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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0053850

Facility Name: Grove Of Elmhurst

Address: 127 West Diversy (Number) Elmhurst (City) 60126 (Zip Code)

County: Dupage

Telephone Number: (630)530-5225 **Fax #** (630)530-7775

HFS ID Number:

Date of Initial License for Current Owners: 10/1/2010

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 01/01/17 to 12/31/17 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, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	176	Skilled (SNF)	176	64,240	1
2		Skilled Pediatric (SNF/PED)			2
3	4	Intermediate (ICF)	4	1,460	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	180	TOTALS	180	65,700	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	13,718	3,974	6,526	24,218	8
9	SNF/PED					9
10	ICF	29,420	3,137	1,885	34,442	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,138	7,111	8,411	58,660	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.28%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 10/1/2010

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/1/2010 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 176 and days of care provided 4,664

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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	368,192	28,045	16,112	412,349		412,349		412,349			1
2	Food Purchase		397,013		397,013		397,013	(22,304)	374,709			2
3	Housekeeping	255,685	43,091	71	298,847		298,847	239	299,086			3
4	Laundry	60,330	29,781	156,782	246,893		246,893	6	246,899			4
5	Heat and Other Utilities			349,016	349,016		349,016	(5,513)	343,503			5
6	Maintenance	85,329	10,668	108,057	204,054		204,054	87,939	291,993			6
7	Other (specify):*											7
8	**TOTAL General Services**	769,536	508,598	630,038	1,908,172		1,908,172	60,368	1,968,540			8
	B. Health Care and Programs											
9	Medical Director			41,373	41,373		41,373	734	42,107			9
10	Nursing and Medical Records	3,692,248	136,737	36,551	3,865,536		3,865,536	105,974	3,971,510			10
10a	Therapy	254,894			254,894		254,894	(555)	254,339			10a
11	Activities	266,951	12,953	880	280,784		280,784	5,581	286,365			11
12	Social Services	143,927		3,760	147,687		147,687	2,004	149,691			12
13	CNA Training											13
14	Program Transportation			9,903	9,903		9,903		9,903			14
15	Other (specify):*							19,152	19,152			15
16	**TOTAL Health Care and Programs**	4,358,020	149,690	92,467	4,600,177		4,600,177	132,890	4,733,067			16
	C. General Administration											
17	Administrative	146,044			146,044		146,044	191,901	337,945			17
18	Directors Fees											18
19	Professional Services			95,286	95,286	(257)	95,029	992	96,021			19
20	Dues, Fees, Subscriptions & Promotions			69,698	69,698		69,698	(28,670)	41,028			20
21	Clerical & General Office Expenses	130,726	12,790	332,771	476,287		476,287	(14,886)	461,401			21
22	Employee Benefits & Payroll Taxes			918,527	918,527		918,527		918,527			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,686	1,686		1,686	2,213	3,899			24
25	Other Admin. Staff Transportation			1,130	1,130		1,130		1,130			25
26	Insurance-Prop.Liab.Malpractice			172,551	172,551		172,551	4,080	176,631			26
27	Other (specify):*							80,319	80,319			27
28	**TOTAL General Administration**	276,770	12,790	1,591,649	1,881,209	(257)	1,880,952	235,950	2,116,902			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,404,326	671,078	2,314,154	8,389,558	(257)	8,389,301	429,208	8,818,509			29

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

Facility Name & ID Number Grove Of Elmhurst #0053850 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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							847,532	847,532			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			107,067	107,067		107,067	1,031,304	1,138,371			32
33	Real Estate Taxes			66,886	66,886	257	67,143	5,167	72,310			33
34	Rent-Facility & Grounds			2,089,232	2,089,232		2,089,232	(2,087,510)	1,722			34
35	Rent-Equipment & Vehicles			12,515	12,515		12,515	5,082	17,597			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,275,700	2,275,700	257	2,275,957	(198,426)	2,077,531			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		543,961	672,736	1,216,697		1,216,697		1,216,697			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			439,271	439,271		439,271		439,271			42
43	Other (specify):*			650,948	650,948		650,948	(650,948)				43
44	**TOTAL Special Cost Centers**		543,961	1,762,955	2,306,916		2,306,916	(650,948)	1,655,968			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,404,326	1,215,039	6,352,809	12,972,174		12,972,174	(420,165)	12,552,009			45

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	(6,908)	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	846,606	30		9
10	Interest and Other Investment Income	(5,723)	32		10
11	Discounts, Allowances, Rebates & Refunds	(21,898)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(481)	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	(3,061)	21		18
19	Entertainment	(1,525)	21		19
20	Contributions	(739)	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	(193,753)	21		24
25	Fund Raising, Advertising and Promotional	(20,994)	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	(1,226,997)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (635,473)		$	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)	215,308		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 215,308		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (420,165)		37

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

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

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

Grove Of Elmhurst

ID# 0053850

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Personal Items	$ (2,122)	10	1
2	Sequestration Expense	(52,738)	21	2
3	Therapy Discount	(555)	10a	3
4	Pharmacy Discount	(14,768)	10	4
5	PAC Dues	(8,121)	20	5
6	Non Allowable Legal	(10,087)	19	6
7	Additional R&M	32,632	06	7
8	Bldg Co - Filing Fees	(250)	20	8
9	Bldg Co - Title Fees	(4,335)	20	9
10	Bldg Co - Accounting Fees	(2,575)	19	10
11	Bldg Co - Legal Fees	(11,601)	19	11
12	Bldg Co - Loan Fees	(55,548)	19	12
13	Bldg Co - Tax Extension Fee	(1,500)	20	13
14	Bldg Co - Property Management Fee	(444,481)	21	14
15	Non Allowable Management Fees	(650,948)	43	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,226,997)		49

Grove Of Elmhurst

ID# 0053850

Report Period Beginning: 01/01/17

Ending: 12/31/17

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Grove Of Elmhurst # 0053850 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(22,379)		54	21								(22,304)	2
3	Housekeeping			239									239	3
4	Laundry			6									6	4
5	Heat and Other Utilities	(6,908)				1,395							(5,513)	5
6	Maintenance	32,632		3,230	50,313	1,764							87,939	6
7	Other (specify):*													7
8	**TOTAL General Services**	3,345		3,530	50,334	3,159							60,368	8
	B. Health Care and Programs													
9	Medical Director			734									734	9
10	Nursing and Medical Records	(16,890)		45	123,240		(422)						105,974	10
10a	Therapy	(555)											(555)	10a
11	Activities			5,560	21								5,581	11
12	Social Services			88	1,916								2,004	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				19,152								19,152	15
16	**TOTAL Health Care and Programs**	(17,445)		6,427	144,330		(422)						132,890	16
	C. General Administration													
17	Administrative			25,272	166,629								191,901	17
18	Directors Fees													18
19	Professional Services	(79,811)	69,724	17,170	421	351			(6,862)				992	19
20	Fees, Subscriptions & Promotions	(35,939)	6,085	976	205	3							(28,670)	20
21	Clerical & General Office Expenses	(695,558)	444,481	200,496	35,693	1							(14,886)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,290	923								2,213	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			1,082	2,637	361							4,080	26
27	Other (specify):*			41,140	39,179								80,319	27
28	**TOTAL General Administration**	(811,308)	520,290	287,427	245,687	716			(6,862)				235,950	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(825,408)	520,290	297,384	440,351	3,875	(422)		(6,862)				429,208	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Grove Of Elmhurst # 0053850 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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	846,606			926								847,532	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(5,723)	1,030,702	21		6,304							1,031,304	32
33	Real Estate Taxes					5,167							5,167	33
34	Rent-Facility & Grounds		(2,087,686)	50,028	72	(49,923)							(2,087,510)	34
35	Rent-Equipment & Vehicles			3,663	1,418								5,082	35
36	Other (specify):*													36
37	TOTAL Ownership	840,883	(1,056,984)	53,711	2,416	(38,452)							(198,426)	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):*	(650,948)											(650,948)	43
44	TOTAL Special Cost Centers	(650,948)											(650,948)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(635,473)	(536,694)	351,096	442,767	(34,577)	(422)		(6,862)				(420,165)	45

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 2,087,686	Elmbrook Real Properties	100.00%	$	$ (2,087,686)	1
2	V	20	Tax Extension Fee		Elmbrook Real Properties	100.00%	1,500	1,500	2
3	V	20	Filing Fees		Elmbrook Real Properties	100.00%	250	250	3
4	V	20	Title Fees		Elmbrook Real Properties	100.00%	4,335	4,335	4
5	V	19	Professional Fees - Accounting		Elmbrook Real Properties	100.00%	2,575	2,575	5
6	V	19	Professional Fees - Legal		Elmbrook Real Properties	100.00%	11,601	11,601	6
7	V	19	Professional Fees - Loan		Elmbrook Real Properties	100.00%	55,548	55,548	7
8	V	21	Property Management Fees		Elmbrook Real Properties	100.00%	444,481	444,481	8
9	V	32	Interest Expense - Mortgage A		Elmbrook Real Properties	100.00%	1,030,702	1,030,702	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,087,686			$ 1,550,992	$ * (536,694)	14

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

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%	$ 54	$ 54	15
16	V	3	HOUSEKEEPING SUPPLIES		Legacy Healthcare Financial Services	100.00%	239	239	16
17	V	4	LINEN REPLACEMENT		Legacy Healthcare Financial Services	100.00%	6	6	17
18	V	6	UTILITIES		Legacy Healthcare Financial Services	100.00%	14	14	18
19	V	6	GROUNDS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	3,217	3,217	19
20	V	9	MEDICAL DIRECTOR CONSULTANT		Legacy Healthcare Financial Services	100.00%	734	734	20
21	V	10	MEDICAL SUPPLIES		Legacy Healthcare Financial Services	100.00%	45	45	21
22	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services	100.00%	5,560	5,560	22
23	V	12	SOCIAL SERVICE CONSULTANT		Legacy Healthcare Financial Services	100.00%	88	88	23
24	V	17	ADMINISTRATIVE SALARY		Legacy Healthcare Financial Services	100.00%	25,272	25,272	24
25	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	17,170	17,170	25
26	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	976	976	26
27	V	21	CLERICAL & GENERAL WAGES		Legacy Healthcare Financial Services	100.00%	195,104	195,104	27
28	V	21	CLERICAL & GENERAL OTHER COSTS		Legacy Healthcare Financial Services	100.00%	5,392	5,392	28
29	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	1,290	1,290	29
30	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	1,082	1,082	30
31	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	41,140	41,140	31
32	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	21	21	32
33	V	34	RENT		Legacy Healthcare Financial Services	100.00%	49,923	49,923	33
34	V	34	STORAGE		Legacy Healthcare Financial Services	100.00%	104	104	34
35	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services	100.00%	25	25	35
36	V	35	AUTO RENTAL		Legacy Healthcare Financial Services	100.00%	3,638	3,638	36
37	V								37
38	V								38
39	Total			$			$ 351,096	$ * 351,096	39

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

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%	$ 21	$ 21	15
16	V	6	MAINTENANCE SALARY		Progressive Healthcare Consulting	100.00%	50,163	50,163	16
17	V	6	BUILDING MAINTENANCE AND R&M		Progressive Healthcare Consulting	100.00%	150	150	17
18	V	10	NURSING SALARIES		Progressive Healthcare Consulting	100.00%	123,240	123,240	18
19	V	11	ACTIVITIES PROGRAM		Progressive Healthcare Consulting	100.00%	21	21	19
20	V	12	CLERGY CONSULTANT		Progressive Healthcare Consulting	100.00%	1,912	1,912	20
21	V	12	SOCIAL SERVICE		Progressive Healthcare Consulting	100.00%	5	5	21
22	V	15	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	19,152	19,152	22
23	V	17	ADMIN SALARY- NON OWNER		Progressive Healthcare Consulting	100.00%	166,629	166,629	23
24	V	19	PROFESSIONAL FEES		Progressive Healthcare Consulting	100.00%	421	421	24
25	V	20	DUES, SUBSCRIPTIONS, LICENSES		Progressive Healthcare Consulting	100.00%	205	205	25
26	V	21	CLERICAL WAGES		Progressive Healthcare Consulting	100.00%	35,317	35,317	26
27	V	21	CLERICAL & GENERAL - OTHER		Progressive Healthcare Consulting	100.00%	377	377	27
28	V	24	SEMINARS		Progressive Healthcare Consulting	100.00%	923	923	28
29	V	27	EMP. BEN.-NON-NURSING		Progressive Healthcare Consulting	100.00%	39,179	39,179	29
30	V	26	INSURANCE		Progressive Healthcare Consulting	100.00%	2,637	2,637	30
31	V	30	DEPRECIATION		Progressive Healthcare Consulting	100.00%	926	926	31
32	V	34	STORAGE RENTAL		Progressive Healthcare Consulting	100.00%	72	72	32
33	V	35	AUTO RENTAL		Progressive Healthcare Consulting	100.00%	1,418	1,418	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 442,767	$ * 442,767	39

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

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%	$ 1,395	$ 1,395	15
16	V	6	REPAIRS & MAINTENANCE		CF ST. LOUIS, LLC	100.00%	1,764	1,764	16
17	V	19	PROFESSIONAL FEES		CF ST. LOUIS, LLC	100.00%	351	351	17
18	V	20	DUES & SUBSCRIPTIONS		CF ST. LOUIS, LLC	100.00%	3	3	18
19	V	21	OFFICE EXPENSE		CF ST. LOUIS, LLC	100.00%	1	1	19
20	V	26	INSURANCE		CF ST. LOUIS, LLC	100.00%	361	361	20
21	V	32	INTEREST EXPENSE		CF ST. LOUIS, LLC	100.00%	6,304	6,304	21
22	V	33	REAL ESTATE TAXES		CF ST. LOUIS, LLC	100.00%	5,167	5,167	22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	49,923	CF ST. LOUIS, LLC	100.00%		(49,923)	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			$ 49,923			$ 15,346	$ * (34,577)	39

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	MEDICAL SUPPLIES	$ 10,358	ReMED SERVICES		$ 9,936	$ (422)	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			$ 10,358			$ 9,936	$ * (422)	39

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	06	MAINTENANCE	$ 17,100	ML GROUP DESIGN AND DEVELOPMENT		$ 17,100	$	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			$ 17,100			$ 17,100	$ *	39

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Payroll Processing	$ 28,674	ProPay HR		$ 21,812	$ (6,862)	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			$ 28,674			$ 21,812	$ * (6,862)	39

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	GPN Family Trust	50.00%	ASTORIA PLACE SKILLED NURSING FACILITY LLC	CHICAGO	BROOK PROPERTIES		BUILDING CO	1
2	Doros Generation Trust	50.00%	AVANTARA LONG GROVE	LONG GROVE	LEGACY HC & FINANCIAL SER	LINCOLNWOOD	HOME OFFICE/BOOKKEEPI	2
3			AVANTARA PARK RIDGE	PARK RIDGE	PROGRESSIVE HC	LINCOLNWOOD	NURSE CONSULTANT	3
4			AZRIA MIDTOWN	OMAHA, NE	ML GROUP DESIGN & DEV	SKOKIE	ASSET MANAGEMENT	4
5			AZRIA MONTCLAIR	OMAHA, NE	REMED SERVICES LLC	LINCOLNWOOD	NURSING EQUIPMENT	5
6			AZRIA OLATHE	OLATHE, KS	AURORA SUPPORTIVE LIVING	AURORA	SUPPORTIVE LIVING	6
7			BETHANY TERRACE	MORTON GROVE	TERRACE GARDENS	MORTON GROVE	ASSISTED LIVING	7
8			CARLTON SKILLED NURSING FACILITY LLC	CHICAGO	LINCOLNSHIRE ASSISTED LIVI	LINCOLNSHIRE	ASSISTED LIVING	8
9			CEDAR SKILLED NURSING FACILITY	CEDAR CITY, UT	CF ST. LOUIS LLC	SKOKIE	BUILDING COMPANY	9
10			CHALET SKILLED NURSING FACILITY LLC	CHICAGO	PROPAY HR	EVANSTON	PAYROLL PROCESSING	10
11			CLARK SKILLED NURSING FACILITY	CHICAGO				11
12			EVANSTON SKILLED NURSING FACILITY LLC	EVANSTON				12
13			GROVE AT THE LAKE SKILLED NURSING FACILITY LLC	ZION				13
14			GROVE OF FOX VALLEY	AURORA				14
15			LAGRANGE SKILLED NURSING FACILITY LLC	LAGRANGE PARK				15
16			LAKEFRONT SKILLED NURSING FACILITY LLC	CHICAGO				16
17			LINCOLN PARK SKILLED NURSING FACILITY LLC	CHICAGO				17
18			LINCOLNSHIRE LIVING & REHAB CENTER LLC	LINCOLNSHIRE				18
19			NORTHBROOK SKILLED NURSING FACILITY	NORTHBROOK				19
20			PARKER SKILLED NURSING FACILITY LLC	PARKER, CO				20
21			PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO				21
22			SKOKIE SKILLED NURSING FACILITY LLC	SKOKIE				22
23			ST. GEORGE SKILLED NURSING FACILITY	ST. GEORGE, UT				23
24			WARREN BARR LIVING AND REHAB	CHICAGO				24
25			WARREN BARR NORTH SHORE	HIGHLAND PARK				25
26			WARREN BARR SOUTH LOOP	CHICAGO				26
27								27
28								28
29								29
30								30

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,789,215	30	$ 1,460	$	65,700	$ 54	1
2	3	HOUSEKEEPING SUPPLIES	AVAIL. BED DAYS	1,789,215	30	6,519		65,700	239	2
3	4	LINEN REPLACEMENT	AVAIL. BED DAYS	1,789,215	30	171		65,700	6	3
4	6	UTILITIES	AVAIL. BED DAYS	1,789,215	30	372		65,700	14	4
5	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	1,789,215	30	87,596		65,700	3,217	5
6	9	MEDICAL DIRECTOR CONSU	AVAIL. BED DAYS	1,789,215	30	20,000		65,700	734	6
7	10	MEDICAL SUPPLIES	AVAIL. BED DAYS	1,789,215	30	1,237		65,700	45	7
8	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,789,215	30	151,405		65,700	5,560	8
9	12	SOCIAL SERVICE CONSULTA	AVAIL. BED DAYS	1,789,215	30	2,392		65,700	88	9
10	17	ADMINISTRATIVE SALARY	AVAIL. BED DAYS	1,789,215	30	688,242	688,242	65,700	25,272	10
11	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,789,215	30	467,580		65,700	17,170	11
12	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,789,215	30	26,590		65,700	976	12
13	21	CLERICAL & GENERAL WAG	AVAIL. BED DAYS	1,789,215	30	5,313,296	5,313,296	65,700	195,104	13
14	21	CLERICAL & GENERAL OTH	AVAIL. BED DAYS	1,789,215	30	146,833		65,700	5,392	14
15	24	SEMINARS	AVAIL. BED DAYS	1,789,215	30	35,138		65,700	1,290	15
16	26	INSURANCE	AVAIL. BED DAYS	1,789,215	30	29,475		65,700	1,082	16
17	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	1,789,215	30	1,120,380		65,700	41,140	17
18	32	INTEREST	AVAIL. BED DAYS	1,789,215	30	561		65,700	21	18
19	34	RENT	AVAIL. BED DAYS	1,789,215	30	1,359,562		65,700	49,923	19
20	34	STORAGE	AVAIL. BED DAYS	1,789,215	30	2,842		65,700	104	20
21	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,789,215	30	694		65,700	25	21
22	35	AUTO RENTAL	AVAIL. BED DAYS	1,789,215	30	99,069		65,700	3,638	22
23										23
24										24
25	TOTALS					$ 9,561,416	$ 6,001,539		$ 351,096	25

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,374,590	21	$ 432	$	65,700	$ 21	1
2	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,374,590	21	1,049,531	1,049,531	65,700	50,163	2
3	6	BUILDING MAINTENANCE AI	AVAIL. BED DAYS	1,374,590	21	3,133		65,700	150	3
4	10	NURSING SALARIES	AVAIL. BED DAYS	1,374,590	21	2,578,462	2,578,462	65,700	123,240	4
5	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,374,590	21	443		65,700	21	5
6	12	CLERGY CONSULTANT	AVAIL. BED DAYS	1,374,590	21	39,998		65,700	1,912	6
7	12	SOCIAL SERVICE	AVAIL. BED DAYS	1,374,590	21	95		65,700	5	7
8	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,374,590	21	400,703		65,700	19,152	8
9	17	ADMIN SALARY- NON OWNE	AVAIL. BED DAYS	1,374,590	21	3,486,246	3,486,246	65,700	166,629	9
10	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,374,590	21	8,800		65,700	421	10
11	20	DUES, SUBSCRIPTIONS, LICE	AVAIL. BED DAYS	1,374,590	21	4,293		65,700	205	11
12	21	CLERICAL WAGES	AVAIL. BED DAYS	1,374,590	21	738,904	738,904	65,700	35,317	12
13	21	CLERICAL & GENERAL - OTI	AVAIL. BED DAYS	1,374,590	21	7,880		65,700	377	13
14	24	SEMINARS	AVAIL. BED DAYS	1,374,590	21	19,314		65,700	923	14
15	27	EMP. BEN.-NON-NURSING	AVAIL. BED DAYS	1,374,590	21	819,705		65,700	39,179	15
16	26	INSURANCE	AVAIL. BED DAYS	1,374,590	21	55,168		65,700	2,637	16
17	30	DEPRECIATION	AVAIL. BED DAYS	1,374,590	21	19,384		65,700	926	17
18	34	STORAGE RENTAL	AVAIL. BED DAYS	1,374,590	21	1,500		65,700	72	18
19	35	AUTO RENTAL	AVAIL. BED DAYS	1,374,590	21	29,674		65,700	1,418	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 9,263,664	$ 7,853,142		$ 442,767	25

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,789,215	30	$ 37,998	$	65,700	$ 1,395	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,789,215	30	48,042		65,700	1,764	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,789,215	30	9,551		65,700	351	3
4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,789,215	30	76		65,700	3	4
5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,789,215	30	32		65,700	1	5
6	26	INSURANCE	AVAIL. BED DAYS	1,789,215	30	9,839		65,700	361	6
7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,789,215	30	171,679		65,700	6,304	7
8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,789,215	30	140,710		65,700	5,167	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					$ 417,927	$		$ 15,346	25

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: ReMED Services
Street Address: 3424 Oakton St, Suite 102
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 440-2600
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	10	MEDICAL SUPPLIES	DIRECT			$	$		$ 9,936	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					$	$		$ 9,936	25

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: ML Group Design and Development
Street Address: 3424 Oakton St
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 676-5300
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	6	MAINTENANCE	DIRECT			$	$		$ 17,100	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					$	$		$ 17,100	25

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: ProPay HR LLC
Street Address: 2201 W. MAIN ST
City / State / Zip Code: EVANSTON , ILLINOIS 60202
Phone Number: ((847) 905 3268
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	19	Payroll Processing	Direct			$	$		$ 21,812	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					$	$		$ 21,812	25

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			X	Mortgage			$	$ 18,934,560			$ 1,030,702	1
2												2
3												3
4												4
5												5
	Working Capital											
6	The Private Bank		X	Note Payable				2,495,323			107,067	6
7												7
8												8
9	TOTAL Facility Related						$	$ 21,429,883			$ 1,137,769	9
	B. Non-Facility Related*											
10	Interest Income		X								(5,723)	10
11	Allocated Legacy Healthcare		X								21	11
12	Allocated CF St Louis		X								6,304	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 602	14
15	TOTALS (line 9+line14)						$	$ 21,429,883			$ 1,138,371	15

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

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

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	60,218	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.)	$	69,126	2
3. Under or (over) accrual (line 2 minus line 1).	$	8,908	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	63,145	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.)**	$	257	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.	$	72,310	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	65,169	8
	2013	66,825	9
	2014	67,195	10
	2015	63,000	11
	2016	63,959	12

2016 Accrual = Beginning Accrual amount because PY was 1st year owned by current owner

Allocated from CF St Louis=$5,167

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grove Of Elmhurst COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0053850

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-26-207-025	Long Term Care Facility	$ 58,926.92	$ 58,926.92
2.	03-26-207-022	Long Term Care Facility	$ 5,031.84	$ 5,031.84
3.	10-23-406-034-0000	Home Office Allocation	$ 463,439.48	$ 5,166.87
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 527,398.24	$ 69,125.63

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 2016 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 2016 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2016.

Please complete the Real Estate Tax Statement below and include it in the 2017 cost report along with a copy of your 2016 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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grove Of Elmhurst COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0053850

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,800 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

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	67,000	2010	$ 606,331	1
2	Allocated CF St Louis		2016	23,868	2
3	TOTALS	67,000		$ 630,199	3

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	180		2010	1977	$ 7,403,102	$	35	$ 211,517	$ 211,517	$ 14,010	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2011	831,792		20	41,590	41,590	291,127	9
10	Various			2012	243,002		20	12,150	12,150	72,901	10
11	Various			2013	155,927		20	7,796	7,796	37,213	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		286,912			13,509	13,509	26,738	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 8,920,735	$		$ 286,562	$ 286,562	$ 441,989	70

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 8,920,735	$		$ 286,562	$ 286,562	$ 441,989	1
2	Basement Hallway/Launch Room - Drop Ceiling, Soffits,Walls,Tili	2014	26,850		20	1,343	1,343	5,370	2
3	Elevator Repairs	2014	6,374		20	319	319	1,275	3
4	Ldry Rm, Bsmt Hall, Dr. Launch Room-Walls/Doors/Drop Ceiling	2014	15,000		20	750	750	3,000	4
5	Lower Level-Reworked Existing Sprinkler System To Meet New C	2014	5,300		20	265	265	1,060	5
6	Disconnected And Removed Existing #1 Circulating Pump, 1 Thru	2014	6,489		20	324	324	1,298	6
7	Green Room - Patch Walls, Paint, Ceiling Light, Cove Base	2014	5,000		20	250	250	1,000	7
8	Repaired Air Conditioner	2014	14,889		20	744	744	2,978	8
9	Drapery And Blinds	2015	3,625		20	181	181	544	9
10	Wallcoverings	2015	2,576		20	129	129	386	10
11	2 Hot Water Storage Tanks And 1 Tankstat	2015	28,884		20	1,444	1,444	4,333	11
12	Nurse Station	2015	8,750		20	438	438	1,313	12
13	Boiler Kit, Burner, Cable	2015	3,003		20	150	150	450	13
14	Patched And Painted Dining Room	2017	20,700		20	690	690	690	14
15	Installed Signage - Side Elevation	2017	12,802		20	427	427	427	15
16	Installed 1 New Carrier Oil Pump For Compressor - Chiller	2017	6,442		20	859	859	859	16
17	Installed New Elevator Valve - Elevator	2017	3,800		20	697	697	697	17
18	Installed Signage - Side Elevation	2017	12,349		20	566	566	566	18
19	Powerwashed Copings, Installed New Copings - Roof	2017	16,500		20	206	206	206	19
20	Floor Tiling In Resident Rooms	2017	11,500		20	575	575	575	20
21	Painting Room, Dry Wall -Resident Rooms	2017	3,250		20	163	163	163	21
22	Installed Branch Pannel And Pipe-Closet/Vent Wing	2017	17,775		20	889	889	889	22
23	Added New Tiles In Resident Room	2017	5,750		20	288	288	288	23
24	Rewired Vent Wiring - Main Vent	2017	5,900		20	295	295	295	24
25	Removed Head, Replaced Condenser Shell Tube - Chiller	2017	4,899		20	245	245	245	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,169,142	$		$ 298,798	$ 298,798	$ 470,894	34

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 9,169,142	$		$ 298,798	$ 298,798	$ 470,894	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,169,142	$		$ 298,798	$ 298,798	$ 470,894	34

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 9,169,142	$		$ 298,798	$ 298,798	$ 470,894	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,169,142	$		$ 298,798	$ 298,798	$ 470,894	34

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 9,169,142	$		$ 298,798	$ 298,798	$ 470,894	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,169,142	$		$ 298,798	$ 298,798	$ 470,894	34

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

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									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)		$	$		$	$	$	34

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 CF St Louis	2016	39,021		35	1,115	1,115	2,230	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated CF St Louis	2016	242,268		20	12,113	12,113	24,227	9
10	Allocated CF St Louis	2017	5,623		20	281	281	281	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)		$ 286,912	$		$ 13,509	$ 13,509	$ 26,738	34

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 286,912	$		$ 13,509	$ 13,509	$ 26,738	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 286,912	$		$ 13,509	$ 13,509	$ 26,738	34

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 5,419,705	$ 926	$ 540,949	$ 540,023	10	$ 4,663,188	71
72	Current Year Purchases	85,848		7,785	7,785	10	7,785	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 5,505,553	$ 926	$ 548,734	$ 547,808		$ 4,670,972	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)	$ 15,304,895	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 926	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 847,532	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 846,606	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,141,866	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Elmbrook Properties

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	Storage Rental				1,546			5
6	Allocated from Legacy & Progressive HC				176			6
7	TOTAL				$ 1,722 **			7

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: *

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: $ 8,200 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	Facility		$	$ 4,340	17
18	Allocated Legacy Healthcare			3,638	18
19	Allocated Progressive Consulting			1,418	19
20					20
21	TOTAL		$	$ 9,396	21

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

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Grove Of Elmhurst

STATE OF ILLINOIS
0053850 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 170,192	$		$ 170,192	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			81,472			81,472	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			375,681			375,681	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				326,154		326,154	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					45,391	217,807		263,198	13
14	TOTAL			$		$ 672,736	$ 543,961		$ 1,216,697	14

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

STATE OF ILLINOIS

Facility Name & ID Number Grove Of Elmhurst **#** 0053850 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,249	$ 25,356	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,602,484	2,602,484	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	139,935	139,935	6
7	Other Prepaid Expenses	15,203	217,743	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	38,341	38,341	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,797,212	$ 3,023,859	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,309,500	13
14	Buildings, at Historical Cost		5,180,335	14
15	Leasehold Improvements, at Historical Cost	135,330	805,461	15
16	Equipment, at Historical Cost	190,302	205,302	16
17	Accumulated Depreciation (book methods)	(13,870)	(1,158,627)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	1,583,644	3,739,129	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,895,406	$ 10,081,100	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,692,618	$ 13,104,959	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 369,525	$ 369,526	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		454,063	29
30	Accrued Salaries Payable	430,737	430,737	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,560	14,560	31
32	Accrued Real Estate Taxes(Sch.IX-B)		63,145	32
33	Accrued Interest Payable		94,432	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	55,708	55,708	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 870,530	$ 1,482,171	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,495,323	2,495,323	39
40	Mortgage Payable		18,480,497	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	1,215,413	1,215,413	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,710,736	$ 22,191,233	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,581,266	$ 23,673,404	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 111,352	$ (10,568,445)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,692,618	$ 13,104,959	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (15,232)	1
2	Restatements (describe):		2
3	**Equity Rounding**	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (15,231)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	126,583	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)**	$ 126,583	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)**	$ 111,352	24 *

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

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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	$ 17,626,131	1
2	Discounts and Allowances for all Levels	(7,647,264)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,978,867	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,690,308	6
7	Oxygen	87	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,690,395	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	311,533	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	40,078	19
20	Radiology and X-Ray		20
21	Other Medical Services	31,432	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 383,043	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,723	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,723	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	40,729	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 40,729	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,098,757	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,908,172	31
32	Health Care	4,600,177	32
33	General Administration	1,881,209	33
	B. Capital Expense		
34	Ownership	2,275,700	34
	C. Ancillary Expense		
35	Special Cost Centers	1,867,645	35
36	Provider Participation Fee	439,271	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,972,174	40
41	**Income before Income Taxes (line 30 minus line 40)****	126,583	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 126,583	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,513,292	44
45	Private Pay - Net Inpatient Revenue	729,060	45
46	Medicare - Net Inpatient Revenue	1,149,820	46
47	Other-(specify) Insurance	586,695	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,978,867	49

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,872	2,072	$ 93,666	$ 45.21	1
2	Assistant Director of Nursing	1,912	2,080	81,098	38.99	2
3	Registered Nurses	35,121	39,168	1,183,046	30.20	3
4	Licensed Practical Nurses	27,791	31,357	796,089	25.39	4
5	CNAs & Orderlies	88,888	96,556	1,428,743	14.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,210	12,366	254,894	20.61	8
9	Activity Director	3,642	3,965	67,483	17.02	9
10	Activity Assistants	13,201	14,833	199,468	13.45	10
11	Social Service Workers	5,978	6,495	143,927	22.16	11
12	Dietician					12
13	Food Service Supervisor	1,880	2,080	42,822	20.59	13
14	Head Cook	10,574	11,178	148,040	13.24	14
15	Cook Helpers/Assistants	15,039	16,421	177,330	10.80	15
16	Dishwashers					16
17	Maintenance Workers	5,238	6,006	85,329	14.21	17
18	Housekeepers	16,018	17,608	255,685	14.52	18
19	Laundry	3,413	3,779	60,330	15.96	19
20	Administrator	1,656	1,909	90,145	47.22	20
21	Assistant Administrator	1,360	1,605	55,899	34.83	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,182	7,934	130,726	16.48	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	3,088	3,512	80,120	22.81	31
32	Other Health Care(specify)					32
33	Other(specify)	1,632	1,960	29,488	15.04	33
34	TOTAL (lines 1 - 33)	256,695	282,884	$ 5,404,328 *	$ 19.10	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	346	$ 16,112	01-03	35
36	Medical Director	Monthly	41,373	09-03	36
37	Medical Records Consultant	4	198	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	13,923	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	18	880	11-03	44
45	Social Service Consultant	65	3,760	12-03	45
46	Other(specify)	Monthly	22,430	10-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	433	$ 98,676		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Elliot Triplett	Administrator	0	$ 3,634
Nichole Lockett	Administrator	0	86,511
Christina Burke	Assnt Administrator	0	40,367
Alba Galindo	Assnt Administrator	0	15,532
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 146,044

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum, LLP	Accounting	$ 16,439
See Attached	Legal	29,439
Documentation Solutions	Compliance Audit	3,004
Compiance Resources	Compliance Audit	1,383
Achieve Accreditation	Accreditation	3,738
Blue Orange Compliance	Compliance	1,484
Central Supply Scale	Machine Consulting	690
Deborah D Cole Goodwill	Education Consultant	2,500
IIT SourcreTech	IT Services	1,870
Lexisnexis Risk Solutions	Compliance	56
Linda Smith, RHIT	LTC Consultant	2,104
See Supplemental Schedule		32,580
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 95,286

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 85,731
Unemployment Compensation Insurance	39,767
FICA Taxes	412,778
Employee Health Insurance	210,384
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	112,689
Other Employee Benefits	12,202
401K Expense	19,014
Voluntary Benefit Contributions	17,477
Employee Physical Exams	8,485
TOTAL (agree to Schedule V, line 22, col.8)	$ 918,527

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	142
Health Care Worker Background Check	
(Indicate # of checks performed 307)	3,069
Patient Background Checks 450	4,500
Dues and Subscriptions	20,728
Licenses	9,968
Permits	1,437
Allocated from Legacy Healthcare	976
See Supplemental Schedule	208
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 41,028

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,686
Allocated from Legacy Healthcare	1,290
Allocated from Progressive Consulting	923
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,899

* Attach copy of IMRF notifications

**See instructions.

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC: $14,922, IHCA $2,196**

(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. $ **69,627** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **439,271**
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? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
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