		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: 0053918

Facility Name: GROVE OF NORTHBROOK

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

County: Cook

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/17 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 NORTHBROOK # 0053918 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	86	Skilled (SNF)	86	31,390	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,520	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	134	TOTALS	134	48,910	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,500	694	1,787	5,981	8
9	SNF/PED					9
10	ICF	35,379	1,875	528	37,782	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,879	2,569	2,315	43,763	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.48%

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 11/01/2012

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/2012 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 86 and days of care provided 1,647

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 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	352,408	24,371		376,779		376,779		376,779			1
2	Food Purchase		240,372		240,372		240,372	(6,613)	233,759			2
3	Housekeeping	120,352	21,513	237	142,102		142,102	178	142,280			3
4	Laundry	69,901	14,590		84,491		84,491	5	84,496			4
5	Heat and Other Utilities			138,485	138,485		138,485	(17,500)	120,985			5
6	Maintenance	83,708	14,669	98,368	196,745		196,745	51,968	248,713			6
7	Other (specify):*											7
8	TOTAL General Services	626,369	315,515	237,090	1,178,974		1,178,974	28,038	1,207,012			8
	B. Health Care and Programs											
9	Medical Director			22,015	22,015		22,015	547	22,562			9
10	Nursing and Medical Records	2,796,315	48,988	57,176	2,902,479		2,902,479	87,685	2,990,164			10
10a	Therapy	173,277	498		173,775		173,775		173,775			10a
11	Activities	136,265	13,179	559	150,003		150,003	4,155	154,158			11
12	Social Services	202,592		9,765	212,357		212,357	1,492	213,849			12
13	CNA Training											13
14	Program Transportation			24,783	24,783		24,783		24,783			14
15	Other (specify):*							14,258	14,258			15
16	TOTAL Health Care and Programs	3,308,449	62,665	114,298	3,485,412		3,485,412	108,136	3,593,548			16
	C. General Administration											
17	Administrative	136,137			136,137		136,137	142,860	278,997			17
18	Directors Fees											18
19	Professional Services			120,037	120,037	(3,491)	116,546	(11,266)	105,281			19
20	Dues, Fees, Subscriptions & Promotions			49,555	49,555		49,555	(11,519)	38,036			20
21	Clerical & General Office Expenses	186,230	3,067	206,029	395,326		395,326	26,329	421,655			21
22	Employee Benefits & Payroll Taxes			643,049	643,049		643,049		643,049			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,283	1,283		1,283	1,648	2,931			24
25	Other Admin. Staff Transportation			1,419	1,419		1,419		1,419			25
26	Insurance-Prop.Liab.Malpractice			128,637	128,637		128,637	3,038	131,675			26
27	Other (specify):*							59,793	59,793			27
28	TOTAL General Administration	322,367	3,067	1,150,009	1,475,443	(3,491)	1,471,952	210,883	1,682,835			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,257,185	381,247	1,501,397	6,139,829	(3,491)	6,136,338	347,057	6,483,395			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number GROVE OF NORTHBROOK #0053918 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation							253,464	253,464			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			48,606	48,606		48,606	457,591	506,197			32
33	Real Estate Taxes			306,000	306,000	3,491	309,491	3,846	313,337			33
34	Rent-Facility & Grounds			929,603	929,603		929,603	(929,472)	131			34
35	Rent-Equipment & Vehicles			10,165	10,165		10,165	3,783	13,948			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,294,374	1,294,374	3,491	1,297,865	(210,788)	1,087,077			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		187,437	341,364	528,801		528,801		528,801			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			341,630	341,630		341,630		341,630			42
43	Other (specify):*			439,777	439,777		439,777	(439,777)				43
44	**TOTAL Special Cost Centers**		187,437	1,122,771	1,310,208		1,310,208	(439,777)	870,431			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,257,185	568,684	3,918,542	8,744,411		8,744,411	(303,507)	8,440,904			45

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

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 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	(18,539)	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	252,774	30		9
10	Interest and Other Investment Income	(7,742)	32		10
11	Discounts, Allowances, Rebates & Refunds	(6,527)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(141)	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	(386)	21		18
19	Entertainment	(405)	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	(126,848)	21		24
25	Fund Raising, Advertising and Promotional	(5,219)	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	(799,752)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (712,785)		$	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)	409,278		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 409,278		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (303,507)		37

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

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

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

GROVE OF NORTHBROOK

ID# 0053918

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Personal Items	$ (3,781)	10	1
2	Sequestration Expense	(21,167)	21	2
3	Building Co - Title Fees	(3,105)	20	3
4	Building Co - Loan Fees	(24,505)	26	4
5	Building Co - Accounting Fees	(4,755)	19	5
6	Building Co - Management Fees	(285,935)	21	6
7	Miscellaneous Income	(695)	21	7
8	PAC Dues	(7,182)	20	8
9	Non Allowable Expense	(439,777)	43	9
10	Additional R&M	10,795	06	10
11	Non Allowable Legal	(19,645)	19	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(799,752)		49

GROVE OF NORTHBROOK

ID# 0053918

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 NORTHBROOK # 0053918 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	(6,668)		40	15								(6,613)	2
3	Housekeeping			178									178	3
4	Laundry			5									5	4
5	Heat and Other Utilities	(18,539)				1,039							(17,500)	5
6	Maintenance	10,795		2,405	37,455	1,313							51,968	6
7	Other (specify):*													7
8	TOTAL General Services	(14,412)		2,628	37,470	2,352							28,038	8
	B. Health Care and Programs													
9	Medical Director			547									547	9
10	Nursing and Medical Records	(3,781)		34	91,746		(313)						87,685	10
10a	Therapy													10a
11	Activities			4,139	16								4,155	11
12	Social Services			65	1,427								1,492	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				14,258								14,258	15
16	TOTAL Health Care and Programs	(3,781)		4,785	107,446		(313)						108,136	16
	C. General Administration													
17	Administrative			18,814	124,046								142,860	17
18	Directors Fees													18
19	Professional Services	(24,400)	4,755	12,782	313	261			(4,977)				(11,266)	19
20	Fees, Subscriptions & Promotions	(15,506)	3,105	727	153	2							(11,519)	20
21	Clerical & General Office Expenses	(435,436)	285,935	149,258	26,572	1							26,329	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			961	687								1,648	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice	(24,505)	24,505	806	1,963	269							3,038	26
27	Other (specify):*			30,627	29,166								59,793	27
28	TOTAL General Administration	(499,847)	318,301	213,974	182,900	533			(4,977)				210,883	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(518,040)	318,301	221,386	327,816	2,885	(313)		(4,977)				347,057	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 **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	252,774			690								253,464	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(7,742)	460,625	15		4,693							457,591	32
33	Real Estate Taxes					3,846							3,846	33
34	Rent-Facility & Grounds		(929,603)	37,243	53	(37,165)							(929,472)	34
35	Rent-Equipment & Vehicles			2,727	1,056								3,783	35
36	Other (specify):*													36
37	TOTAL Ownership	245,032	(468,978)	39,985	1,799	(28,626)							(210,788)	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):*	(439,777)											(439,777)	43
44	TOTAL Special Cost Centers	(439,777)											(439,777)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(712,785)	(150,677)	261,371	329,615	(25,741)	(313)		(4,977)				(303,507)	45

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 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	$ 929,603	Brook Properties	100.00%	$	$ (929,603)	1
2	V	20	Title Fees		Brook Properties	100.00%	3,105	3,105	2
3	V	19	Accounting		Brook Properties	100.00%	4,755	4,755	3
4	V	26	Loan Fees		Brook Properties	100.00%	24,505	24,505	4
5	V	21	Property Management Fees		Brook Properties	100.00%	285,935	285,935	5
6	V	32	Interest Expense - Mortgage A		Brook Properties	100.00%	460,625	460,625	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 929,603			$ 778,926	$ * (150,677)	14

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

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 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%	$ 40	$ 40	15
16	V	3	HOUSEKEEPING SUPPLIES		Legacy Healthcare Financial Services	100.00%	178	178	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%	2,395	2,395	19
20	V	9	MEDICAL DIRECTOR CONSULTANT		Legacy Healthcare Financial Services	100.00%	547	547	20
21	V	10	MEDICAL SUPPLIES		Legacy Healthcare Financial Services	100.00%	34	34	21
22	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services	100.00%	4,139	4,139	22
23	V	12	SOCIAL SERVICE CONSULTANT		Legacy Healthcare Financial Services	100.00%	65	65	23
24	V	17	ADMINISTRATIVE SALARY		Legacy Healthcare Financial Services	100.00%	18,814	18,814	24
25	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	12,782	12,782	25
26	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	727	727	26
27	V	21	CLERICAL & GENERAL WAGES		Legacy Healthcare Financial Services	100.00%	145,244	145,244	27
28	V	21	CLERICAL & GENERAL OTHER COSTS		Legacy Healthcare Financial Services	100.00%	4,014	4,014	28
29	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	961	961	29
30	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	806	806	30
31	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	30,627	30,627	31
32	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	15	15	32
33	V	34	RENT		Legacy Healthcare Financial Services	100.00%	37,165	37,165	33
34	V	34	STORAGE		Legacy Healthcare Financial Services	100.00%	78	78	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%	2,708	2,708	36
37	V								37
38	V								38
39	Total			$			$ 261,371	$ * 261,371	39

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

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 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%	37,344	37,344	16
17	V	6	BUILDING MAINTENANCE AND R&M		Progressive Healthcare Consulting	100.00%	111	111	17
18	V	10	NURSING SALARIES		Progressive Healthcare Consulting	100.00%	91,746	91,746	18
19	V	11	ACTIVITIES PROGRAM		Progressive Healthcare Consulting	100.00%	16	16	19
20	V	12	CLERGY CONSULTANT		Progressive Healthcare Consulting	100.00%	1,423	1,423	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%	14,258	14,258	22
23	V	17	ADMIN SALARY- NON OWNER		Progressive Healthcare Consulting	100.00%	124,046	124,046	23
24	V	19	PROFESSIONAL FEES		Progressive Healthcare Consulting	100.00%	313	313	24
25	V	20	DUES, SUBSCRIPTIONS, LICENSES		Progressive Healthcare Consulting	100.00%	153	153	25
26	V	21	CLERICAL WAGES		Progressive Healthcare Consulting	100.00%	26,291	26,291	26
27	V	21	CLERICAL & GENERAL - OTHER		Progressive Healthcare Consulting	100.00%	280	280	27
28	V	24	SEMINARS		Progressive Healthcare Consulting	100.00%	687	687	28
29	V	27	EMP. BEN.-NON-NURSING		Progressive Healthcare Consulting	100.00%	29,166	29,166	29
30	V	26	INSURANCE		Progressive Healthcare Consulting	100.00%	1,963	1,963	30
31	V	30	DEPRECIATION		Progressive Healthcare Consulting	100.00%	690	690	31
32	V	34	STORAGE RENTAL		Progressive Healthcare Consulting	100.00%	53	53	32
33	V	35	AUTO RENTAL		Progressive Healthcare Consulting	100.00%	1,056	1,056	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 329,615	$ * 329,615	39

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

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 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%	$ 1,039	$ 1,039	15
16	V	6	REPAIRS & MAINTENANCE		CF ST. LOUIS, LLC	100.00%	1,313	1,313	16
17	V	19	PROFESSIONAL FEES		CF ST. LOUIS, LLC	100.00%	261	261	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%	269	269	20
21	V	32	INTEREST EXPENSE		CF ST. LOUIS, LLC	100.00%	4,693	4,693	21
22	V	33	REAL ESTATE TAXES		CF ST. LOUIS, LLC	100.00%	3,846	3,846	22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	37,165	CF ST. LOUIS, LLC	100.00%		(37,165)	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			$ 37,165			$ 11,424	$ * (25,741)	39

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

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 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	$ 7,686	ReMED Services		$ 7,373	$ (313)	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			$ 7,686			$ 7,373	$ * (313)	39

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

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 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	$ 9,000	ML Group Design and Development		$ 9,000	$	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			$ 9,000			$ 9,000	$ *	39

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

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Processing	$ 20,798	ProPay HR		$ 15,821	$ (4,977)	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			$ 20,798			$ 15,821	$ * (4,977)	39

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

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 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 NORTHBROOK # 0053918 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 NORTHBROOK # 0053918 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 NORTHBROOK # 0053918 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	GPN FAMILY TRUST	50.00%	ASTORIA PLACE SKILLED NURSING FACILITY LLC	CHICAGO	BROOK PROPERTIES		BUILDING CO	1
2	DOROS GENERATION TRUST	50.00%	AVANTARA LONG GROVE	LONG GROVE	LEGACY HC & FINANCIAL SER	LINCOLNWOOD	HOME OFFICE/BOOKKEEPI	2
3			AVANTARA PARK RIDGE	PARK RIDGE	PROGRESSIVE HC	LINCOLNWOOD	NURSE CONSULTANT	3
4			AZRIA MIDTOWN	OMAHA, NE	ML GROUP DESIGN & DEV	SKOKIE	ASSET MANAGEMENT	4
5			AZRIA MONTCLAIR	OMAHA, NE	REMED SERVICES LLC	LINCOLNWOOD	NURSING EQUIPMENT	5
6			AZRIA OLATHE	OLATHE, KS	AURORA SUPPORTIVE LIVING	AURORA	SUPPORTIVE LIVING	6
7			BETHANY TERRACE	MORTON GROVE	TERRACE GARDENS	MORTON GROVE	ASSISTED LIVING	7
8			CARLTON SKILLED NURSING FACILITY LLC	CHICAGO	LINCOLNSHIRE ASSISTED LIVI	LINCOLNSHIRE	ASSISTED LIVING	8
9			CEDAR SKILLED NURSING FACILITY	CEDAR CITY, UT	CF ST. LOUIS LLC	SKOKIE	BUILDING COMPANY	9
10			CHALET SKILLED NURSING FACILITY LLC	CHICAGO	PROPAY HR	EVANSTON	PAYROLL PROCESSING	10
11			CLARK SKILLED NURSING FACILITY	CHICAGO				11
12			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			LAGRANGE SKILLED NURSING FACILITY LLC	LAGRANGE PARK				16
17			LAKEFRONT SKILLED NURSING FACILITY LLC	CHICAGO				17
18			LINCOLN PARK SKILLED NURSING FACILITY LLC	CHICAGO				18
19			LINCOLNSHIRE LIVING & REHAB CENTER LLC	LINCOLNSHIRE				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 NORTHBROOK # 0053918 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 NORTHBROOK # 0053918 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 NORTHBROOK # 0053918 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 NORTHBROOK # 0053918 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	$	48,910	$ 40	1
2	3	HOUSEKEEPING SUPPLIES	AVAIL. BED DAYS	1,789,215	30	6,519		48,910	178	2
3	4	LINEN REPLACEMENT	AVAIL. BED DAYS	1,789,215	30	171		48,910	5	3
4	6	UTILITIES	AVAIL. BED DAYS	1,789,215	30	372		48,910	10	4
5	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	1,789,215	30	87,596		48,910	2,395	5
6	9	MEDICAL DIRECTOR CONSU	AVAIL. BED DAYS	1,789,215	30	20,000		48,910	547	6
7	10	MEDICAL SUPPLIES	AVAIL. BED DAYS	1,789,215	30	1,237		48,910	34	7
8	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,789,215	30	151,405		48,910	4,139	8
9	12	SOCIAL SERVICE CONSULTA	AVAIL. BED DAYS	1,789,215	30	2,392		48,910	65	9
10	17	ADMINISTRATIVE SALARY	AVAIL. BED DAYS	1,789,215	30	688,242	688,242	48,910	18,814	10
11	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,789,215	30	467,580		48,910	12,782	11
12	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,789,215	30	26,590		48,910	727	12
13	21	CLERICAL & GENERAL WAG	AVAIL. BED DAYS	1,789,215	30	5,313,296	5,313,296	48,910	145,244	13
14	21	CLERICAL & GENERAL OTH	AVAIL. BED DAYS	1,789,215	30	146,833		48,910	4,014	14
15	24	SEMINARS	AVAIL. BED DAYS	1,789,215	30	35,138		48,910	961	15
16	26	INSURANCE	AVAIL. BED DAYS	1,789,215	30	29,475		48,910	806	16
17	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	1,789,215	30	1,120,380		48,910	30,627	17
18	32	INTEREST	AVAIL. BED DAYS	1,789,215	30	561		48,910	15	18
19	34	RENT	AVAIL. BED DAYS	1,789,215	30	1,359,562		48,910	37,165	19
20	34	STORAGE	AVAIL. BED DAYS	1,789,215	30	2,842		48,910	78	20
21	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,789,215	30	694		48,910	19	21
22	35	AUTO RENTAL	AVAIL. BED DAYS	1,789,215	30	99,069		48,910	2,708	22
23										23
24										24
25	TOTALS					$ 9,561,416	$ 6,001,539		$ 261,371	25

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 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	$	48,910	$ 15	1
2	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,374,590	21	1,049,531	1,049,531	48,910	37,344	2
3	6	BUILDING MAINTENANCE AI	AVAIL. BED DAYS	1,374,590	21	3,133		48,910	111	3
4	10	NURSING SALARIES	AVAIL. BED DAYS	1,374,590	21	2,578,462	2,578,462	48,910	91,746	4
5	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,374,590	21	443		48,910	16	5
6	12	CLERGY CONSULTANT	AVAIL. BED DAYS	1,374,590	21	39,998		48,910	1,423	6
7	12	SOCIAL SERVICE	AVAIL. BED DAYS	1,374,590	21	95		48,910	3	7
8	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,374,590	21	400,703		48,910	14,258	8
9	17	ADMIN SALARY- NON OWNE	AVAIL. BED DAYS	1,374,590	21	3,486,246	3,486,246	48,910	124,046	9
10	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,374,590	21	8,800		48,910	313	10
11	20	DUES, SUBSCRIPTIONS, LICE	AVAIL. BED DAYS	1,374,590	21	4,293		48,910	153	11
12	21	CLERICAL WAGES	AVAIL. BED DAYS	1,374,590	21	738,904	738,904	48,910	26,291	12
13	21	CLERICAL & GENERAL - OTI	AVAIL. BED DAYS	1,374,590	21	7,880		48,910	280	13
14	24	SEMINARS	AVAIL. BED DAYS	1,374,590	21	19,314		48,910	687	14
15	27	EMP. BEN.-NON-NURSING	AVAIL. BED DAYS	1,374,590	21	819,705		48,910	29,166	15
16	26	INSURANCE	AVAIL. BED DAYS	1,374,590	21	55,168		48,910	1,963	16
17	30	DEPRECIATION	AVAIL. BED DAYS	1,374,590	21	19,384		48,910	690	17
18	34	STORAGE RENTAL	AVAIL. BED DAYS	1,374,590	21	1,500		48,910	53	18
19	35	AUTO RENTAL	AVAIL. BED DAYS	1,374,590	21	29,674		48,910	1,056	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 9,263,664	$ 7,853,142		$ 329,615	25

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 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	$	48,910	$ 1,039	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,789,215	30	48,042		48,910	1,313	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,789,215	30	9,551		48,910	261	3
4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,789,215	30	76		48,910	2	4
5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,789,215	30	32		48,910	1	5
6	26	INSURANCE	AVAIL. BED DAYS	1,789,215	30	9,839		48,910	269	6
7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,789,215	30	171,679		48,910	4,693	7
8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,789,215	30	140,710		48,910	3,846	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	$		$ 11,424	25

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 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, LLC
Street Address: 3424 Oakton Street, Suite 102
City / State / Zip Code: Skokie, IL
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			$	$		$ 7,373	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					$	$		$ 7,373	25

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 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 Street
City / State / Zip Code: Skokie, IL
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			$	$		$ 9,000	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					$	$		$ 9,000	25

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: ProPay HR LLC
Street Address: 2201 W. MAIN ST
City / State / Zip Code: EVANSTON , ILLINOIS 60202
Phone Number: ((847) 905 3268
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Payroll Processing	Direct			$	$		$ 15,821	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					$	$		$ 15,821	25

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 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 NORTHBROOK # 0053918 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 NORTHBROOK # 0053918 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 NORTHBROOK # 0053918 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				$	$ 8,347,817			$ 460,625	1
2												2
3												3
4												4
5												5
	Working Capital											
6	The Private Bank		X					361,845			48,606	6
7												7
8												8
9	TOTAL Facility Related						$	$ 8,709,662			$ 509,231	9
	B. Non-Facility Related*											
10	Interest Income		X								(7,742)	10
11	Allocated from Legacy Healthca	X									15	11
12	Allocated from CF St. Louis	X									4,693	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (3,034)	14
15	TOTALS (line 9+line14)						$	$ 8,709,662			$ 506,197	15

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

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

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

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 **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.**	$	295,322	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.)	$	329,146	2
3. Under or (over) accrual (line 2 minus line 1).	$	33,824	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	276,022	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.)**	$	3,491	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.	$	313,337	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	203,281	8
	2013	248,631	9
	2014	256,542	10
	2015	281,261	11
	2016	325,300	12

Beginning Accrual Adjusted
2017 Accrual = $325,300 x .85 = $276,022
Allocated from CF St. Louis $3,846

	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 NORTHBROOK COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053918

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.	04-02-202-047-0000	Long Term Care Property	$ 325,299.59	$ 325,299.59
2.	10-23-406-034-0000	Home Office Allocation	$ 463,439.48	$ 3,846.45
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 788,739.07	$ 329,146.04

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 NORTHBROOK COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053918

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 NORTHBROOK # 0053918 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 667,000	1
2	Allocated from CF St. Louis			17,768	2
3	TOTALS			$ 684,768	3

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 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	134		2012	1976	$ 4,410,000	$	35	$ 126,000	$ 126,000	$ 630,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2012	5,642		20	282	282	1,434	9
10	Various			2013	27,362		20	1,368	1,368	6,371	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 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)		17,904			895	895	5,370	67
68	Related Party Allocations (Pages 12H & 12I)		213,590			10,057	10,057	19,905	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 4,674,498	$		$ 138,602	$ 138,602	$ 663,080	70

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

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 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		$ 4,674,498	$		$ 138,602	$ 138,602	$ 663,080	1
2	Installaton Of Delayed Egrass Locks And Associated Components	2014	6,500		20	325	325	1,273	2
3	Egressable Mag Lock With Reset Switch	2014	6,472		20	1,294	1,294	4,638	3
4	Installed New Chiller	2014	41,296		20	4,130	4,130	15,142	4
5	Re-Install Conduit Lower Level For Camera	2014	2,701		20	540	540	1,756	5
6	Installation Of Entrance Door	2014	4,350		20	218	218	707	6
7	Install Electric And Wanderguard System	2014	24,300		20	4,860	4,860	16,605	7
8	Removal And Replacement Of Asphalt / Sewer Repairs	2014	13,150		20	877	877	2,922	8
9	Applied A Patch To The Field Of Wall Flashings	2014	5,500		20	275	275	1,031	9
10	Repair Of Nurse Call System	2014	7,228		20	1,446	1,446	5,301	10
11	Chiller Replacement	2014	13,764		20	688	688	2,695	11
12	Install Gravel & Mulch	2014	3,380		20	169	169	620	12
13	Kitchen Sink Water & Drain Line	2015	6,750		20	338	338	675	13
14	Repair Leaking Cast Iron Boiler	2015	4,577		20	229	229	458	14
15	Repair Roof	2015	3,600		20	180	180	360	15
16	Two New Fire Rated Stairway Doors - Basement Kitchen	2015	2,950		20	148	148	295	16
17	Wiremold Receptacles In Bedrooms	2015	9,570		20	478	478	957	17
18	Kitchen Storage Room & Basement Wiring Panels	2015	3,103		20	155	155	310	18
19	Architect Fees For Driveway	2015	130,612		20	6,531	6,531	13,061	19
20	Hallways/Dining Rm/Activity Rm/Basement - Prime/Paint/Patch	2016	23,590		20	1,180	1,180	2,359	20
21	Repaired Sprinkler	2016	4,500		20	225	225	450	21
22	Basement Hallway/Therapy Rm/Office/Shower - Replaced Tiling	2016	2,500		20	125	125	250	22
23	Replaced Leaking Pipes And Fittings For Storage Tank	2016	3,748		20	187	187	375	23
24	Installed New Valves For Pump	2016	6,631		20	332	332	663	24
25	Installed Damper On Boiler	2016	2,700		20	135	135	270	25
26	Installed Pit Ladder For Elevator	2016	3,263		20	163	163	326	26
27	1St Floor Lobby - Flooring/Lighting/Ceiling	2016	6,753		20	338	338	675	27
28	Installed New Reception Desk	2016	5,350		20	268	268	535	28
29	Repaired Front Vestibule And Reclocate Generator Panel	2016	40,500		20	2,025	2,025	4,050	29
30	Installed Condenser For Chiller	2016	18,918		20	946	946	1,892	30
31	Installation Of Cables For Phone System	2016	4,593		20	230	230	459	31
32	Removal Of Wallpaper And Painting In Common Areas	2017	9,130		20	304	304	304	32
33	Repaired A/C Unit	2017	9,457		20	394	394	394	33
34	TOTAL (lines 1 thru 33)		$ 5,105,931	$		$ 168,332	$ 168,332	$ 744,888	34

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

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 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		$ 5,105,931	$		$ 168,332	$ 168,332	$ 744,888	1
2	Replacement Of Fan And Exhausting Pipe For The Dishwasher	2017	5,600		20	117	117	117	2
3	Replaced A/C With Air Handler	2017	5,500		20	550	550	550	3
4	Replaced Waterguard Systems	2017	3,595		20	360	360	360	4
5	Performed Load Bank Test And Repaired Exhaust Problem	2017	9,239		20	616	616	616	5
6	Installation Of Light Fixtures	2017	10,600		20	309	309	309	6
7	Signage	2017	5,121		20	256	256	256	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,145,586	$		$ 170,540	$ 170,540	$ 747,096	34

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

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 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		$ 5,145,586	$		$ 170,540	$ 170,540	$ 747,096	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,145,586	$		$ 170,540	$ 170,540	$ 747,096	34

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

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 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		$ 5,145,586	$		$ 170,540	$ 170,540	$ 747,096	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,145,586	$		$ 170,540	$ 170,540	$ 747,096	34

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

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 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	Boiler repair, pressure gauge, heat pump repair	2013	17,904		20	895	895	5,370	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 17,904	$		$ 895	$ 895	$ 5,370	34

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

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 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		$ 17,904	$		$ 895	$	$ 5,370	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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17									17
18									18
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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)		$ 17,904	$		$ 895	$	$ 5,370	34

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

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 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	29,049		35	830	830	1,660	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis	2016	180,355		20	9,018	9,018	18,036	9
10	Allocated from CF St. Louis	2017	4,186		20	209	209	209	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)		$ 213,590	$		$ 10,057	$ 10,057	$ 19,905	34

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

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 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		$ 213,590	$		$ 10,057	$ 10,057	$ 19,905	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 213,590	$		$ 10,057	$ 10,057	$ 19,905	34

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

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 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	$ 717,254	$ 690	$ 82,444	$ 81,754	10	$ 366,466	71
72	Current Year Purchases	5,315		481	481	10	481	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 722,568	$ 690	$ 82,925	$ 82,235		$ 366,947	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)	$ 6,552,923	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 690	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 253,464	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 252,774	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,114,043	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Legal Fees - 2012	$ 4,200	$	$	86
87	Legal Fees - 2012	5,036			87
88					88
89					89
90					90
91	TOTALS	$ 9,236	$	$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 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 Healthcare				78			5
6	Allocated from Progressive Healthcare				53			6
7	TOTAL				$ 131 **			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: $ 7,670 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	Toyota	$ 419	$ 2,514	17
18	Allocated from Legacy Healthcare			2,708	18
19	Allocated from Progressive Healthcare			1,055	19
20					20
21	TOTAL		$ 419	$ 6,277	21

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

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

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 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 NORTHBROOK # 0053918 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	$		$ 106,122	$		$ 106,122	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			50,668			50,668	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			156,854			156,854	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				80,222		80,222	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					27,720	107,215		134,935	13
14	TOTAL			$		$ 341,364	$ 187,437		$ 528,801	14

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

STATE OF ILLINOIS

Facility Name & ID Number GROVE OF NORTHBROOK **#** 0053918 **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	$ 509	$ 12,335	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,048,865	1,048,865	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	71,141	71,141	6
7	Other Prepaid Expenses	9,278	102,010	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	142,854	142,854	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,272,647	$ 1,377,205	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		667,000	13
14	Buildings, at Historical Cost		3,315,819	14
15	Leasehold Improvements, at Historical Cost	141,944	426,748	15
16	Equipment, at Historical Cost	127,645	1,473,266	16
17	Accumulated Depreciation (book methods)	(16,452)	(1,569,012)	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	589,824	1,760,438	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 842,961	$ 6,074,259	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,115,608	$ 7,451,464	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 407,633	$ 407,634	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	361,845	562,031	29
30	Accrued Salaries Payable	244,410	244,410	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,901	7,901	31
32	Accrued Real Estate Taxes(Sch.IX-B)		276,022	32
33	Accrued Interest Payable		42,202	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	210,922	210,922	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,232,711	$ 1,751,122	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,147,631	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	945,756	1,067,066	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 945,756	$ 9,214,697	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,178,467	$ 10,965,819	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (62,859)	$ (3,514,355)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,115,608	$ 7,451,464	48

***(See instructions.)**

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 **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**	$ (55,711)	1
2	Restatements (describe):		2
3	**Equity Adjustment**	(73,740)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (129,451)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	66,592	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)**	$ 66,592	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)**	$ (62,859)	24 *

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

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 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	$ 13,129,302	1
2	Discounts and Allowances for all Levels	(5,725,138)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,404,164	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,300,677	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,300,677	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	79,391	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,378	19
20	Radiology and X-Ray		20
21	Other Medical Services	3,429	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 91,198	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,742	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,742	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	7,222	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,222	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,811,003	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,178,974	31
32	Health Care	3,485,412	32
33	General Administration	1,475,443	33
	B. Capital Expense		
34	Ownership	1,294,374	34
	C. Ancillary Expense		
35	Special Cost Centers	968,578	35
36	Provider Participation Fee	341,630	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,744,411	40
41	**Income before Income Taxes (line 30 minus line 40)****	66,592	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 66,592	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,638,555	44
45	Private Pay - Net Inpatient Revenue	234,354	45
46	Medicare - Net Inpatient Revenue	411,114	46
47	Other-(specify) Insurance	120,141	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,404,164	49

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,984	2,248	$ 104,925	$ 46.67	1
2	Assistant Director of Nursing	2,016	2,080	87,687	42.16	2
3	Registered Nurses	29,670	31,955	1,072,540	33.56	3
4	Licensed Practical Nurses	16,522	17,701	519,150	29.33	4
5	CNAs & Orderlies	55,467	59,328	927,775	15.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,641	8,429	173,277	20.56	8
9	Activity Director	1,960	2,080	34,898	16.78	9
10	Activity Assistants	8,441	8,755	101,367	11.58	10
11	Social Service Workers	8,834	9,655	202,592	20.98	11
12	Dietician					12
13	Food Service Supervisor	2,056	2,189	83,661	38.22	13
14	Head Cook	7,789	8,223	151,215	18.39	14
15	Cook Helpers/Assistants	8,368	8,530	117,532	13.78	15
16	Dishwashers					16
17	Maintenance Workers	3,212	3,456	83,708	24.22	17
18	Housekeepers	7,757	8,673	120,352	13.88	18
19	Laundry	5,072	5,334	69,901	13.10	19
20	Administrator	1,840	2,390	136,137	56.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	864	864	24,215	28.03	23
24	Clerical	10,870	11,309	162,015	14.33	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	1,233	1,301	45,215	34.75	31
32	Other Health Care(specify)					32
33	Other(specify)	1,837	2,050	39,023	19.04	33
34	TOTAL (lines 1 - 33)	183,433	196,550	$ 4,257,185 *	$ 21.66	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	22,015	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	23,590	10-03	38
39	Pharmacist Consultant	Monthly	10,329	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	559	11-03	44
45	Social Service Consultant	160	9,765	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	160	$ 66,258		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	930	23,257	10-03	52
53	TOTAL (lines 50 - 52)	930	$ 23,257		53

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Chaim Dubovick	Administrator	0	$ 30,833
William Pfeiffer	Administrator	0	87,765
Scott Schayer	Administrator	0	17,539
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 136,137

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	$ 21,838
ProPay HR	Payroll Processing	20,798
Achieve Accreditation	Accreditation	6,237
Blue Orange Compliance	Compliance	1,105
IIT/Sourcetech	Data Processing	1,870
Lexisnexis Risk Solutions	Data Processing	41
McCabe Kirshner & Ballester	HC Insurance Solutions	732
MTS Consulting	Tax Consulting	2,160
Personnel Planners	Unemployment Consultant	630
Strauss' Data Consulting	Data Consulting	17
See Attached	Legal Fees	60,770
See Supplemental Schedule		3,839
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 120,038

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 66,501
Unemployment Compensation Insurance	70,467
FICA Taxes	318,773
Employee Health Insurance	126,896
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	18,686
401K Expense	9,641
Voluntary Benefit Contributions	11,703
Employee Physical Exams	10,624
Other Employee Benefits	9,759
TOTAL (agree to Schedule V, line 22, col.8)	$ 643,048

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	142
Health Care Worker Background Check	3,703
(Indicate # of checks performed 370)	
Patient Background Checks 381	3,819
Dues & Subscriptions	20,072
Licenses & Permits	9,417
Allocated from Legacy Healthcare	727
Allocated from Progressive Healthcare	153
See Supplemental Schedule	2
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 38,034

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,283
Allocated from Legacy Healthcare	961
Allocated from Progressive Healthcare	687
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,931

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GROVE OF NORTHBROOK # 0053918 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 $14,365**

(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. $ **26,138** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **341,630**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

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