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: 0053884

Facility Name: GROVE OF LAGRANGE PARK

Address: 701 North Lagrange Road (Number) Lagrange Park (City) 60526 (Zip Code)

County: Cook

Telephone Number: (708) 354-7300 **Fax #** (708) 354-8928

HFS ID Number:

Date of Initial License for Current Owners: 4/1/2009

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 LAGRANGE PARK # 0053884 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	131	Skilled (SNF)	131	47,815	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	131	TOTALS	131	47,815	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	4,777	614	7,047	12,438	8
9	SNF/PED					9
10	ICF	25,089	2,176	944	28,209	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,866	2,790	7,991	40,647	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.01%

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 4/1/2009

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/1/2009 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 131 and days of care provided 4,298

Medicare Intermediary CGS Administrators

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 LAGRANGE PARK # 0053884 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	311,809	23,552	201	335,562		335,562		335,562			1
2	Food Purchase		243,853		243,853		243,853	(28,946)	214,907			2
3	Housekeeping	230,585	38,673	496	269,754		269,754	174	269,928			3
4	Laundry	73,791	23,542		97,333		97,333	5	97,338			4
5	Heat and Other Utilities			128,374	128,374		128,374	(4,354)	124,020			5
6	Maintenance	72,791	16,758	174,615	264,164		264,164	47,611	311,775			6
7	Other (specify):*											7
8	**TOTAL General Services**	688,976	346,378	303,686	1,339,040		1,339,040	14,490	1,353,530			8
	B. Health Care and Programs											
9	Medical Director			63,741	63,741		63,741	534	64,275			9
10	Nursing and Medical Records	2,707,263	91,400	34,719	2,833,382		2,833,382	80,790	2,914,172			10
10a	Therapy	112,721			112,721		112,721		112,721			10a
11	Activities	110,912	6,691	1,241	118,844		118,844	4,062	122,906			11
12	Social Services	98,998		3,658	102,656		102,656	1,459	104,115			12
13	CNA Training											13
14	Program Transportation			19,042	19,042		19,042		19,042			14
15	Other (specify):*							13,938	13,938			15
16	**TOTAL Health Care and Programs**	3,029,894	98,091	122,401	3,250,386		3,250,386	100,783	3,351,169			16
	C. General Administration											
17	Administrative	200,667			200,667		200,667	139,661	340,328			17
18	Directors Fees											18
19	Professional Services			78,066	78,066	(2,937)	75,129	7,915	83,044			19
20	Dues, Fees, Subscriptions & Promotions			51,485	51,485		51,485	(10,628)	40,857			20
21	Clerical & General Office Expenses	140,590	5,741	313,918	460,249		460,249	(61,959)	398,290			21
22	Employee Benefits & Payroll Taxes			716,122	716,122		716,122		716,122			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,787	3,787		3,787	1,611	5,398			24
25	Other Admin. Staff Transportation			1,169	1,169		1,169		1,169			25
26	Insurance-Prop.Liab.Malpractice			133,161	133,161		133,161	2,970	136,131			26
27	Other (specify):*							58,454	58,454			27
28	**TOTAL General Administration**	341,257	5,741	1,297,708	1,644,706	(2,937)	1,641,769	138,025	1,779,794			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,060,127	450,210	1,723,795	6,234,132	(2,937)	6,231,195	253,297	6,484,492			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 LAGRANGE PARK #0053884 **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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							303,237	303,237			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			52,913	52,913		52,913	508,656	561,569			32
33	Real Estate Taxes			268,152	268,152	2,937	271,089	3,760	274,849			33
34	Rent-Facility & Grounds			1,148,654	1,148,654		1,148,654	(1,148,526)	128			34
35	Rent-Equipment & Vehicles			6,925	6,925		6,925	3,698	10,623			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,476,644	1,476,644	2,937	1,479,581	(329,174)	1,150,407			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		403,811	582,144	985,955		985,955		985,955			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			298,715	298,715		298,715		298,715			42
43	Other (specify):*			491,171	491,171		491,171	(491,171)				43
44	**TOTAL Special Cost Centers**		403,811	1,372,030	1,775,841		1,775,841	(491,171)	1,284,670			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,060,127	854,021	4,572,469	9,486,617		9,486,617	(567,048)	8,919,569			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 LAGRANGE PARK # 0053884 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 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(5,369)	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	302,563	30		9
10	Interest and Other Investment Income	(14,638)	32		10
11	Discounts, Allowances, Rebates & Refunds	(28,833)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(167)	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	(3,138)	21		18
19	Entertainment	(1,505)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(159,551)	21		24
25	Fund Raising, Advertising and Promotional	(3,238)	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	(955,490)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (869,366)		$	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)	302,318		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 302,318		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (567,048)		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

STATE OF ILLINOIS

GROVE OF LAGRANGE PARK

ID# 0053884

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Personal Items	$ (5,176)	10	1
2	Sequestration Expense	(51,986)	21	2
3	Pharmacy Discounts	(3,401)	10	3
4	Building Co - Tax Extension Fee	(3,500)	19	4
5	Building Co - Filing Fees	(250)	20	5
6	Building Co - Title Fees	(2,783)	20	6
7	Building Co - Accounting Fees	(2,575)	19	7
8	Building Co - Legal Fees	(6,353)	19	8
9	Building Co - Management Fees	(333,565)	17	9
10	Building Co - Loan Fees	(33,928)	19	10
11	PAC Dues	(8,252)	20	11
12	Additional R&M	7,359	06	12
13	Bank Charges	(17,672)	21	13
14	Non-Allowable Legal	(2,237)	19	14
15	Non-Allowable Expense	(491,171)	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**	(955,490)		49

GROVE OF LAGRANGE PARK

ID# 0053884

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 LAGRANGE PARK # 0053884 **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	(29,000)		39	15								(28,946)	2
3	Housekeeping			174									174	3
4	Laundry			5									5	4
5	Heat and Other Utilities	(5,369)				1,015							(4,354)	5
6	Maintenance	7,359		2,351	36,617	1,284							47,611	6
7	Other (specify):*													7
8	**TOTAL General Services**	(27,010)		2,569	36,632	2,299							14,490	8
	B. Health Care and Programs													
9	Medical Director			534									534	9
10	Nursing and Medical Records	(8,577)		33	89,692		(358)						80,790	10
10a	Therapy													10a
11	Activities			4,046	15								4,062	11
12	Social Services			64	1,395								1,459	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				13,938								13,938	15
16	**TOTAL Health Care and Programs**	(8,577)		4,678	105,040		(358)						100,783	16
	C. General Administration													
17	Administrative	(333,565)	333,565	18,393	121,269								139,661	17
18	Directors Fees													18
19	Professional Services	(48,593)	46,356	12,496	306	255			(2,905)				7,915	19
20	Fees, Subscriptions & Promotions	(14,522)	3,033	711	149	2							(10,628)	20
21	Clerical & General Office Expenses	(233,853)		145,917	25,977	1							(61,959)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			939	672								1,611	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			788	1,919	263							2,970	26
27	Other (specify):*			29,941	28,513								58,454	27
28	**TOTAL General Administration**	(630,533)	382,954	209,183	178,805	521			(2,905)				138,025	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(666,120)	382,954	216,429	320,477	2,820	(358)		(2,905)				253,297	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GROVE OF LAGRANGE PARK **#** 0053884 **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	302,563			674								303,237	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(14,638)	518,691	15		4,588							508,656	32
33	Real Estate Taxes					3,760							3,760	33
34	Rent-Facility & Grounds		(1,148,654)	36,409	52	(36,333)							(1,148,526)	34
35	Rent-Equipment & Vehicles			2,666	1,032								3,698	35
36	Other (specify):*													36
37	TOTAL Ownership	287,925	(629,963)	39,090	1,758	(27,985)							(329,174)	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):*	(491,171)											(491,171)	43
44	TOTAL Special Cost Centers	(491,171)											(491,171)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(869,366)	(247,009)	255,519	322,235	(25,164)	(358)		(2,905)				(567,048)	45

Facility Name & ID Number GROVE OF LAGRANGE PARK # 0053884 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	Rental Income	$ 1,148,654	Grove of LaGrange Healthcare Properties LLC	100.00%	$	$ (1,148,654)	1
2	V	32	Interest	50,161	Grove of LaGrange Healthcare Properties LLC	100.00%	568,852	518,691	2
3	V	19	Tax Extension Fee		Grove of LaGrange Healthcare Properties LLC	100.00%	3,500	3,500	3
4	V	20	Filing Fees		Grove of LaGrange Healthcare Properties LLC	100.00%	250	250	4
5	V	20	Title Fees		Grove of LaGrange Healthcare Properties LLC	100.00%	2,783	2,783	5
6	V	19	Accounting		Grove of LaGrange Healthcare Properties LLC	100.00%	2,575	2,575	6
7	V	19	Legal		Grove of LaGrange Healthcare Properties LLC	100.00%	6,353	6,353	7
8	V	19	Loan Fees		Grove of LaGrange Healthcare Properties LLC	100.00%	33,928	33,928	8
9	V	17	Property Management Fees		Grove of LaGrange Healthcare Properties LLC	100.00%	333,565	333,565	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,198,815			$ 951,806	$ * (247,009)	14

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

Facility Name & ID Number GROVE OF LAGRANGE PARK # 0053884 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%	$ 39	$ 39	15
16	V	3	HOUSEKEEPING SUPPLIES		Legacy Healthcare Financial Services	100.00%	174	174	16
17	V	4	LINEN REPLACEMENT		Legacy Healthcare Financial Services	100.00%	5	5	17
18	V	6	UTILITIES		Legacy Healthcare Financial Services	100.00%	10	10	18
19	V	6	GROUNDS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	2,341	2,341	19
20	V	9	MEDICAL DIRECTOR CONSULTANT		Legacy Healthcare Financial Services	100.00%	534	534	20
21	V	10	MEDICAL SUPPLIES		Legacy Healthcare Financial Services	100.00%	33	33	21
22	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services	100.00%	4,046	4,046	22
23	V	12	SOCIAL SERVICE CONSULTANT		Legacy Healthcare Financial Services	100.00%	64	64	23
24	V	17	ADMINISTRATIVE SALARY		Legacy Healthcare Financial Services	100.00%	18,393	18,393	24
25	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	12,496	12,496	25
26	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	711	711	26
27	V	21	CLERICAL & GENERAL WAGES		Legacy Healthcare Financial Services	100.00%	141,993	141,993	27
28	V	21	CLERICAL & GENERAL OTHER COSTS		Legacy Healthcare Financial Services	100.00%	3,924	3,924	28
29	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	939	939	29
30	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	788	788	30
31	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	29,941	29,941	31
32	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	15	15	32
33	V	34	RENT		Legacy Healthcare Financial Services	100.00%	36,333	36,333	33
34	V	34	STORAGE		Legacy Healthcare Financial Services	100.00%	76	76	34
35	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services	100.00%	19	19	35
36	V	35	AUTO RENTAL		Legacy Healthcare Financial Services	100.00%	2,648	2,648	36
37	V								37
38	V								38
39	Total			$			$ 255,519	$ * 255,519	39

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

Facility Name & ID Number GROVE OF LAGRANGE PARK # 0053884 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%	$ 15	$ 15	15
16	V	6	MAINTENANCE SALARY		Progressive Healthcare Consulting	100.00%	36,508	36,508	16
17	V	6	BUILDING MAINTENANCE AND R&M		Progressive Healthcare Consulting	100.00%	109	109	17
18	V	10	NURSING SALARIES		Progressive Healthcare Consulting	100.00%	89,692	89,692	18
19	V	11	ACTIVITIES PROGRAM		Progressive Healthcare Consulting	100.00%	15	15	19
20	V	12	CLERGY CONSULTANT		Progressive Healthcare Consulting	100.00%	1,391	1,391	20
21	V	12	SOCIAL SERVICE		Progressive Healthcare Consulting	100.00%	3	3	21
22	V	15	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	13,938	13,938	22
23	V	17	ADMIN SALARY- NON OWNER		Progressive Healthcare Consulting	100.00%	121,269	121,269	23
24	V	19	PROFESSIONAL FEES		Progressive Healthcare Consulting	100.00%	306	306	24
25	V	20	DUES, SUBSCRIPTIONS, LICENSES		Progressive Healthcare Consulting	100.00%	149	149	25
26	V	21	CLERICAL WAGES		Progressive Healthcare Consulting	100.00%	25,703	25,703	26
27	V	21	CLERICAL & GENERAL - OTHER		Progressive Healthcare Consulting	100.00%	274	274	27
28	V	24	SEMINARS		Progressive Healthcare Consulting	100.00%	672	672	28
29	V	27	EMP. BEN.-NON-NURSING		Progressive Healthcare Consulting	100.00%	28,513	28,513	29
30	V	26	INSURANCE		Progressive Healthcare Consulting	100.00%	1,919	1,919	30
31	V	30	DEPRECIATION		Progressive Healthcare Consulting	100.00%	674	674	31
32	V	34	STORAGE RENTAL		Progressive Healthcare Consulting	100.00%	52	52	32
33	V	35	AUTO RENTAL		Progressive Healthcare Consulting	100.00%	1,032	1,032	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 322,235	$ * 322,235	39

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

Facility Name & ID Number GROVE OF LAGRANGE PARK # 0053884 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%	$ 1,015	$ 1,015	15
16	V	6	REPAIRS & MAINTENANCE		CF ST. LOUIS, LLC	100.00%	1,284	1,284	16
17	V	19	PROFESSIONAL FEES		CF ST. LOUIS, LLC	100.00%	255	255	17
18	V	20	DUES & SUBSCRIPTIONS		CF ST. LOUIS, LLC	100.00%	2	2	18
19	V	21	OFFICE EXPENSE		CF ST. LOUIS, LLC	100.00%	1	1	19
20	V	26	INSURANCE		CF ST. LOUIS, LLC	100.00%	263	263	20
21	V	32	INTEREST EXPENSE		CF ST. LOUIS, LLC	100.00%	4,588	4,588	21
22	V	33	REAL ESTATE TAXES		CF ST. LOUIS, LLC	100.00%	3,760	3,760	22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	36,333	CF ST. LOUIS, LLC	100.00%		(36,333)	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			$ 36,333			$ 11,169	$ * (25,164)	39

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

Facility Name & ID Number GROVE OF LAGRANGE PARK # 0053884 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	$ 8,803	ReMED Services		$ 8,445	$ (358)	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			$ 8,803			$ 8,445	$ * (358)	39

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

Facility Name & ID Number GROVE OF LAGRANGE PARK # 0053884 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	$ 14,400	ML Group Design and Development		$ 14,400	$	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			$ 14,400			$ 14,400	$ *	39

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

Facility Name & ID Number GROVE OF LAGRANGE PARK # 0053884 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 Services	$ 12,103	ProPay HR LLC	24.00%	$ 9,198	$ (2,905)	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			$ 12,103			$ 9,198	$ * (2,905)	39

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

Facility Name & ID Number GROVE OF LAGRANGE PARK # 0053884 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 LAGRANGE PARK # 0053884 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 LAGRANGE PARK # 0053884 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 LAGRANGE PARK # 0053884 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	GROVE OF LAGRANGE HEALTHCARE PROPERTIES LLC		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			ELMBROOK SKILLED NURSING FACILITY LLC	ELMHURST				12
13			EVANSTON SKILLED NURSING FACILITY LLC	EVANSTON				13
14			GROVE AT THE LAKE SKILLED NURSING FACILITY LLC	ZION				14
15			GROVE OF FOX VALLEY	AURORA				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 LLC	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 LAGRANGE PARK # 0053884 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 LAGRANGE PARK # 0053884 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 LAGRANGE PARK # 0053884 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 LAGRANGE PARK # 0053884 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	$	47,815	$ 39	1
2	3	HOUSEKEEPING SUPPLIES	AVAIL. BED DAYS	1,789,215	30	6,519		47,815	174	2
3	4	LINEN REPLACEMENT	AVAIL. BED DAYS	1,789,215	30	171		47,815	5	3
4	6	UTILITIES	AVAIL. BED DAYS	1,789,215	30	372		47,815	10	4
5	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	1,789,215	30	87,596		47,815	2,341	5
6	9	MEDICAL DIRECTOR CONSU	AVAIL. BED DAYS	1,789,215	30	20,000		47,815	534	6
7	10	MEDICAL SUPPLIES	AVAIL. BED DAYS	1,789,215	30	1,237		47,815	33	7
8	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,789,215	30	151,405		47,815	4,046	8
9	12	SOCIAL SERVICE CONSULTA	AVAIL. BED DAYS	1,789,215	30	2,392		47,815	64	9
10	17	ADMINISTRATIVE SALARY	AVAIL. BED DAYS	1,789,215	30	688,242	688,242	47,815	18,393	10
11	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,789,215	30	467,580		47,815	12,496	11
12	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,789,215	30	26,590		47,815	711	12
13	21	CLERICAL & GENERAL WAG	AVAIL. BED DAYS	1,789,215	30	5,313,296	5,313,296	47,815	141,993	13
14	21	CLERICAL & GENERAL OTH	AVAIL. BED DAYS	1,789,215	30	146,833		47,815	3,924	14
15	24	SEMINARS	AVAIL. BED DAYS	1,789,215	30	35,138		47,815	939	15
16	26	INSURANCE	AVAIL. BED DAYS	1,789,215	30	29,475		47,815	788	16
17	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	1,789,215	30	1,120,380		47,815	29,941	17
18	32	INTEREST	AVAIL. BED DAYS	1,789,215	30	561		47,815	15	18
19	34	RENT	AVAIL. BED DAYS	1,789,215	30	1,359,562		47,815	36,333	19
20	34	STORAGE	AVAIL. BED DAYS	1,789,215	30	2,842		47,815	76	20
21	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,789,215	30	694		47,815	19	21
22	35	AUTO RENTAL	AVAIL. BED DAYS	1,789,215	30	99,069		47,815	2,648	22
23										23
24										24
25	TOTALS					$ 9,561,416	$ 6,001,539		$ 255,519	25

Facility Name & ID Number GROVE OF LAGRANGE PARK # 0053884 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	$	47,815	$ 15	1
2	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,374,590	21	1,049,531	1,049,531	47,815	36,508	2
3	6	BUILDING MAINTENANCE AI	AVAIL. BED DAYS	1,374,590	21	3,133		47,815	109	3
4	10	NURSING SALARIES	AVAIL. BED DAYS	1,374,590	21	2,578,462	2,578,462	47,815	89,692	4
5	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,374,590	21	443		47,815	15	5
6	12	CLERGY CONSULTANT	AVAIL. BED DAYS	1,374,590	21	39,998		47,815	1,391	6
7	12	SOCIAL SERVICE	AVAIL. BED DAYS	1,374,590	21	95		47,815	3	7
8	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,374,590	21	400,703		47,815	13,938	8
9	17	ADMIN SALARY- NON OWNE	AVAIL. BED DAYS	1,374,590	21	3,486,246	3,486,246	47,815	121,269	9
10	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,374,590	21	8,800		47,815	306	10
11	20	DUES, SUBSCRIPTIONS, LICE	AVAIL. BED DAYS	1,374,590	21	4,293		47,815	149	11
12	21	CLERICAL WAGES	AVAIL. BED DAYS	1,374,590	21	738,904	738,904	47,815	25,703	12
13	21	CLERICAL & GENERAL - OTI	AVAIL. BED DAYS	1,374,590	21	7,880		47,815	274	13
14	24	SEMINARS	AVAIL. BED DAYS	1,374,590	21	19,314		47,815	672	14
15	27	EMP. BEN.-NON-NURSING	AVAIL. BED DAYS	1,374,590	21	819,705		47,815	28,513	15
16	26	INSURANCE	AVAIL. BED DAYS	1,374,590	21	55,168		47,815	1,919	16
17	30	DEPRECIATION	AVAIL. BED DAYS	1,374,590	21	19,384		47,815	674	17
18	34	STORAGE RENTAL	AVAIL. BED DAYS	1,374,590	21	1,500		47,815	52	18
19	35	AUTO RENTAL	AVAIL. BED DAYS	1,374,590	21	29,674		47,815	1,032	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 9,263,664	$ 7,853,142		$ 322,235	25

Facility Name & ID Number GROVE OF LAGRANGE PARK # 0053884 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	$	47,815	$ 1,015	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,789,215	30	48,042		47,815	1,284	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,789,215	30	9,551		47,815	255	3
4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,789,215	30	76		47,815	2	4
5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,789,215	30	32		47,815	1	5
6	26	INSURANCE	AVAIL. BED DAYS	1,789,215	30	9,839		47,815	263	6
7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,789,215	30	171,679		47,815	4,588	7
8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,789,215	30	140,710		47,815	3,760	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	$		$ 11,169	25

Facility Name & ID Number GROVE OF LAGRANGE PARK # 0053884 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			$	$		$ 8,445	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					$	$		$ 8,445	25

Facility Name & ID Number GROVE OF LAGRANGE PARK # 0053884 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			$	$		$ 14,400	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					$	$		$ 14,400	25

Facility Name & ID Number GROVE OF LAGRANGE PARK # 0053884 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, IL 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 Services	Direct			$	$		$ 9,198	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					$	$		$ 9,198	25

Facility Name & ID Number GROVE OF LAGRANGE PARK # 0053884 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 LAGRANGE PARK # 0053884 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 LAGRANGE PARK # 0053884 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 LAGRANGE PARK # 0053884 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	The Private Bank		X	Mortgage			$	$ 10,365,957			$ 567,960	1
2	The Private Bank		X	Note Payable				1,151,378			52,913	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 11,517,334			$ 620,873	9
	B. Non-Facility Related*											
10	Interest Income		X								(14,638)	10
11	Interest Income - Bldg Co		X								(50,161)	11
12	Allocated from CF St Louis		X								4,588	12
13	See Supplemental Schedule										15	13
14	TOTAL Non-Facility Related						$	$			$ (60,196)	14
15	TOTALS (line 9+line14)						$	$ 11,517,334			$ 560,677	15

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

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

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

Facility Name & ID Number GROVE OF LAGRANGE PARK # 0053884 **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.**	$	281,565	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.)	$	302,030	2
3. Under or (over) accrual (line 2 minus line 1).	$	20,465	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	251,443	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.)**	$	2,937	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.	$	274,845	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	240,767	8
	2013	247,456	9
	2014	264,044	10
	2015	268,157	11
	2016	298,270	12

2017 Accrual - $298,270 x 0.84 = $251,443 (Rounded)

Allocated CF St Louis = $3,760

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 LAGRANGE PARK COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053884

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.	15-33-128-010-0000	Long Term Care Property	$ 119,628.58	$ 119,628.58
2.	15-33-128-011-0000	Long Term Care Property	$ 178,640.93	$ 178,640.93
3.	10-23-406-034-0000	Home Office Allocation	$ 463,439.48	$ 3,760.34
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 761,708.99	$ 302,029.85

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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 LAGRANGE PARK COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053884

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 LAGRANGE PARK # 0053884 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,000 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

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 [ ] (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	43,000	2015	$ 750,000	1
2	Allocated CF St Louis			17,371	2
3	TOTALS	43,000		$ 767,371	3

Facility Name & ID Number GROVE OF LAGRANGE PARK # 0053884 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	131		2015	1975	$ 3,282,000	$	39	$ 84,154	$ 84,154	$ 522,456	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2009	327,624		20	32,762	32,762	294,862	9
10	Various			2010	115,636		20	11,564	11,564	92,509	10
11	Various			2011	157,995		20	15,800	15,800	110,597	11
12	Various			2012	37,487		20	3,749	3,749	22,492	12
13	Various			2013	344,818		20	34,482	34,482	172,409	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 LAGRANGE PARK # 0053884 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)		208,809			9,832	9,832	19,460	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 4,474,370	$		$ 192,342	$ 192,342	$ 1,234,785	70

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

Facility Name & ID Number GROVE OF LAGRANGE PARK # 0053884 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		$ 4,474,370	$		$ 192,342	$ 192,342	$ 1,234,785	1
2	Rehab Rms, Hallway, Basement - Replaced Sprinkler 4" O.S.Y. V	2014	6,144		20	614	614	2,458	2
3	Common Areas - Installed Heater To Existing Ductwork And Con	2014	9,883		20	988	988	3,953	3
4	Lower Level Restrooms - Plumbing/Replaced Cast Iron Garage Fl	2014	4,500		20	450	450	1,800	4
5	Installed New Grease Trap And New Drains	2014	16,100		20	1,610	1,610	6,440	5
6	Installed New Fire Dampers	2014	4,901		20	490	490	1,960	6
7	Repair P-Tac Units	2014	4,521		20	452	452	1,808	7
8	400 Lbs Of R-11 Refrigerant For $28.00 Each	2014	13,468		20	1,347	1,347	5,387	8
9	10 Retroaire Replacement Ptac Units 15,000 Btu, 1 Retroaire Repl	2014	23,007		20	2,301	2,301	9,203	9
10	3 Roof Mount Exhaust Fans Approx 1200 Cfm, 1 Roof Mount Exh	2014	3,990		20	399	399	1,596	10
11	Design Fee For 1St Floor Lobby, Office, Nurse Station	2014	6,000		20	600	600	2,400	11
12	Kitchen - Installed Fire Rated Door And Floor Tiles	2014	2,650		20	265	265	1,060	12
13	Plumbing - Kitchen Sewer Lines	2014	2,866		20	287	287	1,146	13
14	Installed Two Mechanical Door Restrictors For Elevators	2014	4,520		20	452	452	1,808	14
15	Kitchen - Installed Floor Tiles, Drains, Sinks, Doors; Drywall In	2014	29,750		20	2,975	2,975	11,900	15
16	Break Room;Floor Drain In Laundry Room; Tiles In Locker Roor	2014			20				16
17	Hvac Repair	2017	2,655		20	310	310	310	17
18	Flooring In Common Areas	2017	55,646		20	8,347	8,347	8,347	18
19	Roam Alert System	2017	12,000		20	1,600	1,600	1,600	19
20	Wall Sconces For 1St Floor	2017	5,438		20	272	272	272	20
21	New Vinyl, Drywall, And Tiles In Resident Rooms	2017	33,781		20	1,689	1,689	1,689	21
22	3 Pole 100 Amp Circuit Breaker For Elevator	2017	2,942		20	147	147	147	22
23	New Kitchen Flooring	2017	7,600		20	380	380	380	23
24	Electrical Work 1St Floor Rooms	2017	3,500		20	175	175	175	24
25	Repaired Boiler	2017	12,668		20	633	633	633	25
26	Bathroom - Tiling And Walls/Drywall	2017	3,355		20	168	168	168	26
27	6" Wilkins Double Detector For Sprinkler	2017	7,298		20	365	365	365	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,753,552	$		$ 219,658	$ 219,658	$ 1,301,790	34

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

Facility Name & ID Number GROVE OF LAGRANGE PARK # 0053884 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		$ 4,753,552	$		$ 219,658	$ 219,658	$ 1,301,790	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,753,552	$		$ 219,658	$ 219,658	$ 1,301,790	34

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

Facility Name & ID Number GROVE OF LAGRANGE PARK # 0053884 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		$ 4,753,552	$		$ 219,658	$ 219,658	$ 1,301,790	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,753,552	$		$ 219,658	$ 219,658	$ 1,301,790	34

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

Facility Name & ID Number GROVE OF LAGRANGE PARK # 0053884 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		$ 4,753,552	$		$ 219,658	$ 219,658	$ 1,301,790	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,753,552	$		$ 219,658	$ 219,658	$ 1,301,790	34

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

Facility Name & ID Number GROVE OF LAGRANGE PARK # 0053884 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 LAGRANGE PARK # 0053884 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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number GROVE OF LAGRANGE PARK # 0053884 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 from CF St Louis	2016	28,399		35	811	811	1,623	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St Louis	2016	176,318		20	8,816	8,816	17,632	9
10	Allocated from CF St Louis	2017	4,092		20	205	205	205	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)		$ 208,809	$		$ 9,832	$ 9,832	$ 19,460	34

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

Facility Name & ID Number GROVE OF LAGRANGE PARK # 0053884 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		$ 208,809	$		$ 9,832	$ 9,832	$ 19,460	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		$ 208,809	$		$ 9,832	$ 9,832	$ 19,460	34

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

Facility Name & ID Number GROVE OF LAGRANGE PARK # 0053884 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	$ 744,837	$ 674	$ 74,484	$ 73,810	10	$ 475,026	71
72	Current Year Purchases	91,404		9,095	9,095	10	9,095	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 836,241	$ 674	$ 83,579	$ 82,905		$ 484,121	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,357,164	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 674	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 303,237	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 302,563	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,785,912	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 LAGRANGE PARK # 0053884 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: N/A

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Legacy HC Financial				76			5
6	Allocated from Progressive Consulting				52			6
7	TOTAL				$ 128 **			7

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

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

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

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

	Fiscal Year Ending	Annual Rent
12.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 4,824 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		$	$ 2,120	17
18	Allocated Legacy HC Financial			2,648	18
19	Allocated Progressive Consulting			1,032	19
20					20
21	TOTAL		$	$ 5,800	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 LAGRANGE PARK # 0053884 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 LAGRANGE PARK # 0053884 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	$		$ 202,194	$		$ 202,194	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			148,576			148,576	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			199,078			199,078	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				286,090		286,090	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					32,296	117,721		150,017	13
14	TOTAL			$		$ 582,144	$ 403,811		$ 985,955	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 LAGRANGE PARK **#** 0053884 **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	$	$ 18,106	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,133,851	2,133,851	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	105,287	105,287	6
7	Other Prepaid Expenses	10,818	36,702	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	205,337	561,090	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,455,293	$ 2,855,036	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		750,000	13
14	Buildings, at Historical Cost		3,282,000	14
15	Leasehold Improvements, at Historical Cost	303,771	303,771	15
16	Equipment, at Historical Cost	316,988	316,988	16
17	Accumulated Depreciation (book methods)	(53,229)	(491,530)	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	992,799	5,938,781	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,560,329	$ 10,100,010	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,015,622	$ 12,955,046	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 584,512	$ 586,964	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,151,378	1,399,960	29
30	Accrued Salaries Payable	229,731	229,731	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,436	6,436	31
32	Accrued Real Estate Taxes(Sch.IX-B)		251,443	32
33	Accrued Interest Payable		52,036	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	87,605	210,502	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,059,662	$ 2,737,072	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,117,374	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	1,521,159	1,521,159	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,521,159	$ 11,638,533	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,580,821	$ 14,375,605	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 434,801	$ (1,420,559)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,015,622	$ 12,955,046	48

***(See instructions.)**

Facility Name & ID Number GROVE OF LAGRANGE PARK **#** 0053884 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 44,428	1
2	Restatements (describe):		2
3	Rounding	6	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 44,434	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	390,367	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)**	$ 390,367	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)**	$ 434,801	24 *

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

Facility Name & ID Number GROVE OF LAGRANGE PARK # 0053884 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 12,484,016	1
2	Discounts and Allowances for all Levels	(5,608,837)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,875,179	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,619,325	6
7	Oxygen	8	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,619,333	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	286,694	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	37,494	19
20	Radiology and X-Ray		20
21	Other Medical Services	8,912	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 333,100	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	14,638	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 14,638	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	34,734	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 34,734	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,876,984	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,339,040	31
32	Health Care	3,250,386	32
33	General Administration	1,644,706	33
	B. Capital Expense		
34	Ownership	1,476,644	34
	C. Ancillary Expense		
35	Special Cost Centers	1,477,126	35
36	Provider Participation Fee	298,715	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,486,617	40
41	**Income before Income Taxes (line 30 minus line 40)****	390,367	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 390,367	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,987,032	44
45	Private Pay - Net Inpatient Revenue	257,714	45
46	Medicare - Net Inpatient Revenue	1,046,062	46
47	Other-(specify) Insurance	584,371	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,875,179	49

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

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

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

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

Facility Name & ID Number GROVE OF LAGRANGE PARK # 0053884 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,921	2,088	$ 102,902	$ 49.28	1
2	Assistant Director of Nursing	1,922	2,089	87,662	41.96	2
3	Registered Nurses	25,759	27,999	943,506	33.70	3
4	Licensed Practical Nurses	21,134	22,972	613,619	26.71	4
5	CNAs & Orderlies	58,528	63,617	853,166	13.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,391	4,772	112,721	23.62	8
9	Activity Director	1,776	1,930	34,312	17.78	9
10	Activity Assistants	6,306	6,854	76,600	11.18	10
11	Social Service Workers	4,399	4,782	98,998	20.70	11
12	Dietician					12
13	Food Service Supervisor	2,725	2,962	62,070	20.96	13
14	Head Cook	4,399	4,782	83,879	17.54	14
15	Cook Helpers/Assistants	14,144	15,374	165,860	10.79	15
16	Dishwashers					16
17	Maintenance Workers	3,682	4,002	72,791	18.19	17
18	Housekeepers	18,683	20,308	230,585	11.35	18
19	Laundry	5,290	5,750	73,791	12.83	19
20	Administrator	1,920	2,087	131,969	63.23	20
21	Assistant Administrator	1,920	2,087	68,698	32.92	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,797	9,562	140,590	14.70	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	5,147	5,595	106,408	19.02	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	192,843	209,612	$ 4,060,127 *	$ 19.37	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	4	$ 201	01-03	35
36	Medical Director	Monthly	63,741	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	19,237	10-03	38
39	Pharmacist Consultant	Monthly	10,082	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,241	11-03	44
45	Social Service Consultant	60	3,658	12-03	45
46	Other(specify)				46
47	Transitional Care Consultant	Monthly	5,400	10-03	47
48					48
49	TOTAL (lines 35 - 48)	64	$ 103,560		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

Facility Name & ID Number GROVE OF LAGRANGE PARK # 0053884 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Marie Derzsy	Administrator	0	$ 131,969
Jennifer LaBella	Asst. Admin	0	26,585
Scott C. Morton	Asst. Admin	0	42,112
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 200,666

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 Services	$ 12,834
Paycor	Payroll Service	12,103
McCabe, Kirshner & Ballester, P.C.	Actuarial Study	716
See Attached	Legal Fees	33,019
Achieve Accreditation	Joint Commission Consultant	4,239
IIT/Sourcetech	Data Processing	1,690
MTS Consulting	Tax Consulting	6,634
First Real Estate Services	Real Estate Appraisal	2,750
Personnel Planners	Unemployment Consultant	1,530
PSD Solutions	Data Processing	614
Strauss Data Consulting	Data Processing	17
See Supplemental Schedule		1,921
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 78,065

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 86,071
Unemployment Compensation Insurance	78,807
FICA Taxes	303,863
Employee Health Insurance	174,803
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Executive Insurance	2,625
Union Pension	23,531
Employee Benefits	13,660
401K Expense	6,968
Voluntary Benefit Contribution	10,495
Employee Physical Exams	15,299
TOTAL (agree to Schedule V, line 22, col.8)	$ 716,123

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	144
Health Care Worker Background Check	5,917
(Indicate # of checks performed 592)	
Patient Background Checks 11	110
Dues & Subscriptions	18,679
Licenses & Permits	15,145
Allocated from Legacy HC Financial	711
Allocated from Progressive Consulting	149
See Supplemental Schedule	2
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 40,858

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,787
Allocated from Legacy HC Financial	939
Allocated from Progressive Consulting	672
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,398

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GROVE OF LAGRANGE PARK # 0053884 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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: $15,543; IHCA: $1,598**

(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. $ **32,375** 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. $ **298,715**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

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