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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0053850

Facility Name: Grove Of Elmhurst

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

County: Dupage

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/18 to 12/31/18 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	176	Skilled (SNF)	176	64,240	1
2		Skilled Pediatric (SNF/PED)			2
3	4	Intermediate (ICF)	4	1,460	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	180	TOTALS	180	65,700	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,629	2,851	5,651	22,131	8
9	SNF/PED					9
10	ICF	29,229	2,250	1,835	33,314	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,858	5,101	7,486	55,445	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.39%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/1/2010

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 176 and days of care provided 3,839

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: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	428,394	29,234	36,743	494,371		494,371	1,209	495,580			1
2	Food Purchase		391,227		391,227		391,227	(22,831)	368,396			2
3	Housekeeping	225,033	40,350	356	265,739		265,739	1,901	267,640			3
4	Laundry	58,950	32,966	163,629	255,545		255,545	(4,376)	251,169			4
5	Heat and Other Utilities			342,889	342,889		342,889	(6,639)	336,250			5
6	Maintenance	131,829	19,453	113,286	264,568		264,568	19,067	283,635			6
7	Other (specify):*											7
8	**TOTAL General Services**	844,206	513,230	656,903	2,014,339		2,014,339	(11,669)	2,002,670			8
	B. Health Care and Programs											
9	Medical Director			48,000	48,000		48,000		48,000			9
10	Nursing and Medical Records	3,877,866	160,544	27,958	4,066,368		4,066,368	70,738	4,137,106			10
10a	Therapy	245,658			245,658		245,658		245,658			10a
11	Activities	248,204	9,447	3,984	261,635		261,635	75	261,710			11
12	Social Services	153,885		2,752	156,637		156,637	4,705	161,342			12
13	CNA Training											13
14	Program Transportation			22,013	22,013		22,013		22,013			14
15	Other (specify):*							8,665	8,665			15
16	**TOTAL Health Care and Programs**	4,525,613	169,991	104,707	4,800,311		4,800,311	84,183	4,884,494			16
	C. General Administration											
17	Administrative	193,010			193,010		193,010	100,062	293,072			17
18	Directors Fees											18
19	Professional Services			67,484	67,484		67,484	4,219	71,703			19
20	Dues, Fees, Subscriptions & Promotions			94,960	94,960		94,960	(47,395)	47,565			20
21	Clerical & General Office Expenses	122,634	4,595	326,169	453,398		453,398	171,885	625,283			21
22	Employee Benefits & Payroll Taxes			910,264	910,264		910,264		910,264			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,721	3,721		3,721	3,155	6,876			24
25	Other Admin. Staff Transportation			633	633		633		633			25
26	Insurance-Prop.Liab.Malpractice			208,589	208,589		208,589	6,068	214,657			26
27	Other (specify):*							63,409	63,409			27
28	**TOTAL General Administration**	315,644	4,595	1,611,820	1,932,059		1,932,059	301,404	2,233,463			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,685,463	687,816	2,373,430	8,746,709		8,746,709	373,917	9,120,626			29

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

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

Facility Name & ID Number Grove Of Elmhurst #0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							852,165	852,165			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			208,593	208,593		208,593	1,163,280	1,371,873			32
33	Real Estate Taxes			66,210	66,210		66,210	5,125	71,335			33
34	Rent-Facility & Grounds			1,839,997	1,839,997		1,839,997	(1,839,823)	174			34
35	Rent-Equipment & Vehicles			7,466	7,466		7,466	4,523	11,989			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,122,266	2,122,266		2,122,266	185,270	2,307,536			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	374,245	618,661	781,762	1,774,668		1,774,668		1,774,668			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			417,771	417,771		417,771		417,771			42
43	Other (specify):*			658,507	658,507		658,507	(658,507)				43
44	**TOTAL Special Cost Centers**	374,245	618,661	1,858,040	2,850,946		2,850,946	(658,507)	2,192,439			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,059,708	1,306,477	6,353,736	13,719,921		13,719,921	(99,320)	13,620,601			45

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	(7,769)	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	852,165	30		9
10	Interest and Other Investment Income	(22,760)	32		10
11	Discounts, Allowances, Rebates & Refunds	(22,491)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(360)	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	(534)	21		18
19	Entertainment				19
20	Contributions	(10,000)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(194,603)	21		24
25	Fund Raising, Advertising and Promotional	(20,500)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(985)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,021,282)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (449,119)		$	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)	349,799		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 349,799		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (99,320)		37

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

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

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

Grove Of Elmhurst

ID# 0053850

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Personal Items	$ (2,356)	10	1
2	Meals & Entertainment	(914)	21	2
3	Sequestration Expense	(50,082)	21	3
4	Bldg Co - Filing Fees	(75)	20	4
5	Bldg Co - Title Fees	(4,335)	20	5
6	Bldg Co - Accounting Fees	(2,751)	19	6
7	Bldg Co - Legal Fees	(11,601)	19	7
8	Bldg Co - Loan Fees	(61,955)	19	8
9	Bldg Co - Tax Extension Fee	(2,500)	20	9
10	Bldg Co - Property Management Fee	(206,962)	21	10
11	PAC Dues	(17,588)	20	11
12	Non-allowable Legal	(5,611)	19	12
13	Non-allowable Management Fees	(658,507)	43	13
14	Additional R&M	8,692	06	14
15	Non-allowable Seminar	(160)	24	15
16	Pharmacy Discounts	(4,578)	10	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**	(1,021,282)		49

Grove Of Elmhurst

ID# 0053850

Report Period Beginning: 01/01/18

Ending: 12/31/18

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			1,209									1,209	1
2	Food Purchase	(22,851)		20									(22,831)	2
3	Housekeeping			1,901									1,901	3
4	Laundry			12						(4,388)			(4,376)	4
5	Heat and Other Utilities	(7,769)				1,130							(6,639)	5
6	Maintenance	8,692		9,489		1,522	(636)						19,067	6
7	Other (specify):*													7
8	**TOTAL General Services**	(21,928)		12,631		2,652	(636)			(4,388)			(11,669)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(6,934)		77,865					(194)				70,738	10
10a	Therapy													10a
11	Activities			75									75	11
12	Social Services			4,705									4,705	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				8,665								8,665	15
16	**TOTAL Health Care and Programs**	(6,934)		82,645	8,665				(194)				84,183	16
	C. General Administration													
17	Administrative			100,062									100,062	17
18	Directors Fees													18
19	Professional Services	(81,918)	76,307	12,165		47		(2,382)					4,219	19
20	Fees, Subscriptions & Promotions	(54,998)	6,910	692		1							(47,395)	20
21	Clerical & General Office Expenses	(454,080)	206,962	418,631		372							171,885	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(160)		3,315									3,155	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			5,632		436							6,068	26
27	Other (specify):*			63,409									63,409	27
28	**TOTAL General Administration**	(591,156)	290,179	603,906		856		(2,382)					301,404	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(620,017)	290,179	699,182	8,665	3,508	(636)	(2,382)	(194)	(4,388)			373,917	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Grove Of Elmhurst # 0053850 **Report Period Beginning:** 01/01/18 **Ending:** 12/31/18

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	852,165											852,165	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(22,760)	1,180,618	37		5,385							1,163,280	32
33	Real Estate Taxes					5,125							5,125	33
34	Rent-Facility & Grounds		(1,839,997)	46,734		(46,560)							(1,839,823)	34
35	Rent-Equipment & Vehicles				4,523								4,523	35
36	Other (specify):*													36
37	**TOTAL Ownership**	829,406	(659,379)	46,771	4,523	(36,050)							185,270	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):*	(658,507)											(658,507)	43
44	**TOTAL Special Cost Centers**	(658,507)											(658,507)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(449,119)	(369,200)	745,953	13,189	(32,542)	(636)	(2,382)	(194)	(4,388)			(99,320)	45

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,839,997	Elmbrook Real Properties		$	$ (1,839,997)	1
2	V	20	Tax Extension Fee		Elmbrook Real Properties		2,500	2,500	2
3	V	20	Filing Fees		Elmbrook Real Properties		75	75	3
4	V	20	Title Fees		Elmbrook Real Properties		4,335	4,335	4
5	V	19	Professional Fees - Accounting		Elmbrook Real Properties		2,751	2,751	5
6	V	19	Professional Fees - Legal		Elmbrook Real Properties		11,601	11,601	6
7	V	19	Professional Fees - Loan		Elmbrook Real Properties		61,955	61,955	7
8	V	21	Property Management Fees		Elmbrook Real Properties		206,962	206,962	8
9	V	32	Interest Expense - Mortgage A		Elmbrook Real Properties		1,180,618	1,180,618	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,839,997			$ 1,470,797	$ * (369,200)	14

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	01	DIETICIAN SALARY	$	Legacy Healthcare Financial Services		$ 1,139	$ 1,139	15
16	V	01	DIETARY SUPPLIES		Legacy Healthcare Financial Services		70	70	16
17	V	02	FOOD		Legacy Healthcare Financial Services		20	20	17
18	V	03	HOUSEKEEPING		Legacy Healthcare Financial Services		1,901	1,901	18
19	V	04	LINEN REPLACEMENT		Legacy Healthcare Financial Services		12	12	19
20	V	06	MAINTENANCE SALARY		Legacy Healthcare Financial Services		8,080	8,080	20
21	V	06	REPAIRS AND MAINTENANCE		Legacy Healthcare Financial Services		1,409	1,409	21
22	V	10	NURSING SALARY		Legacy Healthcare Financial Services		74,719	74,719	22
23	V	10	NURSE CONSULTANT		Legacy Healthcare Financial Services		3,060	3,060	23
24	V	10	MEDICAL SUPPLIES		Legacy Healthcare Financial Services		86	86	24
25	V	12	SOCIAL SERVICE SALARY		Legacy Healthcare Financial Services		4,677	4,677	25
26	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services		75	75	26
27	V	12	SOCIAL SERVICE CONSULTANT		Legacy Healthcare Financial Services		27	27	27
28	V	17	CFO/ADMINISTRATIVE SALARY		Legacy Healthcare Financial Services		100,062	100,062	28
29	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services		12,165	12,165	29
30	V	20	DUES/LICENSE/PERMITS		Legacy Healthcare Financial Services		692	692	30
31	V	21	CLERICAL AND GENERAL WAGES		Legacy Healthcare Financial Services		406,863	406,863	31
32	V	21	CLERICAL AND OFFICE EXPENSE		Legacy Healthcare Financial Services		11,768	11,768	32
33	V	24	EDUCATION AND SEMINARS		Legacy Healthcare Financial Services		3,315	3,315	33
34	V	26	INSURANCE- GENERAL		Legacy Healthcare Financial Services		5,632	5,632	34
35	V	27	NON-NURSING PAYROLL TAXES/BENEFITS		Legacy Healthcare Financial Services		63,409	63,409	35
36	V	32	INTEREST		Legacy Healthcare Financial Services		37	37	36
37	V	34	RENT		Legacy Healthcare Financial Services		46,560	46,560	37
38	V	34	OFFSITE STORAGE/PARKING		Legacy Healthcare Financial Services		174	174	38
39	Total			$			$ 745,953	$ * 745,953	39

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services		243	$ 243	15
16	V	35	AUTO RENTAL		Legacy Healthcare Financial Services		4,281	4,281	16
17	V	15	NURSING PAYROLL TAXES/BENEFITS		Legacy Healthcare Financial Services		8,665	8,665	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			$			$ 13,189	$ * 13,189	39

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 1,130	$ 1,130	15
16	V	6	REPAIRS & MAINTENANCE		CF St. Louis LLC		1,522	1,522	16
17	V	19	PROFESSIONAL FEES		CF St. Louis LLC		47	47	17
18	V	20	DUES & SUBSCRIPTIONS		CF St. Louis LLC		1	1	18
19	V	21	OFFICE EXPENSE		CF St. Louis LLC		372	372	19
20	V	26	INSURANCE		CF St. Louis LLC		436	436	20
21	V	32	INTEREST EXPENSE		CF St. Louis LLC		5,385	5,385	21
22	V	33	REAL ESTATE TAXES		CF St. Louis LLC		5,125	5,125	22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	46,560	CF St. Louis LLC			(46,560)	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			$ 46,560			$ 14,018	$ * (32,542)	39

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 8,550	ML GROUP DESIGN AND DEVELOPMENT		$ 7,914	$ (636)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 8,550			$ 7,914	$ * (636)	39

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Processing	$ 9,099	ProPay HR		$ 6,717	$ (2,382)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,099			$ 6,717	$ * (2,382)	39

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 6,750	ReMED SERVICES		$ 6,556	$ (194)	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			$ 6,750			$ 6,556	$ * (194)	39

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	04	Laundry Services	$ 188,306	EcoBrite Linen		$ 183,918	$ (4,388)	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			$ 188,306			$ 183,918	$ * (4,388)	39

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	ELMBROOK REAL PROPERTIES	ELMHURST	BUILDING COMPANY	1
2	Doros Generation Trust	50.00%	AVANTARA BILLINGS	BILLINGS, MT	LEGACY HC & FINANCIAL SERV	LINCOLNWOOD	HOME OFFICE/BOOKKEEPI	2
3			AVANTARA ELGIN	ELGIN	ML GROUP DESIGN & DEV	SKOKIE	ASSET MANAGEMENT	3
4			AVANTARA LONG GROVE	LONG GROVE	REMED SERVICES LLC	LINCOLNWOOD	NURSING EQUIPMENT	4
5			AVANTARA PARK RIDGE	PARK RIDGE	AURORA SUPPORTIVE LIVING	AURORA	SUPPORTIVE LIVING	5
6			AZRIA MIDTOWN	OMAHA, NE	TERRACE GARDENS	MORTON GROVE	ASSISTED LIVING	6
7			AZRIA MONTCLAIR	OMAHA, NE	LINCOLNSHIRE ASSISTED LIVI	LINCOLNSHIRE	ASSISTED LIVING	7
8			AZRIA OLATHE	OLATHE, KS	CF ST. LOUIS LLC	SKOKIE	BUILDING COMPANY	8
9			BETHANY TERRACE	MORTON GROVE	PROPAY HR	EVANSTON	PAYROLL PROCESSING	9
10			CARLTON SKILLED NURSING FACILITY LLC	CHICAGO	ECOBRITE LINEN	SKOKIE	LAUNDRY SUPPLIES	10
11			CHALET SKILLED NURSING FACILITY LLC	CHICAGO				11
12			CLARK SKILLED NURSING FACILITY	CHICAGO				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			GROVE OF ST. CHARLES	ST. CHARLES				16
17			LAGRANGE SKILLED NURSING FACILITY LLC	LAGRANGE PARK				17
18			LAKEFRONT SKILLED NURSING FACILITY LLC	CHICAGO				18
19			LINCOLN PARK SKILLED NURSING FACILITY LLC	CHICAGO				19
20			LINCOLNSHIRE LIVING & REHAB CENTER LLC	LINCOLNSHIRE				20
21			NORTHBROOK SKILLED NURSING FACILITY LLC	NORTHBROOK				21
22			PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO				22
23			SKOKIE SKILLED NURSING FACILITY LLC	SKOKIE				23
24			ST. GEORGE SKILLED NURSING FACILITY	ST. GEORGE, UT				24
25			VALLEY SKILLED NURSING FACILITY	BILLINGS, MT				25
26			WARREN BARR LIVING AND REHAB	CHICAGO				26
27			WARREN BARR NORTH SHORE	HIGHLAND PARK				27
28			WARREN BARR SOUTH LOOP	CHICAGO				28
29								29
30								30

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES

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

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$		13

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

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	01	DIETICIAN SALARY	AVAIL. BED DAYS	1,918,919	34	$ 33,257	$ 33,257	65,700	$ 1,139	1
2	01	DIETARY SUPPLIES	AVAIL. BED DAYS	1,918,919	34	2,031		65,700	70	2
3	02	FOOD	AVAIL. BED DAYS	1,918,919	34	595		65,700	20	3
4	03	HOUSEKEEPING	AVAIL. BED DAYS	1,918,919	34	55,512		65,700	1,901	4
5	04	LINEN REPLACEMENT	AVAIL. BED DAYS	1,918,919	34	343		65,700	12	5
6	06	MAINTENANCE SALARY	AVAIL. BED DAYS	1,918,919	34	235,999	235,999	65,700	8,080	6
7	06	REPAIRS AND MAINTENANCE	AVAIL. BED DAYS	1,918,919	34	41,154		65,700	1,409	7
8	10	NURSING SALARY	AVAIL. BED DAYS	1,918,919	34	2,182,345	2,182,345	65,700	74,719	8
9	10	NURSE CONSULTANT	AVAIL. BED DAYS	1,918,919	34	89,384		65,700	3,060	9
10	10	MEDICAL SUPPLIES	AVAIL. BED DAYS	1,918,919	34	2,503		65,700	86	10
11	12	SOCIAL SERVICE SALARY	AVAIL. BED DAYS	1,918,919	34	136,611	136,611	65,700	4,677	11
12	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,918,919	34	2,204		65,700	75	12
13	12	SOCIAL SERVICE CONSULTAN	AVAIL. BED DAYS	1,918,919	34	800		65,700	27	13
14	17	CFO/ADMINISTRATIVE SALAR	AVAIL. BED DAYS	1,918,919	34	2,922,553	2,922,553	65,700	100,062	14
15	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,918,919	34	355,302		65,700	12,165	15
16	20	DUES/LICENSE/PERMITS	AVAIL. BED DAYS	1,918,919	34	20,207		65,700	692	16
17	21	CLERICAL AND GENERAL WA	AVAIL. BED DAYS	1,918,919	34	11,883,371	11,883,371	65,700	406,863	17
18	21	CLERICAL AND OFFICE EXPEI	AVAIL. BED DAYS	1,918,919	34	343,715		65,700	11,768	18
19	24	EDUCATION AND SEMINARS	AVAIL. BED DAYS	1,918,919	34	96,819		65,700	3,315	19
20	26	INSURANCE- GENERAL	AVAIL. BED DAYS	1,918,919	34	164,496		65,700	5,632	20
21	27	NON-NURSING PAYROLL TAXI	AVAIL. BED DAYS	1,918,919	34	1,852,008		65,700	63,409	21
22	32	INTEREST	AVAIL. BED DAYS	1,918,919	34	1,074		65,700	37	22
23	34	RENT	AVAIL. BED DAYS	1,918,919	34	1,359,900		65,700	46,560	23
24	34	OFFSITE STORAGE/PARKING	AVAIL. BED DAYS	1,918,919	34	5,072		65,700	174	24
25	TOTALS					$ 21,787,253	$ 17,394,136		$ 745,953	25

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,918,919	34	7,088		65,700	243	1
2	35	AUTO RENTAL	AVAIL. BED DAYS	1,918,919	34	125,028		65,700	4,281	2
3	15	NURSING PAYROLL TAXES/BE	AVAIL. BED DAYS	1,918,919	34	253,092		65,700	8,665	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					$ 385,208	$		$ 13,189	25

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	1,916,917	34	$ 32,982	$	65,700	$ 1,130	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,916,917	34	44,396		65,700	1,522	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,916,917	34	1,378		65,700	47	3
4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,916,917	34	23		65,700	1	4
5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,916,917	34	10,860		65,700	372	5
6	26	INSURANCE	AVAIL. BED DAYS	1,916,917	34	12,721		65,700	436	6
7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,916,917	34	157,106		65,700	5,385	7
8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,916,917	34	149,528		65,700	5,125	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					$ 408,994	$		$ 14,018	25

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: ML Group Design and Development
Street Address: 3424 Oakton St
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 676-5300
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINTENANCE	DIRECT			$	$		$ 7,914	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 7,914	25

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Payroll Processing	Direct			$	$		$ 6,717	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					$	$		$ 6,717	25

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: ReMED Services
Street Address: 3424 Oakton St, Suite 102
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 440-2600
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICAL SUPPLIES	DIRECT			$	$		$ 6,556	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					$	$		$ 6,556	25

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

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: EcoBrite Linen
Street Address: 3712 Jarvis Avenue
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 582 4000
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	4	Laundry Services	Direct			$	$		$ 183,918	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					$	$		$ 183,918	25

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1			X	Mortgage			$	$ 18,480,496			$ 1,180,618	1
2												2
3												3
4												4
5												5
	Working Capital											
6	The Private Bank		X	Note Payable				4,010,323			208,593	6
7												7
8												8
9	TOTAL Facility Related						$	$ 22,490,819			$ 1,389,211	9
	B. Non-Facility Related*											
10	Interest Income		X								(22,760)	10
11	Allocated Legacy Healthcare		X								37	11
12	Allocated CF St Louis		X								5,385	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (17,338)	14
15	TOTALS (line 9+line14)						$	$ 22,490,819			$ 1,371,873	15

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

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

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 62,668	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.)		$ 71,598	2
3. Under or (over) accrual (line 2 minus line 1).		$ 8,930	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 62,405	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.)		$	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.		$ 71,335	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	66,825	8
	2014	67,195	9
	2015	63,000	10
	2016	63,959	11
	2017	66,473	12

2018 Accrual = $66,473 x 0.9388 = $62,405 (rounded)

Allocated from CF St Louis=$5,125

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grove Of Elmhurst COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0053850

CONTACT PERSON REGARDING THIS REPORT

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 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-26-207-025	Long Term Care Facility	$ 61,243.06	$ 61,243.06
2.	03-26-207-022	Long Term Care Facility	$ 5,229.62	$ 5,229.62
3.	10-23-406-034-0000	Home Office Allocation	$ 492,481.94	$ 5,124.89
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 558,954.62	$ 71,597.57

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 2017 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 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grove Of Elmhurst COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0053850

CONTACT PERSON REGARDING THIS REPORT

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 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	67,000	2010	$ 606,331	1
2	Allocated from CF St. Louis			6,764	2
3	TOTALS			$ 613,095	3

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	180		2010	1977	$ 7,403,102	$	35	$ 211,517	$ 211,517	$ 423,034	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2011	831,792		20	41,590	41,590	332,717	9
10	Various			2012	243,002		20	12,150	12,150	85,051	10
11	Various			2013	155,927		20	7,796	7,796	45,010	11
12	Various			2014	79,902		20	3,995	3,995	19,976	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		268,069			12,623	12,623	37,580	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 8,981,795	$		$ 289,671	$ 289,671	$ 943,366	70

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 8,981,795	$		$ 289,671	$ 289,671	$ 943,366	1
2	Drapery And Blinds	2015	3,625		20	181	181	725	2
3	Wallcoverings	2015	2,576		20	129	129	515	3
4	2 Hot Water Storage Tanks And 1 Tankstat	2015	28,884		20	1,444	1,444	5,777	4
5	Nurse Station	2015	8,750		20	438	438	1,750	5
6	Boiler Kit, Burner, Cable	2015	3,003		20	150	150	601	6
7	Patched And Painted Dining Room	2017	20,700		20	690	690	1,380	7
8	Installed Signage - Side Elevation	2017	12,802		20	427	427	854	8
9	Installed 1 New Carrier Oil Pump For Compressor - Chiller	2017	6,442		20	859	859	1,718	9
10	Installed New Elevator Valve - Elevator	2017	3,800		20	697	697	1,394	10
11	Installed Signage - Side Elevation	2017	12,349		20	566	566	1,132	11
12	Powerwashed Copings, Installed New Copings - Roof	2017	16,500		20	206	206	412	12
13	Floor Tiling In Resident Rooms	2017	11,500		20	575	575	1,150	13
14	Painting Room, Dry Wall -Resident Rooms	2017	3,250		20	163	163	325	14
15	Installed Branch Pannel And Pipe-Closet/Vent Wing	2017	17,775		20	889	889	1,778	15
16	Added New Tiles In Resident Room	2017	5,750		20	288	288	575	16
17	Rewired Vent Wiring - Main Vent	2017	5,900		20	295	295	590	17
18	Removed Head, Replaced Condenser Shell Tube - Chiller	2017	4,899		20	245	245	490	18
19	Room Repairs To Tile, Lighting, Walls (23,000)	2017	21,289		20	1,064	1,064	1,064	19
20	Window Treatments - 2Nd & 3Rd Floors (8,220)	2018	7,608		20	685	685	685	20
21	Electrical Work & Outlets (3,500)	2018	3,240		20	175	175	175	21
22	Air Damper Replacements For Boiler & Generator Rooms (3,764)	2018	3,484		20	403	403	403	22
23	Chiller Repair (2,786)	2018	2,579		20	129	129	129	23
24	Ejector Pump Replacements (18,515)	2018	17,137		20	857	857	857	24
25	Light Fixture & Window Treatments - 2Nd & 3Rd Floors (5,356.23	2018	4,958		20	248	248	248	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,210,595	$		$ 301,473	$ 301,473	$ 968,092	34

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,210,595	$		$ 301,473	$ 301,473	$ 968,092	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,210,595	$		$ 301,473	$ 301,473	$ 968,092	34

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 9,210,595	$		$ 301,473	$ 301,473	$ 968,092	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,210,595	$		$ 301,473	$ 301,473	$ 968,092	34

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 9,210,595	$		$ 301,473	$ 301,473	$ 968,092	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,210,595	$		$ 301,473	$ 301,473	$ 968,092	34

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	36,422		35	1,041	1,041	3,122	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	226,129		20	11,306	11,306	33,919	9
10	Allocated from CF St. Louis, LLC	2017	5,249		20	262	262	525	10
11									11
12									12
13	Allocated from Legacy HC	2018	270		20	13	13	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)		$ 268,069	$		$ 12,623	$ 12,623	$ 37,580	34

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 268,069	$		$ 12,623	$ 12,623	$ 37,580	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		$ 268,069	$		$ 12,623	$ 12,623	$ 37,580	34

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 5,491,576	$	$ 547,335	$ 547,335	10	$ 2,657,931	71
72	Current Year Purchases	35,136		3,356	3,356	10	3,356	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 5,526,712	$	$ 550,692	$ 550,692		$ 2,661,287	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 15,350,402	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 852,165	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 852,165	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,629,380	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	Construction in Progress	$ 1,760	92
93			93
94			94
95		$ 1,760	95

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

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Legacy Healthcare				174			5
6								6
7	TOTAL				$ 174 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 7,709 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18	Allocated Legacy Healthcare			4,281	18
19					19
20					20
21	TOTAL		$	$ 4,281	21

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

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

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 220,096	$		$ 220,096	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			108,360			108,360	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			304,805			304,805	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				303,290		303,290	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):			374,245		148,501	315,371		838,117	13
14	TOTAL			$ 374,245		$ 781,762	$ 618,661		$ 1,774,668	14

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

STATE OF ILLINOIS

Facility Name & ID Number Grove Of Elmhurst # 0053850 **Report Period Beginning:** 01/01/18 **Ending:** 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (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	$ 527	$ 3,076	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,147,002	3,147,002	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,507	23,507	6
7	Other Prepaid Expenses	18,279	215,412	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	65,914	295,914	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,255,229	$ 3,684,911	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	4,000	1,313,500	13
14	Buildings, at Historical Cost		5,180,335	14
15	Leasehold Improvements, at Historical Cost	182,849	852,980	15
16	Equipment, at Historical Cost	244,084	259,084	16
17	Accumulated Depreciation (book methods)	(49,302)	(1,376,763)	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	1,700,206	2,534,187	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,081,837	$ 8,763,323	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,337,066	$ 12,448,234	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 50,042	$ 50,041	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	441,735	441,735	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,605	16,605	31
32	Accrued Real Estate Taxes(Sch.IX-B)		62,405	32
33	Accrued Interest Payable		101,631	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	195,486	295,486	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 703,868	$ 967,903	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,010,323	4,010,323	39
40	Mortgage Payable		18,480,496	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	1,134,720		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,145,043	$ 22,490,819	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,848,911	$ 23,458,722	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (511,845)	$ (11,010,488)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,337,066	$ 12,448,234	48

***(See instructions.)**

Facility Name & ID Number Grove Of Elmhurst # 0053850 Report Period Beginning: 01/01/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 111,352	1	
2	Restatements (describe):		2	
3	**Prior year depreciation**	(35,432)	3	
4	**Prior year bad debts**	(93,317)	4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (17,397)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(494,448)	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)**	$ (494,448)	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)**	$ (511,845)	24	*

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

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 16,882,670	1
2	Discounts and Allowances for all Levels	(6,637,623)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,245,047	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,568,527	6
7	Oxygen	330	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,568,857	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	297,901	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	43,382	19
20	Radiology and X-Ray	165	20
21	Other Medical Services	20,293	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 361,741	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	22,760	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 22,760	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	27,068	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 27,068	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,225,473	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,014,339	31
32	Health Care	4,800,311	32
33	General Administration	1,932,059	33
	B. Capital Expense		
34	Ownership	2,122,266	34
	C. Ancillary Expense		
35	Special Cost Centers	2,433,175	35
36	Provider Participation Fee	417,771	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,719,921	40
41	**Income before Income Taxes (line 30 minus line 40)****	(494,448)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (494,448)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,171,266	44
45	Private Pay - Net Inpatient Revenue	1,069,774	45
46	Medicare - Net Inpatient Revenue	408,363	46
47	Other-(specify) Insurance / Veterans	595,644	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,245,047	49

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,928	2,072	$ 100,333	$ 48.42	1
2	Assistant Director of Nursing	2,149	2,389	96,802	40.52	2
3	Registered Nurses	26,422	29,423	960,624	32.65	3
4	Licensed Practical Nurses	35,995	40,259	1,145,964	28.46	4
5	CNAs & Orderlies	85,570	93,676	1,461,049	15.60	5
6	CNA Trainees					6
7	Licensed Therapist	11,691	12,740	374,245	29.38	7
8	Rehab/Therapy Aides	10,015	11,190	245,658	21.95	8
9	Activity Director	3,575	3,842	69,874	18.19	9
10	Activity Assistants	10,672	12,351	178,330	14.44	10
11	Social Service Workers	6,804	7,329	153,885	21.00	11
12	Dietician					12
13	Food Service Supervisor	3,712	4,120	111,332	27.02	13
14	Head Cook	9,166	10,092	131,017	12.98	14
15	Cook Helpers/Assistants	14,633	15,587	186,045	11.94	15
16	Dishwashers					16
17	Maintenance Workers	5,744	6,264	131,829	21.05	17
18	Housekeepers	16,058	17,423	225,033	12.92	18
19	Laundry	3,139	3,666	58,950	16.08	19
20	Administrator	2,000	2,400	130,162	54.23	20
21	Assistant Administrator	1,704	1,832	62,848	34.31	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,443	7,095	122,634	17.28	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	2,992	3,488	81,337	23.32	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	1,976	2,080	31,757	15.27	33
34	TOTAL (lines 1 - 33)	262,388	289,318	$ 6,059,708 *	$ 20.94	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	782	$ 36,743	01-03	35
36	Medical Director	Monthly	48,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	17,339	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	81	3,984	11-03	44
45	Social Service Consultant	47	2,752	12-03	45
46	Other(specify)				46
47	Consultant - MDS	Monthly	10,619	10-03	47
48					48
49	TOTAL (lines 35 - 48)	911	$ 119,437		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lockett, Nichole	Administrator	0	$ 13,584
Triplett, Elliot	Administrator	0	116,578
Galindo, Alba	Assistant Administrator	0	19
Patino, Jessica	Assistant Administrator	0	20,252
Provido, Christina M.	Assistant Administrator	0	42,578
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 193,010

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
See Attached	Legal Fees	$ 9,010
Marcum LLP	Accounting Fees	29,069
Compliance Resources	Compliance Audit	2,869
ProPay HR	Payroll Processing	9,099
2401 Incorporated	Architectural Services	2,100
Achieve Accreditation LLC	Accreditation	2,847
Adam Zollinger Interiors	Interior Decorating	2,625
Central Scale Supply Co Inc	Machine Consulting	420
Compliagent	Compliance	1,800
IIT/Sourcetech	IT Services	1,870
Integra Scripts LLC	Pharma Management Services	500
See Supplemental Schedule		5,275
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 67,484

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 88,519
Unemployment Compensation Insurance	34,719
FICA Taxes	450,231
Employee Health Insurance	178,416
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	110,429
Employee Benefits	6,896
401K Expense	24,066
Voluntary Benefit Contributions	8,023
Employee Physical Exams	8,965
TOTAL (agree to Schedule V, line 22, col.8)	$ 910,264

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,985
Advertising: Employee Recruitment	
Health Care Worker Background Check	778
(Indicate # of checks performed 78)	
Patient Background Checks 305	3,050
Dues and Subscriptions	28,157
Licenses and Permits	11,902
Allocated from Legacy Healthcare	692
Allocated CF St Louis	1
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 47,564

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,560
Allocated from Legacy Healthcare	3,315
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,875

**See instructions.

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI - $27,144; IHCA - $12,600**

(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? **NA**

(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. $ **76,206** 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. $ **417,771**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $

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

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees