		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: 0053835

Facility Name: GROVE OF SKOKIE

Address: 9000 Lavergne Avenue (Number) Skokie (City) 60077 (Zip Code)

County: Cook

Telephone Number: (847) 679-2322 **Fax #** (847) 679-9325

HFS ID Number:

Date of Initial License for Current Owners: 9/1/2008

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 SKOKIE # 0053835 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	98	Skilled (SNF)	98	35,770	1
2		Skilled Pediatric (SNF/PED)			2
3	51	Intermediate (ICF)	51	18,615	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	149	TOTALS	149	54,385	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	28,000	1,402	4,339	33,741	8
9	SNF/PED					9
10	ICF	15,592	587	464	16,643	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,592	1,989	4,803	50,384	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.64%

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 9/1/2008

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/1/2008 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 98 and days of care provided 4,339

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 SKOKIE # 0053835 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	428,959	31,662	11,887	472,508		472,508		472,508			1
2	Food Purchase		324,881		324,881		324,881	(67)	324,814			2
3	Housekeeping	169,248	43,730	208	213,186		213,186	198	213,384			3
4	Laundry	40,194	20,346		60,540		60,540	5	60,545			4
5	Heat and Other Utilities			106,352	106,352		106,352	(5,886)	100,466			5
6	Maintenance	111,125	16,554	141,336	269,015		269,015	52,968	321,983			6
7	Other (specify):*											7
8	TOTAL General Services	749,526	437,173	259,783	1,446,482		1,446,482	47,219	1,493,701			8
	B. Health Care and Programs											
9	Medical Director			56,504	56,504		56,504	608	57,112			9
10	Nursing and Medical Records	2,879,031	80,527	33,225	2,992,783		2,992,783	100,026	3,092,809			10
10a	Therapy	190,722			190,722		190,722		190,722			10a
11	Activities	182,979	8,319	288	191,586		191,586	4,620	196,206			11
12	Social Services	182,057		7,584	189,641		189,641	1,659	191,300			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							15,854	15,854			15
16	TOTAL Health Care and Programs	3,434,789	88,846	97,601	3,621,236		3,621,236	122,766	3,744,002			16
	C. General Administration											
17	Administrative	133,745			133,745		133,745	158,851	292,596			17
18	Directors Fees											18
19	Professional Services			116,737	116,737	(25,212)	91,525	(554,167)	(462,642)			19
20	Dues, Fees, Subscriptions & Promotions			50,128	50,128		50,128	(15,409)	34,719			20
21	Clerical & General Office Expenses	106,207	9,768	382,918	498,893		498,893	(99,985)	398,908			21
22	Employee Benefits & Payroll Taxes			681,410	681,410		681,410		681,410			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,423	1,423		1,423	1,832	3,255			24
25	Other Admin. Staff Transportation			235	235		235		235			25
26	Insurance-Prop.Liab.Malpractice			146,822	146,822		146,822	3,378	150,200			26
27	Other (specify):*							66,486	66,486			27
28	TOTAL General Administration	239,952	9,768	1,379,673	1,629,393	(25,212)	1,604,181	(439,013)	1,165,168			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,424,267	535,787	1,737,057	6,697,111	(25,212)	6,671,899	(269,028)	6,402,871			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 SKOKIE #0053835 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			27,943	27,943		27,943	115,566	143,509			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			28,985	28,985		28,985	765,851	794,836			32
33	Real Estate Taxes			474,996	474,996	25,212	500,208	4,277	504,485			33
34	Rent-Facility & Grounds			1,554,957	1,554,957		1,554,957	(1,554,811)	146			34
35	Rent-Equipment & Vehicles			7,005	7,005		7,005	1,376	8,381			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,093,886	2,093,886	25,212	2,119,098	(667,740)	1,451,358			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		234,004	769,310	1,003,314		1,003,314		1,003,314			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			366,438	366,438		366,438		366,438			42
43	Other (specify):*			550,263	550,263		550,263		550,263			43
44	**TOTAL Special Cost Centers**		234,004	1,686,011	1,920,015		1,920,015		1,920,015			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,424,267	769,791	5,516,954	10,711,012		10,711,012	(936,768)	9,774,244			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 SKOKIE # 0053835 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	(7,041)	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	114,799	30		9
10	Interest and Other Investment Income	(7,190)	32		10
11	Discounts, Allowances, Rebates & Refunds	(7,924)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(128)	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	(799)	21		18
19	Entertainment				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	(208,987)	21		24
25	Fund Raising, Advertising and Promotional	(9,997)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(13,904)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,056,687)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,197,858)		$	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)	261,090		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 261,090		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (936,768)		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 SKOKIE

ID# 0053835

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Pharmacy Discounts	$ (1,130)	10	1
2	Patient Personal Items	(730)	10	2
3	Sequestration	(47,104)	21	3
4	Misc. Income	(2,642)	21	4
5	PAC Dues	(6,392)	20	5
6	Non-Allowable Legal	(15,290)	19	6
7	Capitalized R&M	(5,365)	06	7
8	Additional R&M	12,551	06	8
9	Bank Charges	(14,138)	21	9
10	Bldg Co - Tax Extension Fee	(3,900)	21	10
11	Bldg Co - Title Fees	(2,118)	21	11
12	Bldg Co - Accounting	(2,993)	19	12
13	Bldg Co - Loan Fees	(45,980)	19	13
14	Bldg Co - Property Management Fees	(368,362)	17	14
15	Non-Allowable Expense	(550,263)	19	15
16	Non-Allowable Auto Rental	(2,830)	35	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,056,687)		49

GROVE OF SKOKIE

ID# 0053835

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 SKOKIE # 0053835 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	(128)		44	17								(67)	2
3	Housekeeping			198									198	3
4	Laundry			5									5	4
5	Heat and Other Utilities	(7,041)				1,155							(5,886)	5
6	Maintenance	7,186		2,674	41,648	1,460							52,968	6
7	Other (specify):*													7
8	TOTAL General Services	17		2,921	41,665	2,615							47,219	8
	B. Health Care and Programs													
9	Medical Director			608									608	9
10	Nursing and Medical Records	(1,860)		38	102,016		(167)						100,026	10
10a	Therapy													10a
11	Activities			4,602	18								4,620	11
12	Social Services			73	1,586								1,659	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				15,854								15,854	15
16	TOTAL Health Care and Programs	(1,860)		5,320	119,473		(167)						122,766	16
	C. General Administration													
17	Administrative	(368,362)	368,362	20,920	137,932								158,851	17
18	Directors Fees													18
19	Professional Services	(614,526)	48,973	14,213	348	290			(3,464)				(554,167)	19
20	Fees, Subscriptions & Promotions	(16,389)		808	170	2							(15,409)	20
21	Clerical & General Office Expenses	(301,516)	6,018	165,966	29,546	1							(99,985)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,068	764								1,832	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			896	2,183	299							3,378	26
27	Other (specify):*			34,055	32,431								66,486	27
28	TOTAL General Administration	(1,300,793)	423,353	237,926	203,374	593			(3,464)				(439,013)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,302,637)	423,353	246,167	364,512	3,208	(167)		(3,464)				(269,028)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GROVE OF SKOKIE # 0053835 **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	114,799			767								115,566	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(7,190)	767,806	17		5,218							765,851	32
33	Real Estate Taxes					4,277							4,277	33
34	Rent-Facility & Grounds		(1,554,957)	41,412	59	(41,325)							(1,554,811)	34
35	Rent-Equipment & Vehicles	(2,830)		3,032	1,174								1,376	35
36	Other (specify):*													36
37	TOTAL Ownership	104,779	(787,151)	44,461	2,000	(31,830)							(667,740)	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):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,197,858)	(363,798)	290,629	366,512	(28,622)	(167)		(3,464)				(936,768)	45

Facility Name & ID Number GROVE OF SKOKIE # 0053835 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 [X] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,554,957	Grove HC Properties	100.00%	$	$ (1,554,957)	1
2	V	32	Interest	13	Grove HC Properties	100.00%		(13)	2
3	V	21	Tax Extension Fee		Grove HC Properties	100.00%	3,900	3,900	3
4	V	21	Title Fees		Grove HC Properties	100.00%	2,118	2,118	4
5	V	19	Professional Fees - Accounting		Grove HC Properties	100.00%	2,993	2,993	5
6	V	19	Professional Fees - Loan		Grove HC Properties	100.00%	45,980	45,980	6
7	V	17	Property Management Fees		Grove HC Properties	100.00%	368,362	368,362	7
8	V	32	Interest Expense - Mortgage A		Grove HC Properties	100.00%	767,819	767,819	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,554,970			$ 1,191,172	$ * (363,798)	14

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

Facility Name & ID Number GROVE OF SKOKIE # 0053835 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%	$ 44	$ 44	15
16	V	3	HOUSEKEEPING SUPPLIES		Legacy Healthcare Financial Services	100.00%	198	198	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%	11	11	18
19	V	6	GROUNDS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	2,663	2,663	19
20	V	9	MEDICAL DIRECTOR CONSULTANT		Legacy Healthcare Financial Services	100.00%	608	608	20
21	V	10	MEDICAL SUPPLIES		Legacy Healthcare Financial Services	100.00%	38	38	21
22	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services	100.00%	4,602	4,602	22
23	V	12	SOCIAL SERVICE CONSULTANT		Legacy Healthcare Financial Services	100.00%	73	73	23
24	V	17	ADMINISTRATIVE SALARY		Legacy Healthcare Financial Services	100.00%	20,920	20,920	24
25	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	14,213	14,213	25
26	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	808	808	26
27	V	21	CLERICAL & GENERAL WAGES		Legacy Healthcare Financial Services	100.00%	161,503	161,503	27
28	V	21	CLERICAL & GENERAL OTHER COSTS		Legacy Healthcare Financial Services	100.00%	4,463	4,463	28
29	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	1,068	1,068	29
30	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	896	896	30
31	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	34,055	34,055	31
32	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	17	17	32
33	V	34	RENT		Legacy Healthcare Financial Services	100.00%	41,325	41,325	33
34	V	34	STORAGE		Legacy Healthcare Financial Services	100.00%	86	86	34
35	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services	100.00%	21	21	35
36	V	35	AUTO RENTAL		Legacy Healthcare Financial Services	100.00%	3,011	3,011	36
37	V								37
38	V								38
39	Total			$			$ 290,629	$ * 290,629	39

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

Facility Name & ID Number GROVE OF SKOKIE # 0053835 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%	$ 17	$ 17	15
16	V	6	MAINTENANCE SALARY		Progressive Healthcare Consulting	100.00%	41,524	41,524	16
17	V	6	BUILDING MAINTENANCE AND R&M		Progressive Healthcare Consulting	100.00%	124	124	17
18	V	10	NURSING SALARIES		Progressive Healthcare Consulting	100.00%	102,016	102,016	18
19	V	11	ACTIVITIES PROGRAM		Progressive Healthcare Consulting	100.00%	18	18	19
20	V	12	CLERGY CONSULTANT		Progressive Healthcare Consulting	100.00%	1,583	1,583	20
21	V	12	SOCIAL SERVICE		Progressive Healthcare Consulting	100.00%	4	4	21
22	V	15	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	15,854	15,854	22
23	V	17	ADMIN SALARY- NON OWNER		Progressive Healthcare Consulting	100.00%	137,932	137,932	23
24	V	19	PROFESSIONAL FEES		Progressive Healthcare Consulting	100.00%	348	348	24
25	V	20	DUES, SUBSCRIPTIONS, LICENSES		Progressive Healthcare Consulting	100.00%	170	170	25
26	V	21	CLERICAL WAGES		Progressive Healthcare Consulting	100.00%	29,234	29,234	26
27	V	21	CLERICAL & GENERAL - OTHER		Progressive Healthcare Consulting	100.00%	312	312	27
28	V	24	SEMINARS		Progressive Healthcare Consulting	100.00%	764	764	28
29	V	27	EMP. BEN.-NON-NURSING		Progressive Healthcare Consulting	100.00%	32,431	32,431	29
30	V	26	INSURANCE		Progressive Healthcare Consulting	100.00%	2,183	2,183	30
31	V	30	DEPRECIATION		Progressive Healthcare Consulting	100.00%	767	767	31
32	V	34	STORAGE RENTAL		Progressive Healthcare Consulting	100.00%	59	59	32
33	V	35	AUTO RENTAL		Progressive Healthcare Consulting	100.00%	1,174	1,174	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 366,512	$ * 366,512	39

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

Facility Name & ID Number GROVE OF SKOKIE # 0053835 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%	$ 1,155	$ 1,155	15
16	V	6	REPAIRS & MAINTENANCE		CF ST. LOUIS, LLC	100.00%	1,460	1,460	16
17	V	19	PROFESSIONAL FEES		CF ST. LOUIS, LLC	100.00%	290	290	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%	299	299	20
21	V	32	INTEREST EXPENSE		CF ST. LOUIS, LLC	100.00%	5,218	5,218	21
22	V	33	REAL ESTATE TAXES		CF ST. LOUIS, LLC	100.00%	4,277	4,277	22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	41,325	CF ST. LOUIS, LLC	100.00%		(41,325)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 41,325			$ 12,703	$ * (28,622)	39

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

Facility Name & ID Number GROVE OF SKOKIE # 0053835 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	$ 4,097	ReMed Services		$ 3,930	$ (167)	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			$ 4,097			$ 3,930	$ * (167)	39

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

Facility Name & ID Number GROVE OF SKOKIE # 0053835 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance	$ 17,100	ML Group Design and Development		$ 17,100	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 17,100			$ 17,100	$ *	39

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

Facility Name & ID Number GROVE OF SKOKIE # 0053835 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	$ 14,434	ProPay	24.00%	$ 10,970	$ (3,464)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 14,434			$ 10,970	$ * (3,464)	39

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

Facility Name & ID Number GROVE OF SKOKIE # 0053835 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 SKOKIE # 0053835 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 SKOKIE # 0053835 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 SKOKIE # 0053835 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	GPN Family Trust	50.00%	ASTORIA PLACE SKILLED NURSING FACILITY LLC	CHICAGO	GROVE HC PROPERTIES	SKOKIE	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	PROPAY HR LLC	EVANSTON	PAYROLL PROCESSING	9
10			CHALET SKILLED NURSING FACILITY LLC	CHICAGO	CF ST. LOUIS LLC	SKOKIE	BUILDING CO	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			NORTHBROOK SKILLED NURSING FACILITY LLC	NORTHBROOK				20
21			PARKER SKILLED NURSING FACILITY LLC	PARKER, CO				21
22			PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO				22
23			ST. GEORGE SKILLED NURSING FACILITY	ST. GEORGE, UT				23
24			WARREN BARR NORTH SHORE	HIGHLAND PARK				24
25			WARREN BARR SOUTH LOOP	CHICAGO				25
26			WARREN BARR LIVING AND REHAB	CHICAGO				26
27								27
28								28
29								29
30								30

Facility Name & ID Number GROVE OF SKOKIE # 0053835 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 SKOKIE # 0053835 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 SKOKIE # 0053835 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 SKOKIE # 0053835 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	$	54,385	$ 44	1
2	3	HOUSEKEEPING SUPPLIES	AVAIL. BED DAYS	1,789,215	30	6,519		54,385	198	2
3	4	LINEN REPLACEMENT	AVAIL. BED DAYS	1,789,215	30	171		54,385	5	3
4	6	UTILITIES	AVAIL. BED DAYS	1,789,215	30	372		54,385	11	4
5	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	1,789,215	30	87,596		54,385	2,663	5
6	9	MEDICAL DIRECTOR CONSU	AVAIL. BED DAYS	1,789,215	30	20,000		54,385	608	6
7	10	MEDICAL SUPPLIES	AVAIL. BED DAYS	1,789,215	30	1,237		54,385	38	7
8	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,789,215	30	151,405		54,385	4,602	8
9	12	SOCIAL SERVICE CONSULTA	AVAIL. BED DAYS	1,789,215	30	2,392		54,385	73	9
10	17	ADMINISTRATIVE SALARY	AVAIL. BED DAYS	1,789,215	30	688,242	688,242	54,385	20,920	10
11	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,789,215	30	467,580		54,385	14,213	11
12	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,789,215	30	26,590		54,385	808	12
13	21	CLERICAL & GENERAL WAG	AVAIL. BED DAYS	1,789,215	30	5,313,296	5,313,296	54,385	161,503	13
14	21	CLERICAL & GENERAL OTH	AVAIL. BED DAYS	1,789,215	30	146,833		54,385	4,463	14
15	24	SEMINARS	AVAIL. BED DAYS	1,789,215	30	35,138		54,385	1,068	15
16	26	INSURANCE	AVAIL. BED DAYS	1,789,215	30	29,475		54,385	896	16
17	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	1,789,215	30	1,120,380		54,385	34,055	17
18	32	INTEREST	AVAIL. BED DAYS	1,789,215	30	561		54,385	17	18
19	34	RENT	AVAIL. BED DAYS	1,789,215	30	1,359,562		54,385	41,325	19
20	34	STORAGE	AVAIL. BED DAYS	1,789,215	30	2,842		54,385	86	20
21	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,789,215	30	694		54,385	21	21
22	35	AUTO RENTAL	AVAIL. BED DAYS	1,789,215	30	99,069		54,385	3,011	22
23										23
24										24
25	TOTALS					$ 9,561,416	$ 6,001,539		$ 290,629	25

Facility Name & ID Number GROVE OF SKOKIE # 0053835 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	$	54,385	$ 17	1
2	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,374,590	21	1,049,531	1,049,531	54,385	41,524	2
3	6	BUILDING MAINTENANCE AI	AVAIL. BED DAYS	1,374,590	21	3,133		54,385	124	3
4	10	NURSING SALARIES	AVAIL. BED DAYS	1,374,590	21	2,578,462	2,578,462	54,385	102,016	4
5	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,374,590	21	443		54,385	18	5
6	12	CLERGY CONSULTANT	AVAIL. BED DAYS	1,374,590	21	39,998		54,385	1,583	6
7	12	SOCIAL SERVICE	AVAIL. BED DAYS	1,374,590	21	95		54,385	4	7
8	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,374,590	21	400,703		54,385	15,854	8
9	17	ADMIN SALARY- NON OWNE	AVAIL. BED DAYS	1,374,590	21	3,486,246	3,486,246	54,385	137,932	9
10	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,374,590	21	8,800		54,385	348	10
11	20	DUES, SUBSCRIPTIONS, LICE	AVAIL. BED DAYS	1,374,590	21	4,293		54,385	170	11
12	21	CLERICAL WAGES	AVAIL. BED DAYS	1,374,590	21	738,904	738,904	54,385	29,234	12
13	21	CLERICAL & GENERAL - OTI	AVAIL. BED DAYS	1,374,590	21	7,880		54,385	312	13
14	24	SEMINARS	AVAIL. BED DAYS	1,374,590	21	19,314		54,385	764	14
15	27	EMP. BEN.-NON-NURSING	AVAIL. BED DAYS	1,374,590	21	819,705		54,385	32,431	15
16	26	INSURANCE	AVAIL. BED DAYS	1,374,590	21	55,168		54,385	2,183	16
17	30	DEPRECIATION	AVAIL. BED DAYS	1,374,590	21	19,384		54,385	767	17
18	34	STORAGE RENTAL	AVAIL. BED DAYS	1,374,590	21	1,500		54,385	59	18
19	35	AUTO RENTAL	AVAIL. BED DAYS	1,374,590	21	29,674		54,385	1,174	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 9,263,664	$ 7,853,142		$ 366,512	25

Facility Name & ID Number GROVE OF SKOKIE # 0053835 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	$	54,385	$ 1,155	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,789,215	30	48,042		54,385	1,460	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,789,215	30	9,551		54,385	290	3
4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,789,215	30	76		54,385	2	4
5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,789,215	30	32		54,385	1	5
6	26	INSURANCE	AVAIL. BED DAYS	1,789,215	30	9,839		54,385	299	6
7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,789,215	30	171,679		54,385	5,218	7
8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,789,215	30	140,710		54,385	4,277	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	$		$ 12,703	25

Facility Name & ID Number GROVE OF SKOKIE # 0053835 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			$	$		$ 3,930	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					$	$		$ 3,930	25

Facility Name & ID Number GROVE OF SKOKIE # 0053835 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 Desing 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			$	$		$ 17,100	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 17,100	25

Facility Name & ID Number GROVE OF SKOKIE # 0053835 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: ProPay HR LLC
Street Address: 2201 W. Main St
City / State / Zip Code: Evanston, IL 60202
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Payroll Services				$	$		$ 10,970	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					$	$		$ 10,970	25

Facility Name & ID Number GROVE OF SKOKIE # 0053835 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 SKOKIE # 0053835 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 SKOKIE # 0053835 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 SKOKIE # 0053835 Report Period Beginning: 01/01/17 Ending: 12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	The Private Bank		X	Mortgage			$	$ 13,713,871			$ 767,819	1
2	The Private Bank		X	Note Payable							28,985	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 13,713,871			$ 796,804	9
	B. Non-Facility Related*											
10	Interest Income		X								(7,189)	10
11	Allocated from Legacy HC Financial		X								17	11
12	Allocated from CF St. Louis, LLC		X								5,218	12
13	See Supplemental Schedule										(13)	13
14	TOTAL Non-Facility Related						$	$			$ (1,967)	14
15	TOTALS (line 9+line14)						$	$ 13,713,871			$ 794,837	15

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

*** 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 SKOKIE # 0053835 **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.**	$ 426,075	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.)		$ 456,390	2
3. Under or (over) accrual (line 2 minus line 1).		$ 30,315	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 448,958	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.)		$ 25,212	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.		$ 504,485	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2012		8
2013		9
2014	396,320	10
2015	405,789	11
2016	452,113	12

2017 Accruals = $452,113 x 0.99 = $448,958

Allocated from CF. St. Louis, LLC $4,277

Beginning accrual adjusted

	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 SKOKIE COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053835

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.	10-16-411-017-0000	Long Term Care Property	$ 360,623.76	$ 360,623.76
2.	10-16-411-018-0000	Long Term Care Property	$ 91,489.10	$ 91,489.10
3.	Allocated from CF St. Louis, LLC	Home Office	$ 463,439.48	$ 4,277.02
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 915,552.34	$ 456,389.88

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2016 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2016 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2016.

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

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GROVE OF SKOKIE COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053835

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 SKOKIE # 0053835 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,350 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2

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	Allocated from CF St. Louis			$ 19,757	1
2					2
3	TOTALS			$ 19,757	3

Facility Name & ID Number GROVE OF SKOKIE # 0053835 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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2009	826,392		20	41,320	41,320	371,876	9
10	Various			2010	18,355		20	918	918	7,342	10
11	Various			2011	38,602		20	1,930	1,930	13,511	11
12	Various			2012	24,021		20	1,201	1,201	7,206	12
13	Various			2013	504,886		20	25,244	25,244	126,222	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 SKOKIE # 0053835 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)		76,478			3,824	3,824	41,419	67
68	Related Party Allocations (Pages 12H & 12I)		237,500			11,183	11,183	22,133	68
69	Financial Statement Depreciation			27,943			(27,943)		69
70	TOTAL (lines 4 thru 69)		$ 1,726,234	$ 27,943		$ 85,620	$ 57,677	$ 589,709	70

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

Facility Name & ID Number GROVE OF SKOKIE # 0053835 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		$ 1,726,234	$ 27,943		$ 85,620	$ 57,677	$ 589,709	1
2	Air Sealing & Insultation - Roof/Attic	2014	24,521		20	1,226	1,226	4,904	2
3	Electrical Work Resident Rooms 2Nd Floor	2014	13,850		20	693	693	2,770	3
4	Soffits And Drywall Installation Throughout The Building	2014	28,850		20	1,443	1,443	5,770	4
5	Replacing Fire Alarm System Throughout The Facility	2014	13,582		20	679	679	2,716	5
6	Replace 2 Boilers- Mechanical Room	2014	23,889		20	1,194	1,194	4,778	6
7	Replace Locks For Exit Doors	2014	4,429		20	221	221	886	7
8	Cermaic Tile Instllation For Hallway, Kitchen And Storage	2014	11,750		20	588	588	2,350	8
9	Plumbing In Kitchen & Laundry Room	2014	22,850		20	1,143	1,143	4,570	9
10	Replace Doors In Laundry Room	2014	2,975		20	149	149	595	10
11	Replace 5 Fire Rated Door	2014	6,750		20	338	338	1,350	11
12	Plumbing In Resident Rooms #204 And #206	2014	6,950		20	348	348	1,390	12
13	Plumbing: Replace Valves In 2Nd Floor Bathrooms	2014	8,475		20	424	424	1,695	13
14	Power Receptacles Throughout The Facility	2015	4,846		20	242	242	727	14
15	110 Lighting Units Throughout The Facility	2015	5,228		20	261	261	784	15
16	Concrete Work Outside Patio	2015	2,675		20	134	134	401	16
17	Replace Kitchen Exhaust Fan Motor, Capacitor, Belt,	2015	2,690		20	135	135	404	17
18	Replace 2 Water Meters In Boiler Room	2015			20				18
19	Install Autolock On Dining Room Door, Replace Fire Door In	2015	3,575		20	179	179	536	19
20	Kitch, And Seal Fireplace Gas Pipe	2015			20				20
21	Architecture Fees	2015	18,048		20	902	902	2,707	21
22	Repair Heating Pipe Leak In Kitchen, Service Boiler	2015	2,789		20	139	139	418	22
23	Carpet Installation In Office	2017	5,115		20	256	256	256	23
24	Install New Piping For Commercial Boiler	2017	15,964		20	333	333	333	24
25	Walk-In Cooler (Kitchen) Repair	2017	2,750		20	46	46	46	25
26	Elevator Repair	2017	3,794		20	95	95	95	26
27	Repair Leaking Heating Line In Mechanical Room	2017	7,846		20	262	262	262	27
28	Air Handler Repairs	2017	3,018		20	503	503	503	28
29	Replacement Of Both Bearings On Air Handler Unit	2017	4,347		20	725	725	725	29
30	Replaced Condensing Unit For Walk In Freezer, Rewire Controls	2017	4,050		20	540	540	540	30
31	Repaired 2Nd Floor Nursing Station	2017	2,500		20	125	125	125	31
32	Installed New Exhaust Fan	2017	3,500		20	175	175	175	32
33	Repaired Storage Tank And Circulation Pump	2017	8,145		20	407	407	407	33
34	TOTAL (lines 1 thru 33)		$ 1,995,985	$ 27,943		$ 99,521	$ 71,578	$ 632,926	34

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

Facility Name & ID Number GROVE OF SKOKIE # 0053835 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		$ 1,995,985	$ 27,943		$ 99,521	$ 71,578	$ 632,926	1
2	Installed Mount Speaker And Amps	2017	4,376		20	219	219	219	2
3	Repair Leak On Chiller Pipe	2017	5,365		20	268	268	268	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)		$ 2,005,726	$ 27,943		$ 100,008	$ 72,065	$ 633,413	34

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

Facility Name & ID Number GROVE OF SKOKIE # 0053835 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		$ 2,005,726	$ 27,943		$ 100,008	$ 72,065	$ 633,413	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)		$ 2,005,726	$ 27,943		$ 100,008	$ 72,065	$ 633,413	34

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

Facility Name & ID Number GROVE OF SKOKIE # 0053835 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		$ 2,005,726	$ 27,943		$ 100,008	$ 72,065	$ 633,413	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)		$ 2,005,726	$ 27,943		$ 100,008	$ 72,065	$ 633,413	34

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

Facility Name & ID Number GROVE OF SKOKIE # 0053835 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	Allocated from Grove HC Properties	2008	60,573		20	3,029	3,029	32,079	9
10	Allocated from Grove HC Properties	2010	15,905		20	795	795	9,340	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)		$ 76,478	$		$ 3,824	$ 3,824	$ 41,419	34

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

Facility Name & ID Number GROVE OF SKOKIE # 0053835 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		$ 76,478	$		$ 3,824	$	$ 41,419	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)		$ 76,478	$		$ 3,824	$	$ 41,419	34

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

Facility Name & ID Number GROVE OF SKOKIE # 0053835 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, LLC	2016	32,301		35	923	923	1,846	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF. St Louis, LLC	2016	200,544		20	10,027	10,027	20,054	9
10	Allocated from CF. St Louis, LLC	2017	4,655		20	233	233	233	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)		$ 237,500	$		$ 11,183	$ 11,183	$ 22,133	34

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

Facility Name & ID Number GROVE OF SKOKIE # 0053835 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		$ 237,500	$		$ 11,183	$ 11,183	$ 22,133	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)		$ 237,500	$		$ 11,183	$ 11,183	$ 22,133	34

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

Facility Name & ID Number GROVE OF SKOKIE # 0053835 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	$ 428,749	$ 767	$ 42,875	$ 42,108	10	$ 207,175	71
72	Current Year Purchases	7,180		626	626	10	626	72
73	Fully Depreciated Assets	52,301				10	52,301	73
74								74
75	TOTALS	$ 488,230	$ 767	$ 43,501	$ 42,734		$ 260,102	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)	$ 2,513,713	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 28,710	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 143,509	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 114,799	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 893,515	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number GROVE OF SKOKIE # 0053835 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:

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. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Legacy HC Financial				86			5
6	Allocated from Progressive HC Consulting				59			6
7	TOTAL				$ 145 **			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: $ 3,459 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	$ 249	$ 737	17
18	Allocated from Legacy HC Financial			3,011	18
19	Allocated from Progressive HC Consulting			1,174	19
20					20
21	TOTAL		$ 249	$ 4,922	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 SKOKIE # 0053835 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 SKOKIE # 0053835 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 Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 293,078	$		$ 293,078	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			119,480			119,480	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			332,427			332,427	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				133,106		133,106	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					24,325	100,898		125,223	13
14	TOTAL			$		$ 769,310	$ 234,004		$ 1,003,314	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 SKOKIE **#** 0053835 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,100	$ 4,966	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,734,410	2,241,542	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,293	31,293	6
7	Other Prepaid Expenses	9,356	170,028	7
8	Accounts Receivable (owners or related parties)		123,500	8
9	Other(specify): See Attached Schedule	72,244	72,244	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,848,403	$ 2,643,573	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		938,650	13
14	Buildings, at Historical Cost	2,138	8,301,875	14
15	Leasehold Improvements, at Historical Cost	117,063	1,580,366	15
16	Equipment, at Historical Cost	103,980	1,508,438	16
17	Accumulated Depreciation (book methods)	(42,795)	(725,646)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	1,403,340	1,424,642	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,583,726	$ 13,028,325	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,432,129	$ 15,671,898	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 547,569	$ 547,571	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	245,101	245,101	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,957	7,957	31
32	Accrued Real Estate Taxes(Sch.IX-B)		448,958	32
33	Accrued Interest Payable		70,236	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	67,659	404,607	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 868,286	$ 1,724,430	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,713,871	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	1,783,872	347,030	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,783,872	$ 14,060,901	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,652,158	$ 15,785,331	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 779,971	$ (113,433)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,432,129	$ 15,671,898	48

***(See instructions.)**

Facility Name & ID Number GROVE OF SKOKIE # 0053835 **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**	$ 460,363	1
2	Restatements (describe):		2
3	Rounding	4	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 460,367	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	319,604	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)**	$ 319,604	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)**	$ 779,971	24 *

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

Facility Name & ID Number GROVE OF SKOKIE # 0053835 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	$ 15,633,127	1
2	Discounts and Allowances for all Levels	(7,840,925)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,792,202	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,060,895	6
7	Oxygen	4,490	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,065,385	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	131,449	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,981	19
20	Radiology and X-Ray		20
21	Other Medical Services	10,695	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 154,125	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,189	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,189	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	11,715	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,715	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,030,616	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,446,482	31
32	Health Care	3,621,236	32
33	General Administration	1,629,393	33
	B. Capital Expense		
34	Ownership	2,093,886	34
	C. Ancillary Expense		
35	Special Cost Centers	1,553,577	35
36	Provider Participation Fee	366,438	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,711,012	40
41	**Income before Income Taxes (line 30 minus line 40)****	319,604	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 319,604	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,556,552	44
45	Private Pay - Net Inpatient Revenue	161,695	45
46	Medicare - Net Inpatient Revenue	962,690	46
47	Other-(specify) Insurance	111,265	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,792,202	49

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

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

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

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

Facility Name & ID Number GROVE OF SKOKIE # 0053835 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,088	2,215	$ 145,641	$ 65.75	1
2	Assistant Director of Nursing	1,880	2,040	82,983	40.68	2
3	Registered Nurses	28,706	30,803	1,032,059	33.51	3
4	Licensed Practical Nurses	15,380	16,290	429,316	26.35	4
5	CNAs & Orderlies	81,870	87,282	1,142,094	13.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,073	9,102	190,722	20.95	8
9	Activity Director	1,896	2,080	57,208	27.50	9
10	Activity Assistants	8,890	9,946	125,771	12.65	10
11	Social Service Workers	7,330	8,073	182,057	22.55	11
12	Dietician	280	296	5,145	17.38	12
13	Food Service Supervisor	1,904	2,023	56,291	27.83	13
14	Head Cook	8,677	9,730	150,568	15.47	14
15	Cook Helpers/Assistants	17,566	18,333	216,955	11.83	15
16	Dishwashers					16
17	Maintenance Workers	5,871	6,396	111,125	17.37	17
18	Housekeepers	14,214	14,910	169,248	11.35	18
19	Laundry	3,444	3,664	40,194	10.97	19
20	Administrator	1,880	1,952	113,171	57.98	20
21	Assistant Administrator	1,128	1,240	20,574	16.59	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,690	8,181	106,207	12.98	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	1,741	1,893	46,938	24.80	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	220,508	236,449	$ 4,424,267 *	$ 18.71	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	252	$ 11,887	01-03	35
36	Medical Director	Monthly	56,504	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	22,149	10-03	38
39	Pharmacist Consultant	Monthly	11,076	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	288	11-03	44
45	Social Service Consultant	125	7,584	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	377	$ 109,488		49

C. CONTRACT NURSES

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

Facility Name & ID Number GROVE OF SKOKIE # 0053835 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Davis, Patricia D.	Administrator	0	$ 55,543
Recinto, Edson	Assistant Administrator	0	20,574
Simpson, Katherine	Administrator	0	57,628
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 133,745

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
RSM US LLP	Accounting	$ 9,922
Marcum LLP	Accounting	23,325
See Attached	Legal	26,900
Documentation Solution	Compliance Audit	2,059
Compliance Resources	Compliance Audit	3,139
PRoPay HR	Payroll Processing	14,434
McCabe Kirshner & Ballester PC	Insurance Consultant	814
Achieve Accreditation LLC	Joint Commission Consult	5,114
MTS Consulting	Tax Consulting	817
BlueOrange Compliance	Compliance	1,227
IIT/Sourcetech	Data Processing	1,790
See Supplemental Schedule		27,196
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 116,738

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 88,436
Unemployment Compensation Insurance	39,179
FICA Taxes	333,668
Employee Health Insurance	140,173
Employee Meals	112
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	30,951
401K Expense	11,625
Voluntary Benefeit Contributions	9,473
Employee Physical Exams	9,655
Other Employee Benefits	18,138
TOTAL (agree to Schedule V, line 22, col.8)	$ 681,410

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	5,319
(Indicate # of checks performed 531)	
Patient Background Checks 87	871
Dues and Subscriptions	13,980
License and Permits	13,427
Allocated from Legacy HC Financial	808
Allocated from Progressive HC Consult	170
See Supplemental Schedule	2
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 34,718

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,423
Allocated from Legacy HC Financial	1,068
Allocated from Progressive HC Consult	764
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,255

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GROVE OF SKOKIE # 0053835 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 $12,784**

(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. $ **36,327** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **366,438**
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. $ **112** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

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