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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0053918

Facility Name: Grove Of Northbrook L & R

Address: 263 Skokie Boulevard (Number) Northbrook (City) 60062 (Zip Code)

County: Cook

Telephone Number: (847) 564-0505 **Fax #** (847) 564-3775

HFS ID Number:

Date of Initial License for Current Owners: 11/1/2012

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 282-6300
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 01/01/15 to 12/31/15 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) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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 Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	86	Skilled (SNF)	86	31,390	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,520	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	134	TOTALS	134	48,910	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	3,560	417	2,680	6,657	8
9	SNF/PED					9
10	ICF	35,993	1,126	1,246	38,365	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,553	1,543	3,926	45,022	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.05%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

I. On what date did you start providing long term care at this location?
Date started 11/1/2012

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/1/2012 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 83 and days of care provided 2,350

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: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	300,788	48,127	6,403	355,318		355,318		355,318			1
2	Food Purchase		243,099		243,099		243,099	(7,249)	235,850			2
3	Housekeeping	136,714	25,532		162,246		162,246	90	162,336			3
4	Laundry	51,354	13,568	691	65,613		65,613		65,613			4
5	Heat and Other Utilities			151,961	151,961		151,961	(15,500)	136,461			5
6	Maintenance	55,501		130,685	186,186		186,186	2,717	188,903			6
7	Other (specify):*											7
8	**TOTAL General Services**	544,357	330,326	289,740	1,164,423		1,164,423	(19,943)	1,144,480			8
	B. Health Care and Programs											
9	Medical Director			24,156	24,156		24,156		24,156			9
10	Nursing and Medical Records	2,645,383	180,327	65,573	2,891,283		2,891,283	1,757	2,893,040			10
10a	Therapy	160,278		830	161,108		161,108		161,108			10a
11	Activities	78,321	11,018	1,971	91,310		91,310	181	91,491			11
12	Social Services	286,764		11,122	297,886		297,886	48,072	345,958			12
13	CNA Training											13
14	Program Transportation			41,325	41,325		41,325		41,325			14
15	Other (specify):*							7,270	7,270			15
16	**TOTAL Health Care and Programs**	3,170,746	191,345	144,977	3,507,068		3,507,068	57,281	3,564,349			16
	C. General Administration											
17	Administrative	102,276		1,374	103,650		103,650	43,059	146,709			17
18	Directors Fees											18
19	Professional Services			363,826	363,826	(21,183)	342,643	(198,187)	144,456			19
20	Dues, Fees, Subscriptions & Promotions			169,366	169,366		169,366	(99,427)	69,939			20
21	Clerical & General Office Expenses	160,703	2,059	202,933	365,695		365,695	(119,370)	246,325			21
22	Employee Benefits & Payroll Taxes			705,618	705,618		705,618		705,618			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,789	1,789		1,789	870	2,659			24
25	Other Admin. Staff Transportation			1,551	1,551		1,551		1,551			25
26	Insurance-Prop.Liab.Malpractice			145,709	145,709		145,709	3,168	148,877			26
27	Other (specify):*							32,191	32,191			27
28	**TOTAL General Administration**	262,979	2,059	1,592,166	1,857,204	(21,183)	1,836,021	(337,696)	1,498,325			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,978,082	523,730	2,026,883	6,528,695	(21,183)	6,507,512	(300,358)	6,207,154			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 Northbrook L & R #0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			56,208	56,208		56,208	177,000	233,208			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,113	22,113		22,113	378,103	400,216			32
33	Real Estate Taxes			288,000	288,000	21,183	309,183	1,727	310,911			33
34	Rent-Facility & Grounds			773,411	773,411		773,411	(773,411)	(0)			34
35	Rent-Equipment & Vehicles			16,813	16,813		16,813	1,770	18,583			35
36	Other (specify):*			1,680,000	1,680,000		1,680,000	(1,680,000)				36
37	TOTAL Ownership			2,836,545	2,836,545	21,183	2,857,728	(1,894,811)	962,918			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		137,247	414,258	551,505		551,505		551,505			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			329,045	329,045		329,045		329,045			42
43	Other (specify):*			456,574	456,574		456,574	(456,574)				43
44	TOTAL Special Cost Centers		137,247	1,199,877	1,337,124		1,337,124	(456,574)	880,550			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,978,082	660,977	6,063,305	10,702,364		10,702,364	(2,651,743)	8,050,621			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 Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	(16,466)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(41,029)	30		9
10	Interest and Other Investment Income	(974)	32		10
11	Discounts, Allowances, Rebates & Refunds	(8,446)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(83)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,179)	21		18
19	Entertainment				19
20	Contributions	(78,500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(176,385)	21		24
25	Fund Raising, Advertising and Promotional	(17,880)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,352,288)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,694,230)		$	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)	42,487		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 42,487		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,651,743)		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

Grove Of Northbrook L & R

ID# 0053918

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Veterans Expense	$ (30,681)	10	1
2	Sequestration	(29,060)	21	2
3	Patient Personal Items	(2,698)	10	3
4	Meals	(1,485)	21	4
5	Bank Charges	(6,774)	21	5
6	Goodwill Write Off	(1,680,000)	36	6
7	Additional R&M	198	06	7
8	PAC Dues	(3,913)	20	8
9	Non Allowable Legal Fees	(51,772)	19	9
10	Non Allowable Expense	(456,574)	43	10
11	Bldg Co - Accounting	(33,792)	19	11
12	Bldg Co - Legal Fees	(1,785)	19	12
13	Bldg Co - Loan Fees	(46,584)	36	13
14	Bldg Co - Professional Fees	(3,450)	19	14
15	Bldg Co - Title Fees	(518)	21	15
16	Bldg Co - Zoning Fees	(3,400)	21	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**	(2,352,288)		49

Grove Of Northbrook L & R

ID# 0053918

Report Period Beginning: 01/01/15

Ending: 12/31/15

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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													1
2	Food Purchase	(8,529)				1,280							(7,249)	2
3	Housekeeping			90									90	3
4	Laundry													4
5	Heat and Other Utilities	(16,466)		966									(15,500)	5
6	Maintenance	198		2,205		314							2,717	6
7	Other (specify):*													7
8	**TOTAL General Services**	(24,797)		3,260		1,594							(19,943)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(33,379)				35,136							1,757	10
10a	Therapy													10a
11	Activities			181									181	11
12	Social Services					48,072							48,072	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					7,270							7,270	15
16	**TOTAL Health Care and Programs**	(33,379)		181		90,478							57,281	16
	C. General Administration													
17	Administrative			1,374		41,685							43,059	17
18	Directors Fees													18
19	Professional Services	(90,799)	39,027	(146,843)		428							(198,187)	19
20	Fees, Subscriptions & Promotions	(100,293)		800		66							(99,427)	20
21	Clerical & General Office Expenses	(219,801)	3,918	99,456		(2,943)							(119,370)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			806		64							870	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			611		2,557							3,168	26
27	Other (specify):*			24,903		7,288							32,191	27
28	**TOTAL General Administration**	(410,893)	42,945	(18,893)		49,145							(337,696)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(469,069)	42,945	(15,452)		141,218							(300,358)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Grove Of Northbrook L & R** **#** **0053918** **Report Period Beginning:** **01/01/15** **Ending:** **12/31/15**

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(41,029)	214,867	1,367	1,795								177,000	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(974)	378,095	10	971								378,103	32
33	Real Estate Taxes		1	1,726									1,727	33
34	Rent-Facility & Grounds		(773,411)	6,425	(6,425)								(773,411)	34
35	Rent-Equipment & Vehicles			1,246		524							1,770	35
36	Other (specify):*	(1,726,584)	46,584										(1,680,000)	36
37	**TOTAL Ownership**	(1,768,587)	(133,864)	10,775	(3,658)	524							(1,894,811)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(456,574)											(456,574)	43
44	**TOTAL Special Cost Centers**	(456,574)											(456,574)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(2,694,230)	(90,919)	(4,677)	(3,658)	141,742							(2,651,743)	45

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 773,411	Brooks Properties	100.00%	$	$ (773,411)	1
2	V	19	Accounting Fees		Brooks Properties	100.00%	33,792	33,792	2
3	V	30	Depreciation		Brooks Properties	100.00%	214,867	214,867	3
4	V	32	Interest	63	Brooks Properties	100.00%	378,158	378,095	4
5	V	19	Legal Fees		Brooks Properties	100.00%	1,785	1,785	5
6	V	36	Loan Fees		Brooks Properties	100.00%	46,584	46,584	6
7	V	19	Professional Fees		Brooks Properties	100.00%	3,450	3,450	7
8	V	33	Taxes-Property		Brooks Properties	100.00%	1	1	8
9	V	21	Title Fees		Brooks Properties	100.00%	518	518	9
10	V	21	Zoning Fees		Brooks Properties	100.00%	3,400	3,400	10
11	V								11
12	V								12
13	V								13
14	Total			$ 773,474			$ 682,555	$ * (90,919)	14

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

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	3	HOUSEKEEPING SUPPLIES	$	Legacy Healthcare Financial Services	100.00%	$ 90	$ 90	15
16	V	5	UTILITIES		Legacy Healthcare Financial Services	100.00%	966	966	16
17	V	6	GROUNDS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	2,205	2,205	17
18	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services	100.00%	181	181	18
19	V	17	MANAGEMENT FEES - Y. ZUCKERMAN		Legacy Healthcare Financial Services	100.00%	1,374	1,374	19
20	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	18,157	18,157	20
21	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	800	800	21
22	V	21	CLERICAL & GENERAL WAGES		Legacy Healthcare Financial Services	100.00%	90,286	90,286	22
23	V	21	CLERICAL & GENERAL OTHER COSTS		Legacy Healthcare Financial Services	100.00%	9,169	9,169	23
24	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	806	806	24
25	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	611	611	25
26	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	24,903	24,903	26
27	V	30	DEPRECIATION		Legacy Healthcare Financial Services	100.00%	1,367	1,367	27
28	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	10	10	28
29	V	33	REAL ESTATE TAXES		Legacy Healthcare Financial Services	100.00%	1,726	1,726	29
30	V	34	RENT		Legacy Healthcare Financial Services	100.00%	6,425	6,425	30
31	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services	100.00%	1,246	1,246	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V	19	BOOKKEEPING FEES	165,000	Legacy Healthcare Financial Services	100.00%		(165,000)	36
37	V								37
38	V								38
39	Total			$ 165,000			$ 160,323	$ * (4,677)	39

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

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	DEPRECIATION		Legacy Real Properties	100.00%	1,795	$ 1,795	15
16	V	32	INTEREST EXPENSE		Legacy Real Properties	100.00%	971	971	16
17	V								17
18	V								18
19	V	34	RENT	6,425	Legacy Real Properties	100.00%		(6,425)	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			$ 6,425			$ 2,767	$ * (3,658)	39

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

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	FOOD	$	Progressive Healthcare Consulting	100.00%	$ 1,280	$ 1,280	15
16	V	6	MAINTENANCE SALARY		Progressive Healthcare Consulting	100.00%	3	3	16
17	V	6	BUILDING MAINTENANCE AND R&M		Progressive Healthcare Consulting	100.00%	706	706	17
18	V	10	MEDICAL AND NURSING SUPPLIES		Progressive Healthcare Consulting	100.00%	2	2	18
19	V	10	NURSING SALARIES		Progressive Healthcare Consulting	100.00%	48,934	48,934	19
20	V	12	ACTIVITIES PROGRAM		Progressive Healthcare Consulting	100.00%	8	8	20
21	V	12	CLERGY SALARY		Progressive Healthcare Consulting	100.00%	1,238	1,238	21
22	V	12	ADMISSIONS SALARY		Progressive Healthcare Consulting	100.00%	56,922	56,922	22
23	V	15	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	9,090	9,090	23
24	V	17	ADMIN SALARY- NON OWNER		Progressive Healthcare Consulting	100.00%	60,093	60,093	24
25	V	19	PROFESSIONAL FEES		Progressive Healthcare Consulting	100.00%	428	428	25
26	V	20	FEES, SUBSCRIPTIONS		Progressive Healthcare Consulting	100.00%	66	66	26
27	V	21	CLERICAL & GENERAL		Progressive Healthcare Consulting	100.00%	848	848	27
28	V	24	SEMINARS		Progressive Healthcare Consulting	100.00%	64	64	28
29	V	27	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	11,393	11,393	29
30	V	26	INSURANCE		Progressive Healthcare Consulting	100.00%	2,557	2,557	30
31	V	35	AUTO RENTAL		Progressive Healthcare Consulting	100.00%	524	524	31
32	V	17	ADMINISTRATOR	18,408	Progressive Healthcare Consulting	100.00%		(18,408)	32
33	V	10	NURSING	13,800	Progressive Healthcare Consulting	100.00%		(13,800)	33
34	V	12	SOCIAL SERVICE	10,096	Progressive Healthcare Consulting	100.00%		(10,096)	34
35	V	06	MAINTENANCE	395	Progressive Healthcare Consulting	100.00%		(395)	35
36	V	21	CLERICAL	3,791	Progressive Healthcare Consulting	100.00%		(3,791)	36
37	V	15	PAYROLL TAXES-NURSING	1,820	Progressive Healthcare Consulting	100.00%		(1,820)	37
38	V	27	PAYROLL TAXES	4,105	Progressive Healthcare Consulting	100.00%		(4,105)	38
39	Total			$ 52,415			$ 194,157	$ * 141,742	39

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

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	YAIR ZUCKERMAN	0.90%	ASTORIA PLACE SKILLED NURSING FACILITY LLC	CHICAGO	BROOK PROPERTIES		BUILDING CO	1
2	DINA ZUCKERMAN	0.10%	BETHANY TERRACE	MORTON GROVE	LEGACY REAL PROPERTIES	LINCOLNWOOD	BUILDING CO	2
3	10 PACK TENANT LLC	99.00%	CARLTON SKILLED NURSING FACILITY LLC	CHICAGO	LEGACY HC & FINANCIAL SER	LINCOLNWOOD	HOME OFFICE/BOOKKEEPI	3
4			CHALET SKILLED NURSING FACILITY LLC	CHICAGO	ML GROUP DESIGN & DEV	SKOKIE	ASSET MANAGEMENT	4
5			ELMBROOK SKILLED NURSING FACILITY LLC	ELMHURST	REMED SERVICES LLC	LINCOLNWOOD	NURSING EQUIPMENT	5
6			EVANSTON SKILLED NURSING FACILITY LLC	EVANSTON	AURORA SUPPORTIVE LIVING	AURORA	SUPPORTIVE LIVING	6
7			GROVE OF FOX VALLEY	AURORA	TERRACE GARDENS	MORTON GROVE	ASSISTED LIVING	7
8			LAGRANGE SKILLED NURSING FACILITY LLC	LAGRANGE PARK	LINCOLNSHIRE ASSISTED LIVI	LINCOLNSHIRE	ASSISTED LIVING	8
9			GROVE AT THE LAKE SKILLED NURSING FACILITY LLC	ZION				9
10			LAKEFRONT SKILLED NURSING FACILITY LLC	CHICAGO				10
11			LINCOLN PARK SKILLED NURSING FACILITY LLC	CHICAGO				11
12			LINCOLNSHIRE LIVING & REHAB CENTER LLC	LINCOLNSHIRE				12
13			AVANTARA LONG GROVE	LONG GROVE				13
14			SKOKIE SKILLED NURSING FACILITY LLC	SKOKIE				14
15			WARREN BARR NORTH SHORE	HIGHLAND PARK				15
16			AVANTARA PARK RIDGE	PARK RIDGE				16
17			PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO				17
18			WARREN BARR SOUTH LOOP	CHICAGO				18
19			WARREN BARR LIVING AND REHAB	CHICAGO				19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

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

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Yair Zuckerman	Owner	Administrative	0.90%	See Attached	1.68	4.20%	Alloc Sal/Fee	$ 8,377	17-3/17-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 8,377		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 Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Legacy Healthcare Financial Services
Street Address: 7040 N. Ridgeway
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: (847) 679-9797
Fax Number: (847) 679-1126

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING SUPPLIES	AVAIL. BED DAYS	1,253,624	23	$ 2,296	$	48,910	$ 90	1
2	5	UTILITIES	AVAIL. BED DAYS	1,253,624	23	24,766		48,910	966	2
3	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	1,253,624	23	56,504		48,910	2,205	3
4	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,253,624	23	4,642		48,910	181	4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,253,624	23	465,391		48,910	18,157	5
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,253,624	23	20,516		48,910	800	6
7	21	CLERICAL & GENERAL WAG	AVAIL. BED DAYS	1,253,624	23	2,314,153	2,314,153	48,910	90,286	7
8	21	CLERICAL & GENERAL OTH	AVAIL. BED DAYS	1,253,624	23	235,020		48,910	9,169	8
9	24	SEMINARS	AVAIL. BED DAYS	1,253,624	23	20,662		48,910	806	9
10	26	INSURANCE	AVAIL. BED DAYS	1,253,624	23	15,655		48,910	611	10
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	1,253,624	23	638,286		48,910	24,903	11
12	30	DEPRECIATION	AVAIL. BED DAYS	1,253,624	23	35,040		48,910	1,367	12
13	32	INTEREST	AVAIL. BED DAYS	1,253,624	23	267		48,910	10	13
14	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,253,624	23	44,250		48,910	1,726	14
15	34	RENT	AVAIL. BED DAYS	1,253,624	23	164,669		48,910	6,425	15
16	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,253,624	23	31,945		48,910	1,246	16
17										17
18	17	MGMT FEES- Y. ZUCKERMAN	AVG HOURS WKD	50	20	32,807		2.09	1,374	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,106,869	$ 2,314,153		$ 160,323	25

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	AVAIL. BED DAYS	1,253,624	23	46,013		48,910	1,795	1
2	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,253,624	23	24,899		48,910	971	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					$ 70,912	$		$ 2,767	25

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	FOOD	AVAIL. BED DAYS	1,167,679	20	$ 30,560	$	48,910	$ 1,280	1
2	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,167,679	20	65	65	48,910	3	2
3	6	BUILDING MAINTENANCE AI	AVAIL. BED DAYS	1,167,679	20	16,865		48,910	706	3
4	10	MEDICAL AND NURSING SUP	AVAIL. BED DAYS	1,167,679	20	47		48,910	2	4
5	10	NURSING SALARIES	AVAIL. BED DAYS	1,167,679	20	1,168,252	1,168,252	48,910	48,934	5
6	12	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,167,679	20	187		48,910	8	6
7	12	CLERGY SALARY	AVAIL. BED DAYS	1,167,679	20	29,559	29,559	48,910	1,238	7
8	12	ADMISSIONS SALARY	AVAIL. BED DAYS	1,167,679	20	1,358,960	1,358,960	48,910	56,922	8
9	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,167,679	20	217,026		48,910	9,090	9
10	17	ADMIN SALARY- NON OWNE	AVAIL. BED DAYS	1,167,679	20	1,434,659	1,434,659	48,910	60,093	10
11	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,167,679	20	10,207		48,910	428	11
12	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,167,679	20	1,577		48,910	66	12
13	21	CLERICAL & GENERAL	AVAIL. BED DAYS	1,167,679	20	20,243		48,910	848	13
14	24	SEMINARS	AVAIL. BED DAYS	1,167,679	20	1,535		48,910	64	14
15	27	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,167,679	20	272,007		48,910	11,393	15
16	26	INSURANCE	AVAIL. BED DAYS	1,167,679	20	61,041		48,910	2,557	16
17	35	AUTO RENTAL	AVAIL. BED DAYS	1,167,679	20	12,512		48,910	524	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,635,301	$ 3,991,495		$ 194,157	25

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	The Private Bank		X	Mortgage Note			$	$ 9,794,673			$ 280,306	1
2	G.A.F. Associates		X	Promissory Note							96,370	2
3												3
4												4
5												5
	Working Capital											
6	The Private Bank		X	Note Payable				440,000			22,113	6
7	The Private Bank		X	Line of Credit							1,482	7
8												8
9	TOTAL Facility Related						$	$ 10,234,673			$ 400,271	9
	B. Non-Facility Related*											
10	Interest Income		X								(974)	10
11	Allocated from Legacy HC	X									10	11
12	Allocated from Legacy Real Pro	X									971	12
13	See Supplemental Schedule										(63)	13
14	TOTAL Non-Facility Related						$	$			$ (56)	14
15	TOTALS (line 9+line14)						$	$ 10,234,673			$ 400,215	15

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

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

**** 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 Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15	Interest Income - Bldg Co		X				$	$			$ (63)	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related										(63)	20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 203,369	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.)		$ 258,268	2
3. Under or (over) accrual (line 2 minus line 1).		$ 54,899	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 234,828	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.**		$ 21,183	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** $ 255 **For** 10-12 **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.		$ 310,911	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2010		8
2011		9
2012	203,281	10
2013	248,631	11
2014	256,542	12

2015 Accrual = Monthly Amounts x 12
Allocated from Legacy HC = $1,726
Beginning Accrual Adjusted

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grove Of Northbrook L & R COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053918

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-02-202-040-0000	Long Term Care Facility	$ 256,541.95	$ 256,541.95
2.	See Attached	See Attached	$ 39,271.59	$ 1,532.18
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 295,813.54	$ 258,074.13

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grove Of Northbrook L & R COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053918

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

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

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame Brick Number of Stories 1

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).

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 667,000	1
2	Allocated from Legacy Real Properties			3,192	2
3	TOTALS			$ 670,192	3

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	134		2012	1976	$ 4,410,000	$ 214,867	35	$ 126,000	$ (88,867)	$ 378,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

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
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51									51
52									52
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62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		17,904			895	895	3,580	67
68	Related Party Allocations (Pages 12H & 12I)		54,611	1,561		2,275	714	12,669	68
69	Financial Statement Depreciation			56,207			(56,207)		69
70	TOTAL (lines 4 thru 69)		$ 4,482,515	$ 272,635		$ 129,170	$ (143,465)	$ 394,249	70

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

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 4,482,515	$ 272,635		$ 129,170	$ (143,465)	$ 394,249	1
2	New Pump	2012	2,988		20	149	149	461	2
3	Furnished And Installed 1-New Watts 3-Way Mixing	2012	2,654		20	133	133	409	3
4	Copper Tube Hot Water Heater	2013	8,997		20	450	450	975	4
5	Wiring & Circuit Breakers In Main Switch Gears	2013	5,675		20	284	284	757	5
6	Switches, Lock Systems	2013	12,690		20	635	635	1,904	6
7	Installaton Of Delayed Egrass Locks And Associated Components	2014	6,500		20	325	325	623	7
8	Egressable Mag Lock With Reset Switch	2014	6,472		20	1,294	1,294	2,049	8
9	Installed New Chiller	2014	41,296		20	4,130	4,130	6,883	9
10	Re-Install Conduit Lower Level For Camera	2014	2,701		20	540	540	675	10
11	Installation Of Entrance Door	2014	4,350		20	218	218	272	11
12	Install Electric And Wanderguard System	2014	24,300		20	4,860	4,860	6,885	12
13	Removal And Replacement Of Asphalt / Sewer Repairs	2014	13,150		20	877	877	1,169	13
14	Applied A Patch To The Field Of Wall Flashings	2014	5,500		20	275	275	481	14
15	Repair Of Nurse Call System	2014	7,228		20	1,446	1,446	2,409	15
16	Chiller Replacement	2014	13,764		20	688	688	1,319	16
17	Install Gravel & Mulch	2014	3,380		20	169	169	282	17
18	Kitchen Sink Water & Drain Line	2015	6,750		20	338	338	338	18
19	Repair Leaking Cast Iron Boiler	2015	4,577		20	229	229	229	19
20	Repair Roof	2015	3,600		20	180	180	180	20
21	Two New Fire Rated Stairway Doors - Basement Kitchen	2015	2,950		20	148	148	148	21
22	Wiremold Receptacles In Bedrooms	2015	9,570		20	478	478	478	22
23	Kitchen Storage Room & Basement Wiring Panels	2015	3,103		20	155	155	155	23
24	Architect Fees For Driveway	2015	130,612		20	6,531	6,531	6,531	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,805,321	$ 272,635		$ 153,700	$ (118,935)	$ 429,859	34

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

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,805,321	$ 272,635		$ 153,700	$ (118,935)	$ 429,859	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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,805,321	$ 272,635		$ 153,700	$ (118,935)	$ 429,859	34

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

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,805,321	$ 272,635		$ 153,700	$ (118,935)	$ 429,859	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,805,321	$ 272,635		$ 153,700	$ (118,935)	$ 429,859	34

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

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,805,321	$ 272,635		$ 153,700	$ (118,935)	$ 429,859	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,805,321	$ 272,635		$ 153,700	$ (118,935)	$ 429,859	34

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

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Boiler repair, pressure gauge, heat pump repair	2013	17,904		20	895	895	3,580	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 17,904	$		$ 895	$ 895	$ 3,580	34

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

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 12F, Carried Forward		$ 17,904	$		$ 895	$ 895	$ 3,580	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 17,904	$		$ 895	$ 895	$ 3,580	34

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

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Legacy Real Properties	2009	24,730	841	35	824	(17)	5,358	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Legacy HC Financial Services	2012	1,113	73	20	56	(17)	223	9
10	Allocated from Legacy HC Financial Services	2013	3,558	232	20	178	(54)	534	10
11	Allocated from Legacy HC Financial Services	2014	347	23	20	17	(6)	35	11
12	Allocated from Legacy HC Financial Services	2015	479	31	20	24	(7)	24	12
13									13
14	Allocated from Legacy Real Properties	2009	14,044	208	20	702	494	4,038	14
15	Allocated from Legacy Real Properties	2010	4,270	63	20	171	108	940	15
16	Allocated from Legacy Real Properties	2011	6,070	90	20	303	213	1,517	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 54,611	$ 1,561		$ 2,275	$ 714	$ 12,669	34

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

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 12H, Carried Forward		$ 54,611	$ 1,561		$ 2,275	$ 714	$ 12,669	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 54,611	$ 1,561		$ 2,275	$ 714	$ 12,669	34

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

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 625,237	$ 1,551	$ 73,241	$ 71,690	10	$ 206,847	71
72	Current Year Purchases	62,669	51	6,267	6,216	10	6,267	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 687,906	$ 1,602	$ 79,508	$ 77,906		$ 213,114	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,163,418	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 274,237	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 233,208	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (41,029)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 642,973	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	Legal Fees - 2012	$ 4,200	$	$	86
87	Legal Fees - 2012	5,036			87
88					88
89					89
90					90
91	TOTALS	$ 9,236	$	$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 18,058 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Progressive HC		$	$ 524	17
18					18
19					19
20					20
21	TOTAL		$	$ 524	21

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

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

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 159,359	$		$ 159,359	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			59,619			59,619	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			165,023			165,023	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				114,554		114,554	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					30,257	22,693		52,950	13
14	TOTAL			$		$ 414,258	$ 137,247		$ 551,505	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.

STATE OF ILLINOIS

Facility Name & ID Number Grove Of Northbrook L & R **#** 0053918 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15 **(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	$	$ 1,015,279	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,227,371	1,227,371	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	147,819	147,819	6
7	Other Prepaid Expenses	10,264	48,212	7
8	Accounts Receivable (owners or related parties)	17,296	17,296	8
9	Other(specify):	1,732	277,545	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,404,482	$ 2,733,522	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		667,000	13
14	Buildings, at Historical Cost		3,315,819	14
15	Leasehold Improvements, at Historical Cost	6,750	291,554	15
16	Equipment, at Historical Cost	3,107	1,348,728	16
17	Accumulated Depreciation (book methods)	(237)	(1,018,982)	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):		1,031,807	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 9,620	$ 5,635,926	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,414,102	$ 8,369,448	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 820,078	$ 677,569	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	440,000	440,000	29
30	Accrued Salaries Payable	191,025	191,025	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,760	4,760	31
32	Accrued Real Estate Taxes(Sch.IX-B)		234,828	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36			196,923	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,455,863	$ 1,745,105	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,794,673	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)**	$	$ 9,794,673	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,455,863	$ 11,539,778	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (41,761)	$ (3,170,330)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,414,102	$ 8,369,448	48

***(See instructions.)**

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3	**Prior Ownership Equity**	1,548,508	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,548,508	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,590,269)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,590,269)	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)**	$ (41,761)	24 *

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

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,085,728	1
2	Discounts and Allowances for all Levels	(4,214,048)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,871,680	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,053,445	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,053,445	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	149,666	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,890	19
20	Radiology and X-Ray	2,125	20
21	Other Medical Services	5,869	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 177,550	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	974	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 974	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	8,446	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,446	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,112,095	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,164,423	31
32	Health Care	3,507,068	32
33	General Administration	1,857,204	33
	B. Capital Expense		
34	Ownership	2,836,545	34
	C. Ancillary Expense		
35	Special Cost Centers	1,008,079	35
36	Provider Participation Fee	329,045	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,702,364	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,590,269)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,590,269)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,720,363	44
45	Private Pay - Net Inpatient Revenue	274,746	45
46	Medicare - Net Inpatient Revenue	(322,031)	46
47	Other-(specify) Insurance	37,399	47
48	Other-(specify) Veterans	161,203	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,871,680	49

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

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

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

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

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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	2,318	2,350	$ 103,990	$ 44.25	1
2	Assistant Director of Nursing	2,040	2,080	79,558	38.25	2
3	Registered Nurses	28,152	28,670	819,667	28.59	3
4	Licensed Practical Nurses	21,576	22,056	627,019	28.43	4
5	CNAs & Orderlies	76,970	79,008	962,427	12.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,390	8,646	160,278	18.54	8
9	Activity Director	1,423	1,439	22,637	15.73	9
10	Activity Assistants	4,800	4,912	55,684	11.34	10
11	Social Service Workers	9,138	9,282	206,219	22.22	11
12	Dietician					12
13	Food Service Supervisor	2,440	2,480	68,492	27.62	13
14	Head Cook	6,881	7,025	110,259	15.70	14
15	Cook Helpers/Assistants	11,507	11,787	122,037	10.35	15
16	Dishwashers					16
17	Maintenance Workers	2,190	2,230	55,501	24.89	17
18	Housekeepers	11,628	11,996	136,714	11.40	18
19	Laundry	5,920	6,073	51,354	8.46	19
20	Administrator	2,333	2,357	102,276	43.39	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,292	1,316	22,630	17.20	23
24	Clerical	10,898	11,107	138,073	12.43	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	839	879	13,789	15.69	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	6,885	7,368	119,479	16.22	33
34	TOTAL (lines 1 - 33)	217,620	223,061	$ 3,978,083 *	$ 17.83	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	123	$ 6,403	01-03	35
36	Medical Director	Monthly	24,156	09-03	36
37	Medical Records Consultant	Monthly	2,776	10-03	37
38	Nurse Consultant	Monthly	36,380	10-03	38
39	Pharmacist Consultant	Monthly	10,705	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	8	830	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,971	11-03	44
45	Social Service Consultant	182	11,122	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	313	$ 94,343		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	314	$ 15,712	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	314	$ 15,712		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jonathan Dixon	Administrator	0	$ 58,972
Chaim Dubovick	Administrator	0	43,304
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 102,276

B. Administrative - Other

Description	Amount
Yair Zuckerman - Management Fees	$ 1,374
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,374
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R/Marcum LLP	Accounting	$ 20,827
Legacy Healthcare	Bookkeeping	165,000
Documentation Solutions	Compliance Audits	840
Creative Technology Solutions	Data Processing	9,542
Health Data Systems	Data Processing	6,788
Prime Care Technologies	Data Processing	1,815
Second to None	Customer Satisfaction	900
Wescom Solutions	Data Processing	16,609
Achieve Accreditation	Accreditation	6,970
Paycor	Payroll Processing	21,454
IIT/Sourcetech	Energy Management	1,870
See Supplemental Schedule		111,212
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 363,826

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 99,480
Unemployment Compensation Insurance	78,281
FICA Taxes	303,670
Employee Health Insurance	172,393
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	23,705
401K Expense	2,430
Employee Physical Exam	4,590
Other Employee Benefits	21,070
TOTAL (agree to Schedule V, line 22, col.8)	$ 705,620

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	17,000
Health Care Worker Background Check	
(Indicate # of checks performed 1838)	18,388
Patient Background Checks	
Dues & Subscriptions	22,914
Licenses & Permits	8,782
Allocated from Legacy HC	800
Allocated from Progressive HC	66
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 69,940

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,789
Allocated from Legacy HC	806
Allocated from Progressive HC	64
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,659

**See instructions.

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

Facility Name & ID Number Grove Of Northbrook L & R # 0053918 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC $11,859**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **30,655** Line **10**

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

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

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

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
IDPH #0052050, November 1, 2015

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **329,045**
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. $ Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

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

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.