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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0053918

Facility Name: The Grove of Northbrook

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: Steven N. 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 01/01/16 to 12/31/16 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)
** Subject to the attached Accountants Consulting Report*
(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 The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	31,476	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,568	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	134	TOTALS	134	49,044	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	3,674	523	2,131	6,328	8
9	SNF/PED					9
10	ICF	37,143	1,414	1,328	39,885	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,817	1,937	3,459	46,213	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.23%

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 86 and days of care provided 1,779

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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	327,246	30,400		357,646		357,646		357,646			1
2	Food Purchase		262,226		262,226		262,226	(4,439)	257,787			2
3	Housekeeping	134,102	26,790	282	161,174		161,174	94	161,268			3
4	Laundry	55,284	11,882		67,166		67,166		67,166			4
5	Heat and Other Utilities			142,998	142,998		142,998	(18,744)	124,254			5
6	Maintenance	65,655	7,840	84,194	157,689		157,689	66,430	224,119			6
7	Other (specify):*											7
8	TOTAL General Services	582,287	339,138	227,474	1,148,899		1,148,899	43,340	1,192,239			8
	B. Health Care and Programs											
9	Medical Director			30,492	30,492		30,492		30,492			9
10	Nursing and Medical Records	2,880,830	51,870	58,981	2,991,681		2,991,681	71,226	3,062,907			10
10a	Therapy	178,413			178,413		178,413	(8,307)	170,106			10a
11	Activities	108,424	16,227	1,060	125,711		125,711		125,711			11
12	Social Services	149,811		3,096	152,907		152,907	93,189	246,096			12
13	CNA Training											13
14	Program Transportation			33,259	33,259		33,259	5	33,264			14
15	Other (specify):*							12,755	12,755			15
16	TOTAL Health Care and Programs	3,317,478	68,097	126,888	3,512,463		3,512,463	168,868	3,681,331			16
	C. General Administration											
17	Administrative	99,408		6,020	105,428		105,428	100,399	205,827			17
18	Directors Fees											18
19	Professional Services			92,219	92,219	(600)	91,619	(3,932)	87,688			19
20	Dues, Fees, Subscriptions & Promotions			40,792	40,792		40,792	(6,591)	34,201			20
21	Clerical & General Office Expenses	224,167	3,743	234,880	462,790		462,790	8,871	471,661			21
22	Employee Benefits & Payroll Taxes			727,374	727,374		727,374		727,374			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,120	6,120		6,120	1,844	7,964			24
25	Other Admin. Staff Transportation			5,918	5,918		5,918		5,918			25
26	Insurance-Prop.Liab.Malpractice			161,923	161,923		161,923	3,844	165,767			26
27	Other (specify):*							56,082	56,082			27
28	TOTAL General Administration	323,575	3,743	1,275,246	1,602,564	(600)	1,601,964	160,518	1,762,482			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,223,340	410,978	1,629,608	6,263,926	(600)	6,263,326	372,726	6,636,052			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 The Grove of Northbrook #0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation							243,337	243,337			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,354	43,354		43,354	467,855	511,209			32
33	Real Estate Taxes			288,000	288,000	600	288,600	1,459	290,059			33
34	Rent-Facility & Grounds			1,074,294	1,074,294		1,074,294	(1,074,214)	80			34
35	Rent-Equipment & Vehicles			21,333	21,333		21,333	(369)	20,964			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,426,981	1,426,981	600	1,427,581	(361,932)	1,065,649			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		208,362	381,314	589,676		589,676		589,676			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			345,617	345,617		345,617		345,617			42
43	Other (specify):*			450,625	450,625		450,625	(450,625)	0			43
44	**TOTAL Special Cost Centers**		208,362	1,177,556	1,385,918		1,385,918	(450,625)	935,293			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,223,340	619,340	4,234,145	9,076,825		9,076,825	(439,831)	8,636,994			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 The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Reference	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	(20,589)	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	(132,953)	30		9
10	Interest and Other Investment Income	(5,515)	32		10
11	Discounts, Allowances, Rebates & Refunds	(4,926)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(110)	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	(410)	21		18
19	Entertainment	(2,514)	21		19
20	Contributions	(170)	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	(114,364)	21		24
25	Fund Raising, Advertising and Promotional	(4,179)	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	(967,248)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,252,978)		$	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)	813,148		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 813,148		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (439,830)		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

The Grove of Northbrook

ID# 0053918

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Additional R&M	$ 50,059	06	1
2	Patient Personal Items	(2,496)	10	2
3	Marketing	(4,786)	43	3
4	Bank Charges	(4,116)	21	4
5	Sequestration	(19,247)	21	5
6	Therapy Discounts	(8,307)	10A	6
7	Pharmacy Discounts	(6,916)	10	7
8	Non-Allowable Auto Lease	(419)	35	8
9	Non-Allowable Legal	(25,236)	19	9
10	Building Co - Title Fees	(3,355)	20	10
11	Building Co - Loan Fees	(24,505)	26	11
12	Building Co - Legal Fees	(5,118)	19	12
13	Building Co - Management Fees	(462,673)	21	13
14	PAC Dues	(3,794)	20	14
15	Annual Report	(500)	20	15
16	Non-Allowable Expense	(445,839)	43	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(967,248)		49

The Grove of Northbrook

ID# 0053918

Report Period Beginning: 01/01/16

Ending: 12/31/16

	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 The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	(5,036)		131		466							(4,439)	2
3	Housekeeping			94									94	3
4	Laundry													4
5	Heat and Other Utilities	(20,589)		410			1,435						(18,744)	5
6	Maintenance	50,059		5,441		9,322	1,607						66,430	6
7	Other (specify):*													7
8	**TOTAL General Services**	24,434		6,076		9,788	3,042						43,340	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(9,412)				80,638							71,226	10
10a	Therapy	(8,307)											(8,307)	10a
11	Activities													11
12	Social Services					93,189							93,189	12
13	CNA Training													13
14	Program Transportation					5							5	14
15	Other (specify):*					12,755							12,755	15
16	**TOTAL Health Care and Programs**	(17,719)				186,588							168,868	16
	C. General Administration													
17	Administrative			8,458		91,942							100,399	17
18	Directors Fees													18
19	Professional Services	(30,354)	5,118	19,225	56	1,374	649						(3,932)	19
20	Fees, Subscriptions & Promotions	(11,998)	3,355	1,667		383	2						(6,591)	20
21	Clerical & General Office Expenses	(603,324)	462,673	148,111		1,391	20						8,871	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,108		736							1,844	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice	(24,505)	24,505	956		2,600	288						3,844	26
27	Other (specify):*			32,040		24,042							56,082	27
28	**TOTAL General Administration**	(670,181)	495,651	211,564	56	122,468	960						160,518	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(663,467)	495,651	217,640	56	318,843	4,003						372,726	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Grove of Northbrook # 0053918 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(132,953)	374,340	439	1,511								243,337	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(5,515)	469,601	7	547		3,215						467,855	32
33	Real Estate Taxes			777			682						1,459	33
34	Rent-Facility & Grounds		(1,074,294)	41,166		31	(41,118)						(1,074,214)	34
35	Rent-Equipment & Vehicles	(419)		50									(369)	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(138,887)	(230,353)	42,439	2,058	31	(37,220)						(361,932)	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):*	(450,625)											(450,625)	43
44	**TOTAL Special Cost Centers**	(450,625)											(450,625)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,252,978)	265,298	260,078	2,114	318,875	(33,218)						(439,831)	45

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Rent	$ 1,074,294	Brooks Properties	100.00%	$	$ (1,074,294)	1
2	V	20	Title Fees		Brooks Properties	100.00%	3,355	3,355	2
3	V	32	Interest	1	Brooks Properties	100.00%	469,602	469,601	3
4	V	21	Management Fees		Brooks Properties	100.00%	462,673	462,673	4
5	V	26	Loan Fees		Brooks Properties	100.00%	24,505	24,505	5
6	V	19	Legal Fees		Brooks Properties	100.00%	5,118	5,118	6
7	V	30	Depreciation		Brooks Properties	100.00%	374,340	374,340	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,074,295			$ 1,339,593	$ * 265,298	14

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	FOOD	$	Legacy Healthcare Financial Services	100.00%	$ 131	$ 131	15
16	V	3	HOUSEKEEPING SUPPLIES		Legacy Healthcare Financial Services	100.00%	94	94	16
17	V	5	UTILITIES		Legacy Healthcare Financial Services	100.00%	410	410	17
18	V	6	GROUNDS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	4,090	4,090	18
19	V	6	MAINTENANCE SALARY		Legacy Healthcare Financial Services	100.00%	1,351	1,351	19
20	V	17	CFO SALARY		Legacy Healthcare Financial Services	100.00%	8,458	8,458	20
21	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	19,225	19,225	21
22	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	1,667	1,667	22
23	V	21	CLERICAL & GENERAL WAGES		Legacy Healthcare Financial Services	100.00%	128,273	128,273	23
24	V	21	CLERICAL & GENERAL OTHER COSTS		Legacy Healthcare Financial Services	100.00%	19,838	19,838	24
25	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	1,108	1,108	25
26	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	956	956	26
27	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	32,040	32,040	27
28	V	30	DEPRECIATION		Legacy Healthcare Financial Services	100.00%	439	439	28
29	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	7	7	29
30	V	33	REAL ESTATE TAXES		Legacy Healthcare Financial Services	100.00%	777	777	30
31	V	34	RENT		Legacy Healthcare Financial Services	100.00%	41,118	41,118	31
32	V	34	STORAGE		Legacy Healthcare Financial Services	100.00%	48	48	32
33	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services	100.00%	50	50	33
34	V								34
35	V								35
36	V	17	MANAGEMENT FEES	6,020	Legacy Healthcare Financial Services	100.00%		(6,020)	36
37	V	17	MANAGEMENT FEES - YAIR ZUCKERMAN		Legacy Healthcare Financial Services	100.00%	6,020	6,020	37
38	V								38
39	Total			$ 6,020			$ 266,098	$ * 260,078	39

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	19	PROFESSIONAL FEES	$	Legacy Real Properties	100.00%	$ 56	$ 56	15
16	V	30	DEPRECIATION		Legacy Real Properties	100.00%	1,511	1,511	16
17	V	32	INTEREST EXPENSE		Legacy Real Properties	100.00%	547	547	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			$			$ 2,114	$ * 2,114	39

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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%	$ 466	$ 466	15
16	V	6	MAINTENANCE SALARY		Progressive Healthcare Consulting	100.00%	9,002	9,002	16
17	V	6	BUILDING MAINTENANCE AND R&M		Progressive Healthcare Consulting	100.00%	320	320	17
18	V	10	MEDICAL AND NURSING SUPPLIES		Progressive Healthcare Consulting	100.00%	124	124	18
19	V	10	NURSING SALARIES		Progressive Healthcare Consulting	100.00%	89,561	89,561	19
20	V	12	ACTIVITIES PROGRAM		Progressive Healthcare Consulting	100.00%	112	112	20
21	V	12	CLERGY SALARY		Progressive Healthcare Consulting	100.00%	1,626	1,626	21
22	V	12	ADMISSIONS SALARY		Progressive Healthcare Consulting	100.00%	91,451	91,451	22
23	V	14	PATIENT TRANSPORTATION		Progressive Healthcare Consulting	100.00%	5	5	23
24	V	15	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	13,408	13,408	24
25	V	17	ADMIN SALARY- NON OWNER		Progressive Healthcare Consulting	100.00%	94,081	94,081	25
26	V	19	PROFESSIONAL FEES		Progressive Healthcare Consulting	100.00%	1,374	1,374	26
27	V	20	FEES, SUBSCRIPTIONS		Progressive Healthcare Consulting	100.00%	383	383	27
28	V	21	CLERICAL & GENERAL		Progressive Healthcare Consulting	100.00%	1,391	1,391	28
29	V	24	SEMINARS		Progressive Healthcare Consulting	100.00%	736	736	29
30	V	27	EMP. BEN.-NON-NURSING		Progressive Healthcare Consulting	100.00%	27,776	27,776	30
31	V	26	INSURANCE		Progressive Healthcare Consulting	100.00%	2,600	2,600	31
32	V	34	STORAGE RENTAL		Progressive Healthcare Consulting	100.00%	31	31	32
33	V								33
34	V	10	NURSING	9,048	Progressive Healthcare Consulting	100.00%		(9,048)	34
35	V	17	ADMINISTRATIVE	2,139	Progressive Healthcare Consulting	100.00%		(2,139)	35
36	V	15	PAYROLL TAXES - NURSING	653	Progressive Healthcare Consulting	100.00%		(653)	36
37	V	27	PAYROLL TAXES - NON-NURSING	3,734	Progressive Healthcare Consulting	100.00%		(3,734)	37
38	V								38
39	Total			$ 15,574			$ 334,449	$ * 318,875	39

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	CF ST. LOUIS, LLC	100.00%	$ 1,435	$ 1,435	15
16	V	6	REPAIRS & MAINTENANCE		CF ST. LOUIS, LLC	100.00%	1,607	1,607	16
17	V	19	PROFESSIONAL FEES		CF ST. LOUIS, LLC	100.00%	649	649	17
18	V	20	DUES & SUBSCRIPTIONS		CF ST. LOUIS, LLC	100.00%	2	2	18
19	V	21	OFFICE EXPENSE		CF ST. LOUIS, LLC	100.00%	20	20	19
20	V	26	INSURANCE		CF ST. LOUIS, LLC	100.00%	288	288	20
21	V	32	INTEREST EXPENSE		CF ST. LOUIS, LLC	100.00%	3,215	3,215	21
22	V	33	REAL ESTATE TAXES		CF ST. LOUIS, LLC	100.00%	682	682	22
23	V								23
24	V	34	RENT	41,118	CF ST. LOUIS, LLC	100.00%		(41,118)	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			$ 41,118			$ 7,900	$ * (33,218)	39

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	CF ST. LOUIS LLC	SKOKIE	BUILDING CO	9
10			LAKEFRONT SKILLED NURSING FACILITY LLC	CHICAGO	PROGRESSIVE HC	SKOKIE	NURSE CONSULTANT	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			CEDAR SKILLED NURSING FACILITY	CEDAR CITY, UT				20
21			ST. GEORGE SKILLED NURSING FACILITY	ST. GEORGE, UT				21
22			CLARK SKILLED NURSING FACILITY	CHICAGO				22
23			PARKER SKILLED NURSING FACILITY LLC	PARKER, CO				23
24			AZRIA MONTCLAIR	OMAHA, NE				24
25			AZRIA OLATHE	OLATHE, KS				25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	1.5	3.00%	Mgmt Fees	$ 6,020	17-3	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	$ 6,020		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 The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 679-9797
Fax Number: (847) 683-2900

	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	1,629,488	29	$ 4,354	$	49,044	$ 131	1
2	3	HOUSEKEEPING SUPPLIES	AVAIL. BED DAYS	1,629,488	29	3,107		49,044	94	2
3	5	UTILITIES	AVAIL. BED DAYS	1,629,488	29	13,622		49,044	410	3
4	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	1,629,488	29	135,883		49,044	4,090	4
5	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,629,488	29	44,897	44,897	49,044	1,351	5
6	17	CFO SALARY	AVAIL. BED DAYS	1,629,488	29	281,003	281,003	49,044	8,458	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,629,488	29	638,760		49,044	19,225	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,629,488	29	55,387		49,044	1,667	8
9	21	CLERICAL & GENERAL WAG	AVAIL. BED DAYS	1,629,488	29	4,261,866	4,261,866	49,044	128,273	9
10	21	CLERICAL & GENERAL OTH	AVAIL. BED DAYS	1,629,488	29	659,124		49,044	19,838	10
11	24	SEMINARS	AVAIL. BED DAYS	1,629,488	29	36,800		49,044	1,108	11
12	26	INSURANCE	AVAIL. BED DAYS	1,629,488	29	31,752		49,044	956	12
13	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	1,629,488	29	1,064,526		49,044	32,040	13
14	30	DEPRECIATION	AVAIL. BED DAYS	1,629,488	29	14,600		49,044	439	14
15	32	INTEREST	AVAIL. BED DAYS	1,629,488	29	234		49,044	7	15
16	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,629,488	29	25,813		49,044	777	16
17	34	RENT	AVAIL. BED DAYS	1,629,488	29	1,366,146		49,044	41,118	17
18	34	STORAGE	AVAIL. BED DAYS	1,629,488	29	1,600		49,044	48	18
19	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,629,488	29	1,654		49,044	50	19
20										20
21	17	MANAGEMENT FEES- Y. ZUC	AVG HOURS WKD	50	29	200,000		1.95	6,020	21
22										22
23										23
24										24
25	TOTALS					$ 8,841,129	$ 4,587,766		$ 266,098	25

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 679-9797
Fax Number: (847) 683-2900

	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	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,629,488	29	$ 1,852	$	49,044	$ 56	1
2	30	DEPRECIATION	AVAIL. BED DAYS	1,629,488	29	50,196		49,044	1,511	2
3	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,629,488	29	18,179		49,044	547	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					$ 70,227	$		$ 2,114	25

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 679-9797
Fax Number: (847) 683-2900

	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	21	$ 11,123	$	48,910	$ 466	1
2	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,167,679	21	214,912	214,912	48,910	9,002	2
3	6	BUILDING MAINTENANCE AI	AVAIL. BED DAYS	1,167,679	21	7,646		48,910	320	3
4	10	MEDICAL AND NURSING SUP	AVAIL. BED DAYS	1,167,679	21	2,971		48,910	124	4
5	10	NURSING SALARIES	AVAIL. BED DAYS	1,167,679	21	2,138,189	2,138,189	48,910	89,561	5
6	12	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,167,679	21	2,679		48,910	112	6
7	12	CLERGY SALARY	AVAIL. BED DAYS	1,167,679	21	38,812	38,812	48,910	1,626	7
8	12	ADMISSIONS SALARY	AVAIL. BED DAYS	1,167,679	21	2,183,313	2,183,313	48,910	91,451	8
9	14	PATIENT TRANSPORTATION	AVAIL. BED DAYS	1,167,679	21	128		48,910	5	9
10	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,167,679	21	320,111		48,910	13,408	10
11	17	ADMIN SALARY- NON OWNE	AVAIL. BED DAYS	1,167,679	21	2,246,090	2,246,090	48,910	94,081	11
12	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,167,679	21	32,793		48,910	1,374	12
13	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,167,679	21	9,154		48,910	383	13
14	21	CLERICAL & GENERAL	AVAIL. BED DAYS	1,167,679	21	33,203		48,910	1,391	14
15	24	SEMINARS	AVAIL. BED DAYS	1,167,679	21	17,580		48,910	736	15
16	27	EMP. BEN.-NON-NURSING	AVAIL. BED DAYS	1,167,679	21	663,131		48,910	27,776	16
17	26	INSURANCE	AVAIL. BED DAYS	1,167,679	21	62,063		48,910	2,600	17
18	34	STORAGE RENTAL	AVAIL. BED DAYS	1,167,679	21	750		48,910	31	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 7,984,649	$ 6,821,317		$ 334,449	25

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: CF St. Louis LLC
Street Address: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 676-5300
Fax Number: (847) 676-5348

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. BED DAYS	1,629,488	29	$ 47,675	$	49,044	$ 1,435	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,629,488	29	53,400		49,044	1,607	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,629,488	29	21,572		49,044	649	3
4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,629,488	29	76		49,044	2	4
5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,629,488	29	678		49,044	20	5
6	26	INSURANCE	AVAIL. BED DAYS	1,629,488	29	9,585		49,044	288	6
7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,629,488	29	106,824		49,044	3,215	7
8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,629,488	29	22,674		49,044	682	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					$ 262,484	$		$ 7,900	25

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	The Private Bank		X				$	$ 9,582,547			$ 469,602	1
2												2
3												3
4												4
5					-							5
	Working Capital											
6	The Private Bank		X					1,588,105			43,354	6
7	Allocated from Legacy HC	X									7	7
8	See Supplemental Schedule				-						3,762	8
9	TOTAL Facility Related						$	$ 11,170,652			$ 516,725	9
	B. Non-Facility Related*											
10	Interest Income		X								(5,515)	10
11	Interest Income - Building Co		X								(1)	11
12												12
13					-							13
14	TOTAL Non-Facility Related						$	$			$ (5,516)	14
15	TOTALS (line 9+line14)						$	$ 11,170,652			$ 511,209	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 The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Alloc from Legacy Real Propert	X					$	$			$ 547	8
9	Allocated from CF St. Louis	X									3,215	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										3,762	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 540,089	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.)		$ 282,720	2
3. Under or (over) accrual (line 2 minus line 1).		$ (257,369)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 546,828	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.)		$ 600	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 290,059	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011		8
2012	203,281	9
2013	248,631	10
2014	256,542	11
2015	281,261	12

Beginning Accrual Adjusted
2016 Accrual: $281,261 x 1.94 = $546,828
Allocated from Legacy HC: $777
Allocated from CF St. Louis LLC: $682

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Grove of Northbrook COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053918

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-02-202-047-0000	Long Term Care Facility	$ 281,260.81	$ 281,260.81
2.	10-35-104-076-0000	Home Office Allocation	$ 40,927.41	$ 1,231.82
3.	10-23-406-034-0000	Home Office Allocation	$ 440,762.19	$ 4,027.83
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 762,950.41	$ 286,520.46

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

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 Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Grove of Northbrook COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053918

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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			2,462	2
3	TOTALS			$ 669,462	3

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 374,340	35	$ 126,000	$ (248,340)	$ 504,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2012	5,642		20	282	282	1,152	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 The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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54									54
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		17,904			895	895	4,475	67
68	Related Party Allocations (Pages 12H & 12I)		69,426	1,105		3,120	2,015	12,894	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 4,502,972	$ 375,445		$ 130,297	$ (245,148)	$ 522,521	70

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 4,502,972	$ 375,445		$ 130,297	$ (245,148)	$ 522,521	1
2	Copper Tube Hot Water Heater	2013	8,997		20	450	450	1,425	2
3	Wiring & Circuit Breakers In Main Switch Gears	2013	5,675		20	284	284	1,040	3
4	Switches, Lock Systems	2013	12,690		20	635	635	2,538	4
5	Installaton Of Delayed Egrass Locks And Associated Components	2014	6,500		20	325	325	948	5
6	Egressable Mag Lock With Reset Switch	2014	6,472		20	1,294	1,294	3,344	6
7	Installed New Chiller	2014	41,296		20	4,130	4,130	11,012	7
8	Re-Install Conduit Lower Level For Camera	2014	2,701		20	540	540	1,215	8
9	Installation Of Entrance Door	2014	4,350		20	218	218	489	9
10	Install Electric And Wanderguard System	2014	24,300		20	4,860	4,860	11,745	10
11	Removal And Replacement Of Asphalt / Sewer Repairs	2014	13,150		20	877	877	2,046	11
12	Applied A Patch To The Field Of Wall Flashings	2014	5,500		20	275	275	756	12
13	Repair Of Nurse Call System	2014	7,228		20	1,446	1,446	3,855	13
14	Chiller Replacement	2014	13,764		20	688	688	2,007	14
15	Install Gravel & Mulch	2014	3,380		20	169	169	451	15
16	Kitchen Sink Water & Drain Line	2015	6,750		20	338	338	338	16
17	Repair Leaking Cast Iron Boiler	2015	4,577		20	229	229	229	17
18	Repair Roof	2015	3,600		20	180	180	180	18
19	Two New Fire Rated Stairway Doors - Basement Kitchen	2015	2,950		20	148	148	148	19
20	Wiremold Receptacles In Bedrooms	2015	9,570		20	478	478	478	20
21	Kitchen Storage Room & Basement Wiring Panels	2015	3,103		20	155	155	155	21
22	Architect Fees For Driveway	2015	130,612		20	6,531	6,531	6,531	22
23	Hallways/Dining Rm/Activity Rm/Basement - Prime/Paint/Patch	2016	23,590		20	1,180	1,180	1,180	23
24	Repaired Sprinkler	2016	4,500		20	225	225	225	24
25	Basement Hallway/Therapy Rm/Office/Shower - Replaced Tiling	2016	2,500		20	125	125	125	25
26	Replaced Leaking Pipes And Fittings For Storage Tank	2016	3,748		20	187	187	187	26
27	Installed New Valves For Pump	2016	6,631		20	332	332	332	27
28	Installed Damper On Boiler	2016	2,700		20	135	135	135	28
29	Installed Pit Ladder For Elevator	2016	3,263		20	163	163	163	29
30	1St Floor Lobby - Flooring/Lighting/Ceiling	2016	6,753		20	338	338	338	30
31	Installed New Reception Desk	2016	5,350		20	268	268	268	31
32	Repaired Front Vestibule And Reclocate Generator Panel	2016	40,500		20	2,025	2,025	2,025	32
33	Installed Condenser For Chiller	2016	18,918		20	946	946	946	33
34	TOTAL (lines 1 thru 33)		$ 4,938,588	$ 375,445		$ 160,467	$ (214,978)	$ 579,373	34

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 4,938,588	$ 375,445		$ 160,467	$ (214,978)	$ 579,373	1
2	Installation Of Cables For Phone System	2016	4,593		20	230	230	230	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,943,180	$ 375,445		$ 160,697	$ (214,748)	$ 579,602	34

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 4,943,180	$ 375,445		$ 160,697	$ (214,748)	$ 579,602	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,943,180	$ 375,445		$ 160,697	$ (214,748)	$ 579,602	34

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 4,943,180	$ 375,445		$ 160,697	$ (214,748)	$ 579,602	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		$ 4,943,180	$ 375,445		$ 160,697	$ (214,748)	$ 579,602	34

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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									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	4,475	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	$ 4,475	34

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 4,475	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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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	$ 4,475	34

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	19,078	708	30	636	(72)	4,769	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Legacy Healthcare & Financial Services	2012	858	19	20	43	24	215	9
10	Allocated from Legacy Healthcare & Financial Services	2013	2,745	60	20	137	77	549	10
11	Allocated from Legacy Healthcare & Financial Services	2014	268	6	20	13	7	40	11
12	Allocated from Legacy Healthcare & Financial Services	2015	370	8	20	18	10	37	12
13								,m	13
14	Allocated from Legacy Real Properties	2009	10,834	175	20	542	367	3,657	14
15	Allocated from Legacy Real Properties	2010	3,294	53	20	132	79	857	15
16	Allocated from Legacy Real Properties	2011	4,682	76	20	234	158	1,405	16
17									17
18	Allocated from CF St. Louis LLC	2016	27,297		20	1,365	1,365	1,365	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)		$ 69,426	$ 1,105		$ 3,120	$ 2,015	$ 12,894	34

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 69,426	$ 1,105		$ 3,120	$ 2,015	$ 12,894	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 69,426	$ 1,105		$ 3,120	$ 2,015	$ 12,894	34

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 684,667	$ 760	$ 79,185	$ 78,425	10	$ 284,790	71
72	Current Year Purchases	34,561	86	3,455	3,369	10	3,455	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 719,228	$ 846	$ 82,641	$ 81,795		$ 288,246	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)	$ 6,331,870	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 376,291	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 243,338	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (132,953)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 867,848	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 The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Allocated from Legacy HC				79			5
6								6
7	TOTAL				$ 79 **			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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 20,963 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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.

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	$		$ 145,460	$		$ 145,460	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			28,146			28,146	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			172,041			172,041	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				125,562		125,562	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					35,667	82,800		118,467	13
14	TOTAL			$		$ 381,314	$ 208,362		$ 589,676	14

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

Facility Name & ID Number The Grove of Northbrook **#** 0053918 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ 500	$ 262,326	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,522,208	2,522,208	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	93,296	93,296	6
7	Other Prepaid Expenses	9,601	41,124	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	109,857	109,857	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,735,462	$ 3,028,811	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	125,526	410,330	15
16	Equipment, at Historical Cost	88,958	1,434,579	16
17	Accumulated Depreciation (book methods)	(160)	(1,552,720)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	203,956	1,448,137	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 418,280	$ 5,723,145	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,153,742	$ 8,751,956	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 406,992	$ 406,993	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,588,105	1,588,105	29
30	Accrued Salaries Payable	202,318	202,318	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,840	6,840	31
32	Accrued Real Estate Taxes(Sch.IX-B)		546,828	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	57,093	57,093	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,261,348	$ 2,808,177	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,582,547	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	948,105	1,038,767	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 948,105	$ 10,621,314	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,209,453	$ 13,429,491	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (55,711)	$ (4,677,535)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,153,742	$ 8,751,956	48

***(See instructions.)**

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (41,761)	1
2	Restatements (describe):		2
3	**Prior Year Office Expense**	77	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (41,684)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(14,027)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	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)**	$ (14,027)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (55,711)	24 *

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 13,780,291	1
2	Discounts and Allowances for all Levels	(6,301,285)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,479,006	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,412,920	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,412,920	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	119,975	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,915	19
20	Radiology and X-Ray	3,365	20
21	Other Medical Services	5,953	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 145,208	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,515	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,515	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	20,149	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 20,149	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,062,798	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,148,899	31
32	Health Care	3,512,463	32
33	General Administration	1,602,564	33
	B. Capital Expense		
34	Ownership	1,426,981	34
	C. Ancillary Expense		
35	Special Cost Centers	1,040,301	35
36	Provider Participation Fee	345,617	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,076,825	40
41	**Income before Income Taxes (line 30 minus line 40)****	(14,027)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (14,027)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,984,378	44
45	Private Pay - Net Inpatient Revenue	353,447	45
46	Medicare - Net Inpatient Revenue	154,689	46
47	Other-(specify) Insurance	(13,508)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,479,006	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.**

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,921	2,088	$ 94,934	$ 45.47	1
2	Assistant Director of Nursing	1,928	2,096	85,084	40.59	2
3	Registered Nurses	29,463	32,025	919,423	28.71	3
4	Licensed Practical Nurses	23,450	25,490	731,545	28.70	4
5	CNAs & Orderlies	70,961	77,132	1,033,758	13.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,505	9,244	178,413	19.30	8
9	Activity Director	1,950	2,120	33,438	15.77	9
10	Activity Assistants	6,427	6,986	74,986	10.73	10
11	Social Service Workers	6,070	6,598	149,811	22.71	11
12	Dietician					12
13	Food Service Supervisor	2,001	2,174	75,247	34.61	13
14	Head Cook	5,966	6,485	118,994	18.35	14
15	Cook Helpers/Assistants	11,257	12,236	133,005	10.87	15
16	Dishwashers					16
17	Maintenance Workers	2,371	2,577	65,655	25.48	17
18	Housekeepers	10,889	11,835	134,102	11.33	18
19	Laundry	4,625	5,027	55,284	11.00	19
20	Administrator	1,971	2,142	99,408	46.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,002	1,089	27,744	25.48	23
24	Clerical	12,012	13,056	196,423	15.04	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					31
32	Other Health Care(specify)					32
33	Other(specify)	717	780	16,085	20.62	33
34	TOTAL (lines 1 - 33)	203,486	221,180	$ 4,223,339 *	$ 19.09	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		$		35
36	Medical Director	Monthly	30,492	09-03	36
37	Medical Records Consultant	Monthly	800	10-03	37
38	Nurse Consultant	Monthly	46,538	10-03	38
39	Pharmacist Consultant	Monthly	11,323	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,060	11-03	44
45	Social Service Consultant	51	3,096	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	51	$ 93,309		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	13	320	10-03	52
53	TOTAL (lines 50 - 52)	13	$ 320		53

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Chaim M. Dubovick	Administrator	0.00%	$ 99,408
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 99,408

B. Administrative - Other

Description	Amount
Management Fees - Yair Zuckerman	$ 6,020
TOTAL (agree to Schedule V, line 17, col. 3)	$ 6,020
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 2,555
Achieve Accreditation	Joint Commission Consult	7,600
IIT/Source Tech	Data Processing	1,870
IL Rytes Corporation	Compliance	10,076
Lexis Nexis	Data Processing	499
ProPay HR LLC	Payroll Processing	21,371
Personnel Planners	Unemployment Consultant	840
Prospect Resources Inc.	Natural Gas Procurement	750
Lighthouse Services Inc.	Compliance	351
Documentation Solutions	Compliance Audit	3,114
See Attached	Legal	42,644
See Supplemental Schedule		549
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 92,220

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 74,247
Unemployment Compensation Insurance	98,239
FICA Taxes	319,586
Employee Health Insurance	184,836
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	22,384
401K Expense	4,949
Employee Physical Exams	2,070
Other Employee Benefits	21,063
TOTAL (agree to Schedule V, line 22, col.8)	$ 727,373

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	337
Health Care Worker Background Check	5,773
(Indicate # of checks performed 578)	
Patient Background Checks	
Dues and Subscriptions	14,565
License and Permits	11,474
Allocated from Legacy HC	1,667
Allocated from Progressive HC	383
Allocated from CF St. Louis LLC	2
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 34,201

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,120
Allocated from Legacy HC	1,108
Allocated from Progressive HC	736
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,964

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/16 Ending: 12/31/16

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC $11,498**

(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. $ **29,239** 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. $ **345,617**
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