
21	Clerical & General Office Expenses	280,819	35,320	297,351	613,490		613,490	(138,427)	475,063			21
22	Employee Benefits & Payroll Taxes			664,717	664,717		664,717		664,717			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,408	10,408		10,408	(8,410)	1,998			24
25	Other Admin. Staff Transportation			11,993	11,993		11,993		11,993			25
26	Insurance-Prop.Liab.Malpractice			132,204	132,204		132,204	1,019	133,223			26
27	Other (specify):* Home Ofc- EE Benefi							29,219	29,219			27
28	**TOTAL General Administration**	408,515	35,320	2,001,032	2,444,867		2,444,867	(770,830)	1,674,037			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,971,372	578,611	2,573,985	7,123,968		7,123,968	(801,672)	6,322,296			29

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

Facility Name & ID Number Grove of Skokie L & R #0050237 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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			57,094	57,094		57,094	18,301	75,395			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,841	2,841		2,841	(2,841)				32
33	Real Estate Taxes			382,200	382,200		382,200	2,972	385,172			33
34	Rent-Facility & Grounds			770,454	770,454		770,454	(61,739)	708,715			34
35	Rent-Equipment & Vehicles			63,473	63,473		63,473		63,473			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,276,062	1,276,062		1,276,062	(43,307)	1,232,755			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		390,085	907,337	1,297,422		1,297,422	(75)	1,297,347			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			340,830	340,830		340,830		340,830			42
43	Other (specify):* **Non-Allowable Cos**	68,708		514,600	583,308		583,308	(583,308)				43
44	**TOTAL Special Cost Centers**	68,708	390,085	1,762,767	2,221,560		2,221,560	(583,383)	1,638,177			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,040,080	968,696	5,612,814	10,621,590		10,621,590	(1,428,362)	9,193,228			45

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

Facility Name & ID Number Grove of Skokie L & R # 0050237 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	8,740	30		9
10	Interest and Other Investment Income	(13,879)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(75)	43		18
19	Entertainment				19
20	Contributions	(91,250)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,848)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(203,972)	43		24
25	Fund Raising, Advertising and Promotional	(109,789)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(184,057)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (597,130)		$	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)	(831,232)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (831,232)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,428,362)		37

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

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

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

Grove of Skokie L & R

ID# 0050237

Report Period Beginning: 01/01/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	X-Rays - Part A	$ (20,373)	43	1
2	Patient Personal Items	(5,617)	43	2
3	Cable TV	(5,448)	43	3
4	Sequestration	(53,247)	43	4
5	Admitting non Certified	(68,708)	43	5
6	PY Adjustment	924	43	6
7	Discount	5,744	43	7
8	State Income Tax	(25,000)	43	8
9	Disallow travel & seminar	(9,650)	24	9
10	Reclass to repairs & maintenance	3,815	6	10
11	Charity Discounts	(6,497)	43	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**	(184,057)		49

Facility Name & ID Number Grove of Skokie L & R # 0050237 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Pg 6-Supp		See Pg 6-Supp		See Pg6-Supp		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,152,524	Grove Healthcare Properties, LLC	100.00%	$ 770,454	$ (382,070)	1
2	V	19	Computer Services		Grove Healthcare Properties, LLC	100.00%	2,238	2,238	2
3	V	34	Rent		Grove Healthcare Properties, LLC	100.00%	320,331	320,331	3
4	V	30	Depreciation		Grove Healthcare Properties, LLC	100.00%	3,559	3,559	4
5	V	32	Interest Expense		Grove Healthcare Properties, LLC	100.00%	8,204	8,204	5
6	V	30	Depreciation		Grove Healthcare Properties, LLC	100.00%	328	328	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,152,524			$ 1,105,114	$ * (47,410)	14

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

Facility Name & ID Number Grove of Skokie L & R # 0050237 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	Dietary	$	Legacy Healthcare Financial Services LLC	100.00%	$ 18	$ 18	15
16	V	3	Housekeeping Salaries		Legacy Healthcare Financial Services LLC	100.00%	960	960	16
17	V	5	Utilities		Legacy Healthcare Financial Services LLC	100.00%	1,110	1,110	17
18	V	6	Repairs & Maintenance		Legacy Healthcare Financial Services LLC	100.00%	3,045	3,045	18
19	V	17	Administrative Salary - Mgmt. Alloc.	702,121	Legacy Healthcare Financial Services LLC	100.00%	26,864	(675,257)	19
20	V	19	Other Professional Fees		Legacy Healthcare Financial Services LLC	100.00%	7,736	7,736	20
21	V	20	Dues, Licenses & Fees		Legacy Healthcare Financial Services LLC	100.00%	508	508	21
22	V	21	Office Supplies	264,000	Legacy Healthcare Financial Services LLC	100.00%	123,960	(140,040)	22
23	V	25	Education & Seminars		Legacy Healthcare Financial Services LLC	100.00%	1,185	1,185	23
24	V	26	Insurance Expense		Legacy Healthcare Financial Services LLC	100.00%	1,019	1,019	24
25	V	27	Employee Benefits - Mgmt Alloc		Legacy Healthcare Financial Services LLC	100.00%	28,351	28,351	25
26	V	30	Depreciation Expense		Legacy Healthcare Financial Services LLC	100.00%	2,353	2,353	26
27	V	32	Interest Expense		Legacy Healthcare Financial Services LLC	100.00%	16	16	27
28	V	34	Rent Expense		Legacy Healthcare Financial Services LLC	100.00%	8,897	8,897	28
29	V	30	Depreciation Expense		Legacy Healthcare Financial Services LLC	100.00%	(1,232)	(1,232)	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			$ 966,121			$ 204,790	$ * (761,331)	39

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

Facility Name & ID Number Grove of Skokie L & R # 0050237 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues and Subscription	$	Legacy Real Properties, LLC	100.00%	$ 25	$ 25	15
16	V	30	Depreciation		Legacy Real Properties, LLC	100.00%	3,371	3,371	16
17	V	32	Interest		Legacy Real Properties, LLC	100.00%	2,818	2,818	17
18	V	33	Real Estate Taxes		Legacy Real Properties, LLC	100.00%	2,972	2,972	18
19	V	30	Depreciation		Legacy Real Properties, LLC	100.00%	1,182	1,182	19
20	V	34	Rent	8,897	Legacy Real Properties, LLC	100.00%		(8,897)	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			$ 8,897			$ 10,368	$ * 1,471	39

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

Facility Name & ID Number Grove of Skokie L & R # 0050237 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	RN Salary	$ 54,000	Progressive Healthcare Consulting	100.00%	$ 9,233	$ (44,767)	15
16	V	12	Clergy Salary		Progressive Healthcare Consulting	100.00%	610	610	16
17	V	15	Emp Ben - Nursing		Progressive Healthcare Consulting	100.00%	244	244	17
18	V	17	Administrative Salary-Non Owner		Progressive Healthcare Consulting	100.00%	13,045	13,045	18
19	V	19	Professional Fees		Progressive Healthcare Consulting	100.00%	297	297	19
20	V	20	Fees and Subscriptions		Progressive Healthcare Consulting	100.00%	25	25	20
21	V	21	Clerical & General Office		Progressive Healthcare Consulting	100.00%	1,613	1,613	21
22	V	27	Employee Benefits - Mgmt Alloc		Progressive Healthcare Consulting	100.00%	624	624	22
23	V	25	Seminars		Progressive Healthcare Consulting	100.00%	55	55	23
24	V	12	Admission Salary		Progressive Healthcare Consulting	100.00%	4,367	4,367	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			$ 54,000			$ 30,113	$ * (23,887)	39

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

Facility Name & ID Number Grove of Skokie L & R # 0050237 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	39	Ambulance	$ 429	Lifeline Ambulance	100.00%	$ 354	$ (75)	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			$ 429			$ 354	$ * (75)	39

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

Facility Name & ID Number Grove of Skokie L & R # 0050237 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	29	Grove Lincoln Park Living & Rehab Ctr.	Chicago	Legacy Healthcare	Lincolnwood	Management Co.	1
2	Menachem Shabat	29	Pine Acres Rehab & Living Center	Dekalb	Financial Srvcs, LLC			2
3	Jack Rajchenbach	6.1	Astoria Place Living & Rehab	Chicago				3
4	The Rajchenbach Family Trust	15.5	The Grove of Evanston	Evanston	Legacy Real	Lincolnwood	Real Estate	4
5	Ronald Shabat	15.5	Elmbrook Nursing	Chicago	Properties, LLC			5
6	The Robert Hartman Family Trust	4.9	The Grove of LaGrange Park	Elmbrook				6
7			Lakefront Nursing & Rehab Center	LaGrange Park	Grove Healthcare	Lincolnwood	Real Estate	7
8			Warren Barr Living & Rehab Center	Chicago	Properties, LLC			8
9			The Carlton at the Lake	Bridgeview				9
10			Clark Manor Convalescent Center	Chicago	Remed Services,	Lincolnwood	Medical	10
11			Grove of Northbrook L & R	Chicago	LLC		Equipment Sales	11
12			Renaissance Park South	Springfield				12
13			Glenview Terrace Nursing Center	South Elgin	Progressive	Lincolnwood	Consulting	13
14			The Imperial Grove Pavilion	Glenview	Healthcare			14
15			Villa at Evergreen Park	Chicago	Consulting			15
16			Peterson Park Health Care Center	Jacksonville				16
17			Harmony Nursing & Rehab Center	Chicago	Astoria Real	Lincolnwood	Real Estate	17
18			Florence Nursing Home	Wilmington	Property, LLC			18
19			Park Villa Nrsg & Rehab Center	Deerfield				19
20			Grove at the Lake Lvg & Rehab	Chicago	Lifeline Ambulance	Chicago	Ambulance	20
21			Chalet Living & Rehab Center	Marengo			Services	21
22			The Villa at Windsor Park	Chicago				22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Grove of Skokie L & R # 0050237 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	29.00	See Attached	See Att.	See Att.	Mgmt. Salary	13,432	17(8)	1
2	Menachem Shabat	Owner	Administrative	29.00	See Attached	See Att.	See Att.	Mgmt. Salary	13,432	17(8)	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 26,864		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 Skokie L & R # 0050237 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Dietary	Bed Days Available	809,780	17	$ 271		54,385	$ 18	1
2	3	Housekeeping	Bed Days Available	809,780	17	14,291	12,745	54,385	960	2
3	5	Utilities	Bed Days Available	809,780	17	16,531		54,385	1,110	3
4	6	Repairs & Maintenance	Bed Days Available	809,780	17	45,337		54,385	3,045	4
5	17	Administrative Salary - Mgmt. Al	Hours	100	17	400,000		7	26,864	5
6	19	Other Professional Fees	Bed Days Available	809,780	17	115,181		54,385	7,736	6
7	20	Dues, Licenses & Fees	Bed Days Available	809,780	17	7,563		54,385	508	7
8	21	Office Supplies	Bed Days Available	809,780	17	1,845,746	1,700,817	54,385	123,960	8
9	25	Education & Seminars	Bed Days Available	809,780	17	17,652		54,385	1,185	9
10	26	Insurance Expense	Bed Days Available	809,780	17	15,170		54,385	1,019	10
11	27	Employee Benefits - Mgmt Alloc	Bed Days Available	809,780	17	289,128		54,385	19,415	11
12	27	Employee Benefits - Mgmt Alloc	Hours	100	17	133,004		7	8,936	12
13	30	Depreciation Expense	Bed Days Available	809,780	17	35,039		54,385	2,353	13
14	32	Interest Expense	Bed Days Available	809,780	17	242		54,385	16	14
15	34	Rent Expense	Bed Days Available	809,780	17	132,473		54,385	8,897	15
16	30	Depreciation Expense	Direct Allocation						(1,232)	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,067,628	$ 1,713,562		$ 204,790	25

Facility Name & ID Number Grove of Skokie L & R # 0050237 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 North Ridgeway Avenue
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: (847) 679-9797
Fax Number: (847) 679-3676

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	RN Salary	Patient Days	550,071	11	$ 93,385	$ 93,385	54,385	$ 9,233	1
2	12	Clergy Salary	Patient Days	550,071	11	6,165	6,165	54,385	610	2
3	15	Emp Ben - Nursing	Patient Days	550,071	11	2,467		54,385	244	3
4	17	Administrative Salary-Mgmt Allo	Patient Days	550,071	11	131,937	131,937	54,385	13,045	4
5	19	Professional Fees	Patient Days	550,071	11	3,003		54,385	297	5
6	20	Fees and Subscriptions	Patient Days	550,071	11	250		54,385	25	6
7	21	Clerical & General Office	Patient Days	550,071	11	16,314	11,963	54,385	1,613	7
8	24	Seminars	Patient Days	550,071	11	560		54,385	55	8
9	27	Employee Benefits - Mgmt Alloc	Patient Days	550,071	11	6,314		54,385	624	9
10	12	Admissions Salary	Patient Days	550,071	11	44,165	44,165	54,385	4,367	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					$ 304,560	$ 287,615		$ 30,113	25

Facility Name & ID Number Grove of Skokie L & R # 0050237 Report Period Beginning: 01/01/13 Ending: 12/31/13

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: Lifeline Ambulance LLC
Street Address: 2424 S. Wabash Ave
City / State / Zip Code: Chicago, IL 60616
Phone Number: (312) 949-9595
Fax Number: (312) 949-9262

	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	39	Ambulance	Direct Allocation			$	$		$ 354	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					$	$		$ 354	25

Facility Name & ID Number Grove of Skokie L & R # 0050237 Report Period Beginning: 01/01/13 Ending: 12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Private Bank		X	Capital Expenditures	$10,186.00	10/23/08	$ 671,440	$	10/1/13	3.7606	$ 2,841	1
2	Private Bank		X	Line of Credit		10/31/11	560,000	560,000	10/31/14	Var		2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$10,186.00		$ 1,231,440	$ 560,000			$ 2,841	9
	B. Non-Facility Related*											
10							Interest Income Offset				(13,879)	10
11							Allocated from Management Company				16	11
12							Allocated from Legacy Real Properties, LLC				2,818	12
13							Allocated from Grove Healthcare Properties				8,204	13
14	TOTAL Non-Facility Related						$	$			$ (2,841)	14
15	TOTALS (line 9+line14)						$ 1,231,440	$ 560,000			$	15

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

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

**** 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 Skokie L & R # 0050237 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 173,669	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.)	**2012 & 2013**	$ 355,110	2
3. Under or (over) accrual (line 2 minus line 1).		$ 181,441	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 200,750	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
	Allocation from Home Office	2,981	
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.		$ 385,172	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	83,959	8
	2009	183,952	9
	2010	336,689	10
	2011	347,131	11
	2012	364,151	12

Estimated accrual based on PY tax plus a 5% increase.

FY12 Taxes = $364,151 X 1.05=382,359-181,881=200,478. Used $200,750.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grove of Skokie L & R COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050237

CONTACT PERSON REGARDING THIS REPORT Chaim Rajchenbach

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

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

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-16-411-018-0000	9000 Lavergne Ave	$ 73,813.13	$ 73,813.13
2.	10-16-411-017-0000	9000 Gross Point Rd	$ 290,337.94	$ 290,337.94
3.	10-35-104-076-0000	7040 Ridgeway Avenue	$ 44,384.14	$ 2,980.85
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 408,535.21	$ 367,131.92

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

Facility Name & ID Number Grove of Skokie L & R # 0050237 Report Period Beginning: 01/01/13 Ending: 12/31/13

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

N/A

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

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Allocated from Legacy Real Properties			$ 5,495	1
2					2
3	TOTALS			$ 5,495	3

Facility Name & ID Number Grove of Skokie L & R # 0050237 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	Allocated from Legacy Real Properties				$ 42,570	$		$ 1,419	$ 1,419	$ 6,386	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Landscaping			2009	10,000	666	15	666		2,997	9
10	Landscaping			2009	32,000	2,134	15	2,134		9,603	10
11	Built-in Cabinets			2009	66,890	1,672	40	1,672		7,524	11
12	Satellite System Installation			2009	11,305	283	40	283		1,273	12
13	Exterior Painting			2009	44,020	1,101	40	1,101		4,954	13
14	1st Floor remodel			2009	18,589	465	40	465		2,092	14
15	Electrical Work			2009	11,488	287	40	287		1,292	15
16	Painting & Décor			2009	107,803	2,695	40	2,695		12,128	16
17	Rehab Bathrooms			2009	25,000	625	40	625		2,813	17
18	2nd Floor & Nurses Station Remodel			2009	131,292	3,282	40	3,282		14,769	18
19	Install Locks			2009	8,500	213	40	213		958	19
20	New Roof			2009	39,725	993	40	993		4,469	20
21	Call Light System			2009	15,988	400	40	400		1,800	21
22	Kitchen Remodel			2009	46,284	1,157	40	1,157		5,207	22
23	Vent System Installation			2009	15,466	387	40	387		1,741	23
24	Therapy Room Remodel			2009	29,544	739	40	739		3,325	24
25	Elevator Repairs			2009	16,128	403	40	403		1,814	25
26	Rehab DON Office			2009	5,767	144	40	144		648	26
27	Rehab 34 Resident Bathrooms			2009	14,593	365	40	365		1,642	27
28	Building Improvement			2009	5,767	144	40	144		648	28
29	Electrical & Lighting			2009	4,025	101	40	101		454	29
30	Fire Sprinkler System			2009	7,952	199	40	199		895	30
31	Ventilation System Installation			2009	15,466	387	40	387		1,741	31
32	Window Coverings & Installation			2009	29,706	743	40	743		3,343	32
33	Ceiling Fixtures			2009	4,530	113	40	113		509	33
34	Flooring			2009	51,071	1,277	40	1,277		5,746	34
35	Smoke Detectors			2009	6,174	154	40	154		693	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 Skokie L & R # 0050237 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	Irrigation System	2009	$ 21,000	$ 525	40	$ 525	$	$ 2,363	37
38	Patch & Paint Conference Room	2009	1,860	47	40	47		211	38
39	Fire Sprinkler System	2009	2,100	53	40	53		238	39
40	Nurse Call System	2009	15,556	389	40	389		1,751	40
41	Tile Installation on 2nd Floor	2009	2,700	68	40	68		306	41
42	Rewire for Cable	2009	2,703	68	40	68		306	42
43	MDS Office Cabinetry	2009	7,400	185	40	185		833	43
44	Tile installation	2010	3,908	98	40	98		343	44
45	Electrical for new sign	2010	14,447	361	40	361		1,264	45
46									46
47	Demolition & Replacement of walls, retiling to include plumbing,	2011	21,977	1,466	15	1,466		3,665	47
48	electrical, and replacement of fixtures, tub, etc.								48
49									49
50	Doors	2011	3,228	462	7	462		1,155	50
51	Storm Sewer	2011	3,500	175	20	175		438	51
52	Landscaping	2011	3,020	202	15	202		505	52
53	Replacement of Water Heating Pipe	2011	3,377	85	40	85		212	53
54	Storm Sewer Repair	2011	3,500	88	40	88		220	54
55									55
56	Railings for Existing Stairways	2012	5,500	138	40	138		207	56
57	Remove Windows and Repair after Removal	2012	6,045	151	40	151		227	57
58	Replace Leaking Pipes in Dining Room	2012	4,146	104	40	104		156	58
59	Flooring in Dining Room	2012	5,055	126	40	126		190	59
60	Replace Leaking Pipes in Dining Room	2012	3,275	82	40	82		123	60
61									61
62	Porecelain Tile - Dining Room	2013	15,048	188	40	188		188	62
63	Fire Alarm Panel & Piping	2013	8,154	102	40	102		102	63
64	Replace double door	2013	4,960	62	40	62		62	64
65	Sprinklers - partial pmt and engineering fees	2013	178,856	2,236	40	2,236		2,236	65
66	3 phase fire pump start up fee -	2013	12,735	159	40	159		159	66
67	Air cooled chiller	2013	89,390	1,117	40	1,117		1,117	67
68	Relocate electrical wares, install light fix	2013	5,125	64	40	64		64	68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,266,208	$ 29,930		$ 31,349	$ 1,419	$ 120,105	70

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

Facility Name & ID Number Grove of Skokie L & R # 0050237 Report Period Beginning: 01/01/13 Ending: 12/31/13

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		$ 1,266,208	$ 29,930		$ 31,349	$ 1,419	$ 120,105	1
2	Replaced temperature controller	2013	2,921	37	40	37		37	2
3	Outside storage room	2013	4,615	58	40	58		58	3
4	Hot water heater	2013	10,788	135	40	135		135	4
5	Door locks for stairwells	2013	8,859	111	40	111		111	5
6	Kitchen AC outdoor unit	2013	10,787	135	40	135		135	6
7	Remove and replace driveway	2013	15,680	196	40	196		196	7
8	Wiring and cables	2013	5,706	71	40	71		71	8
9	Conduit sleeves	2013	3,330	42	40	42		42	9
10	Install new flooring in women's locker room	2013	4,900	61	40	61		61	10
11	Concrete sidewalk ramp	2013	4,840	61	40	61		61	11
12	Fire alarm system work	2013	11,118	139	40	139		139	12
13	Dining room remodel	2013	50,302	629	40	629		629	13
14	- Light fixtures, Wallpaper, design fees, labor, etc.								14
15									15
16	Electrical service for new fire pump	2013	14,950	187	40	187		187	16
17	Wireless network	2013	22,470	281	40	281		281	17
18	New Phone system	2013	39,552	494	40	494		494	18
19									19
20	Allocated from Legacy Real Properties	2009	24,175			1,209	1,209	4,533	20
21	Allocated from Legacy Real Properties	2010	7,351			294	294	1,030	21
22	Allocated from Legacy Real Properties	2011	10,449			522	522	1,567	22
23									23
24									24
25	Allocated from Legacy Healthcare Financial Services	2012	1,915			96	96	192	25
26	Allocated from Legacy Healthcare Financial Services	2013	6,125			306	306	306	26
27									27
28	Allocated from Grove HC Properties	2008	60,573			2,441	2,441	13,065	28
29	Allocated from Grove HC Properties	2010	15,905			578	578	1,490	29
30									30
31	Reconcile to Book Depreciation			(14,700)			14,700		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,603,519	$ 17,867		$ 39,432	$ 21,565	$ 144,925	34

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

Facility Name & ID Number Grove of Skokie L & R # 0050237 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 224,530	$ 35,948	$ 29,988	$ (5,960)	10	$ 133,506	71
72	Current Year Purchases	65,575	3,279	3,279		10	3,279	72
73	Fully Depreciated Assets							73
74	See Schedule 13A	34,047		2,696	2,696		12,722	74
75	TOTALS	$ 324,152	$ 39,227	$ 35,963	$ (3,264)		$ 149,507	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	N/A			$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,933,166	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 57,094	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 75,395	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 18,301	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 294,432	85	

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

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

G. Construction-in-Progress

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

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

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

Grove of Skokie Living and Rehab Center
0050237
12/31/2013

Schedule 13A

	Category of Equipment	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Component Life	Accumulated Depreciation
1	Allocation from LHFS, Inc	7,194		719	719	7	1,493
2	Allocated from Grove HC Properties	15,768		868		7	7,050
3	Allocated from Legacy Real Properties	11,085		1,109	1,109	7	4,179
	Totals	34,047	-	2,696	1,828		12,722

Facility Name & ID Number Grove of Skokie L & R # 0050237 Report Period Beginning: 01/01/13 Ending: 12/31/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Chicago Title Land Trust Company (Master Lessor); Grove HC Properties (Sub-Lessor--Related Party)

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1983	149	9/1/08	$ 770,454	3	7	3
4	Additions							4
5								5
6	Home Office Allocation				(61,739)			6
7	TOTAL		149		$ 708,715 **			7

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

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

10. Effective dates of current rental agreement:
Beginning 9/1/08
Ending 8/31/18

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

	Fiscal Year Ending	Annual Rent
12.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 46,667 Description: Nursing Equipment: $42,517; Bed Rental $4,150
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	See Schedule 14A	See Schedule 14A	$ 1,750.14	$ 16,806	17
18					18
19					19
20					20
21	TOTAL		$ 1,750.14	$ 16,806	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.

Use	Model Year and Make	Monthly Lease Payment	Rental Expense for this Period
Facility Related	Toyota Camry	600.06	7,231
Facility Related	2011 Nissan Maxima	425.08	850
Facility Related	2011 Acura MDX	725.00	8,725
		1,750	16,806

Facility Name & ID Number Grove of Skokie L & R # 0050237 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Grove of Skokie L & R # 0050237 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$	3,141	$ 263,840	$	3,141	$ 263,840	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,221	102,545		1,221	102,545	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		6,320	530,878		6,320	530,878	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				348,670		348,670	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	39(2)					41,415		41,415	12
13	Other (specify): Ambulance	39(2)				10,074			10,074	13
14	TOTAL			$	10,682	$ 907,337	$ 390,085	10,682	$ 1,297,422	14

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

Facility Name & ID Number Grove of Skokie L & R # 0050237 Report Period Beginning: 01/01/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13 (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	$ 122,458	$ 122,458	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (412,454))	3,371,856	3,371,856	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	82,922	82,922	6
7	Other Prepaid Expenses	90,809	90,809	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Sch17A	2,382,292	2,382,292	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,050,337	$ 6,050,337	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	(12,600)	5,495	13
14	Buildings, at Historical Cost		42,570	14
15	Leasehold Improvements, at Historical Cost	1,420,651	1,560,949	15
16	Equipment, at Historical Cost	319,270	324,152	16
17	Accumulated Depreciation (book methods)	(236,351)	(294,432)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,490,970	$ 1,638,734	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,541,307	$ 7,689,071	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 404,336	$ 404,336	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	473,722	473,722	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,276	20,276	31
32	Accrued Real Estate Taxes(Sch.IX-B)	200,750	200,750	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch17A	1,143,014	1,143,014	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,242,098	$ 2,242,098	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	560,000	560,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 560,000	$ 560,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,802,098	$ 2,802,098	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,739,209	$ 4,886,973	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,541,307	$ 7,689,071	48

***(See instructions.)**

Grove of Skokie Living and Rehab Center
0050237
12/31/2013

Schedule 17A

XV: Special Services

Line 9 - Other Current Assets

	Operating	After Consolidation
Trust Clearing Acct	26,724	26,724
Lease Deposit	521,500	521,500
Due to Medicare	(20,977)	(20,977)
Due to Others	712,175	712,175
IL B L F	20,115	20,115
Leg. Charity	(5,248)	(5,248)
Lagrange	134	134
Due to 1st Health	8,105	8,105
Due To/From Related	1,100,043	1,100,043
Due To/From Northbrook	870	870
Due To/From Peterson	2,800	2,800
LIF INS	18	18
Due To/From Progressive	16,033	16,033
	2,382,292	2,382,292

Line 36 - Other Current Liabilities

	Operating	After Consolidation
HDSI Transfer Acct	450	450
Due to IDPA	73,963	73,963
Cur Year Additions	(2,175)	(2,175)
Admin Bonus	55,000	55,000
Accrued Management Fees	21,667	21,667
Emp Loan, ADV, W/A	(93)	(93)
Union Dues Payable	(1,828)	(1,828)
Accrued Seqstr	1,017	1,017
GHCP	799,377	799,377

Members	172,300	172,300
Due Lessor/Prior Own	23,336	23,336
	1,143,014	1,143,014

Facility Name & ID Number Grove of Skokie L & R **#** 0050237 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,437,082	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	100,000	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,537,082	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,377,834	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	(2,175,707)	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)**	$ (797,873)	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)**	$ 4,739,209	24 *

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

Facility Name & ID Number Grove of Skokie L & R # 0050237 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 10,552,621	1
2	Discounts and Allowances for all Levels	1,176,141	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,728,762	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	173,471	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 173,471	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	15,569	17
18	Sale of Supplies to Non-Patients	2,096	18
19	Laboratory	215	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 17,880	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	79,311	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 79,311	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)**	$ 11,999,424	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,311,772	31
32	Health Care	3,367,329	32
33	General Administration	2,444,867	33
	B. Capital Expense		
34	Ownership	1,276,062	34
	C. Ancillary Expense		
35	Special Cost Centers	1,880,730	35
36	Provider Participation Fee	340,830	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,621,590	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,377,834	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,377,834	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,709,532	44
45	Private Pay - Net Inpatient Revenue	401,560	45
46	Medicare - Net Inpatient Revenue	4,617,670	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,728,762	49

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

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

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

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

^ - LLC members are cash basis tax payers.

Facility Name & ID Number Grove of Skokie L & R # 0050237 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,110	2,514	$ 125,962	$ 50.10	1
2	Assistant Director of Nursing	2,139	2,205	85,412	38.74	2
3	Registered Nurses	32,946	35,756	998,298	27.92	3
4	Licensed Practical Nurses	9,083	9,772	242,153	24.78	4
5	CNAs & Orderlies	88,543	92,893	959,580	10.33	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,133	7,720	118,579	15.36	8
9	Activity Director	1,988	2,199	43,854	19.94	9
10	Activity Assistants	6,509	7,103	117,832	16.59	10
11	Social Service Workers	7,023	7,454	118,816	15.94	11
12	Dietician					12
13	Food Service Supervisor	3,628	3,762	93,032	24.73	13
14	Head Cook	7,803	8,343	103,954	12.46	14
15	Cook Helpers/Assistants	13,822	14,707	145,751	9.91	15
16	Dishwashers					16
17	Maintenance Workers	6,703	7,269	103,219	14.20	17
18	Housekeepers	15,272	16,238	149,229	9.19	18
19	Laundry	4,646	5,473	58,556	10.70	19
20	Administrator	1,883	2,141	116,908	54.60	20
21	Assistant Administrator	215	254	10,788	42.47	21
22	Other Administrative	3,148	3,327	68,708	20.65	22
23	Office Manager					23
24	Clerical	17,742	19,182	280,819	14.64	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	4,673	5,019	98,630	19.65	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	237,009	253,331	$ 4,040,080 *	$ 15.95	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	94	$ 9,778	1(3)	35
36	Medical Director	Monthly	99,600	9(3)	36
37	Medical Records Consultant	33	4,512	10(3)	37
38	Nurse Consultant	628	27,000	10(3)	38
39	Pharmacist Consultant	Monthly	10,565	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	2,415	10(3)	42
43	Speech Therapy Consultant				43
44	Activity Consultant	46	2,288	11(3)	44
45	Social Service Consultant	69	5,510	12(3)	45
46	Other(specify) MDS Consulting	Monthly	63,798	10(3)	46
47	Nursing Consultant	Monthly	3,850	10(3)	47
48					48
49	TOTAL (lines 35 - 48)	870	$ 229,316		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	3,645	63,779	10(3)	52
53	TOTAL (lines 50 - 52)	3,645	$ 63,779		53

Facility Name & ID Number Grove of Skokie L & R # 0050237 Report Period Beginning: 01/01/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ambreen Qureshi	Administrator	0	$ 116,908
Patricia Davis	Asst. Administrator	0	10,788
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 127,696

B. Administrative - Other

Description	Amount
Management Fees "Eliminated in Col. 7"	$ 702,121
(Eliminated in Col. 7)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 702,121

C. Professional Services

Vendor/Payee	Type	Amount
See Schedule 21C		$ 152,261
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 152,261

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 107,059
Unemployment Compensation Insurance	69,165
FICA Taxes	277,617
Employee Health Insurance	149,144
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	12,276
Employee Life Insurance	25,254
Employee Physicals	5,340
Unreimbursed Payroll Taxes	18,862
TOTAL (agree to Schedule V, line 22, col.8)	$ 664,717

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	224
Health Care Worker Background Check	
(Indicate # of checks performed 213)	2,560
Patient Background Checks 470	5,639
IL Council on Long Term Care	15,578
Miscellaneous Licenses & Fees	5,546
Legacy HC Allocation	533
Grove HC Properties Allocation	25
Miscellaneous Dues & Subscription	430
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,535

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,998
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,998

**See instructions.

Provider Na Grove of Skokie Living and Rehab Center
Provider #: 0050237
Year End 12/31/2013
Schedule 21C

XIX.C. Professional Services

Vendor/Payee	Type	Amount	
McGladrey LLP	Accounting	20,810	
FR&R	Accounting	1,825	
Misc	Accounting	250	
ADM CONSULTANTS		2,025	
CORPORATION SERVICE COMPANY	Legal	177	
		2,290	
GUTNICKI LLP	Legal	28	Out of period
KOREY COTTER HEATHER & RICHARD	Legal	65	
LEGACY REIMBURSEMENT	Legal	10,698	
MEYER MAGENCE	Legal	4,813	
MUCH SHELIST	Legal	104	
OGLETREE, DEAKINS, NASH,	Legal	243	
SCOTT & KRAUS LLC	Legal	820	
SKIKIDELSKY & ASSOCIATES	Legal	185	Out of period
STONE, MCGUIRE & SIEGAL	Legal	279	
ACHIEVE ACCREDITATION, LLC	Purchasing Consultant	13,773	
IIT/SOURCETECH	thcare Regulatory Consu	1,790	
ILLINOIS RYTES CORP.	Purchasing Consultant	12,048	
LEGACY REIMBURSEMENT	Other	11,510	
MTS CONSULTING, LLC	Purchasing Consultant	1,576	
PERSONNEL PLANNERS,INC.	Workers comp Consultant	1,438	
PREMIER MEDICAL SERVICES INC	Purchasing Consultant	10,800	
PROFESSIONAL SEARCH NETWORK	Purchasing Consultant	1,455	
PROSPECT RESOURCES INC	Risk Management	800	
ZIMMET HEALTHCARE SERVICES	Healthcare Consultant	347	
AMERICAN DATA	Computer	4,560	
AMERICAN EXPRESS	Computer	616	
ARDENT COMMUNICATIONS, INC.	Computer	320	
CREATIVE TECHNOLOGY	Computer	9,120	
E-HEALTH DATA SOLUTIONS	Computer	5,026	
HEALTH DATA SYSTEMS, INC.	Computer	1,124	
HEALTH DATA SYSTEMS,INC.	Computer	12,047	
LEGACY REIMBURSEMENT	Computer	2,879	
THE JOINT COMMISSION	Computer	59	
WESCOM SOLUTIONS INC.	Computer	16,364	
		152,261	

Schedule V, Line 19, Column 3	152,261	0
Legacy HC Finance Svcs, LLC Allocation	7,736	
Grove Healthcare Properties, LLC Allocation	2,238	
Progressive Healthcare Consulting Allocation	297	
Disallow Legal due to error	(2,635)	
Out of Period Legal	(213)	
Schedule V, Line 19, Column 8	159,684	
	0	

Facility Name & ID Number Grove of Skokie L & R # 0050237 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

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

Facility Name & ID Number Grove of Skokie L & R # 0050237 Report Period Beginning: 01/01/13 Ending: 12/31/13

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ILCLTC: $15,578**

(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**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **39,762** Line **10(2)**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **340,830**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

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

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.