		FOR BHF USE				

LL1

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

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.

I. IDPH License ID Number: 0053884

Facility Name: Grove Of Lagrange Park

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

County: Cook

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/18 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 Lagrange Park # 0053884 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	131	Skilled (SNF)	131	47,815	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	131	TOTALS	131	47,815	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,656	520	6,843	12,019	8
9	SNF/PED					9
10	ICF	24,454	1,845	853	27,152	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,110	2,365	7,696	39,171	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.92%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 4/1/2009

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 131 and days of care provided 4,359

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number: Grove Of Lagrange Park # 0053884 Report Period Beginning: 01/01/18 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	317,392	15,856		333,248		333,248	880	334,128			1
2	Food Purchase		252,198		252,198		252,198	(16,647)	235,551			2
3	Housekeeping	181,015	35,533	103	216,651		216,651	1,383	218,034			3
4	Laundry	54,045	17,937	85,763	157,745		157,745	(2,257)	155,488			4
5	Heat and Other Utilities			135,650	135,650		135,650	(5,299)	130,351			5
6	Maintenance	103,522	14,848	194,028	312,398		312,398	9,065	321,463			6
7	Other (specify):*											7
8	**TOTAL General Services**	655,974	336,372	415,544	1,407,890		1,407,890	(12,875)	1,395,015			8
	B. Health Care and Programs											
9	Medical Director			59,199	59,199		59,199		59,199			9
10	Nursing and Medical Records	2,714,095	67,409	23,148	2,804,652		2,804,652	52,833	2,857,485			10
10a	Therapy	156,234			156,234		156,234		156,234			10a
11	Activities	125,163	6,386	2,816	134,365		134,365	55	134,420			11
12	Social Services	149,971		3,360	153,331		153,331	3,424	156,755			12
13	CNA Training											13
14	Program Transportation			17,266	17,266		17,266		17,266			14
15	Other (specify):*							6,306	6,306			15
16	**TOTAL Health Care and Programs**	3,145,463	73,795	105,789	3,325,047		3,325,047	62,618	3,387,665			16
	C. General Administration											
17	Administrative	190,251			190,251		190,251	72,823	263,074			17
18	Directors Fees											18
19	Professional Services			173,137	173,137		173,137	(11,382)	161,755			19
20	Dues, Fees, Subscriptions & Promotions			74,329	74,329		74,329	(40,190)	34,139			20
21	Clerical & General Office Expenses	106,935	5,123	340,543	452,601		452,601	44,517	497,118			21
22	Employee Benefits & Payroll Taxes			720,091	720,091		720,091		720,091			22
23	Inservice Training & Education											23
24	Travel and Seminar			160	160		160	2,413	2,573			24
25	Other Admin. Staff Transportation			3,082	3,082		3,082		3,082			25
26	Insurance-Prop.Liab.Malpractice			225,056	225,056		225,056	4,416	229,472			26
27	Other (specify):*							46,148	46,148			27
28	**TOTAL General Administration**	297,186	5,123	1,536,398	1,838,707		1,838,707	118,745	1,957,452			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,098,623	415,290	2,057,731	6,571,644		6,571,644	168,488	6,740,132			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.

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			133,331	133,331		133,331	174,834	308,165			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			80,556	80,556		80,556	635,388	715,944			32
33	Real Estate Taxes			293,392	293,392		293,392	(18,641)	274,751			33
34	Rent-Facility & Grounds			1,014,819	1,014,819		1,014,819	(1,014,693)	126			34
35	Rent-Equipment & Vehicles			9,690	9,690		9,690	3,292	12,982			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,531,788	1,531,788		1,531,788	(219,820)	1,311,968			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		309,934	706,581	1,016,515		1,016,515		1,016,515			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			283,815	283,815		283,815		283,815			42
43	Other (specify):*			498,562	498,562		498,562	(498,562)				43
44	**TOTAL Special Cost Centers**		309,934	1,488,958	1,798,892		1,798,892	(498,562)	1,300,330			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,098,623	725,224	5,078,477	9,902,324		9,902,324	(549,894)	9,352,430			45

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

Facility Name & ID Number Grove Of Lagrange Park # 0053884 Report Period Beginning: 01/01/18 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	(6,122)	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	90,680	30		9
10	Interest and Other Investment Income	(19,128)	32		10
11	Discounts, Allowances, Rebates & Refunds	(16,510)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(152)	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	(662)	21		18
19	Entertainment	(1,332)	21		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	(202,266)	21		24
25	Fund Raising, Advertising and Promotional	(17,752)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(798,282)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (981,526)		$	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)	431,632		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 431,632		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (549,894)		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 Lagrange Park

ID# 0053884

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Personal Items	$ (2,242)	10	1
2	Bank Charges	(389)	21	2
3	Sequestration Expense	(55,775)	21	3
4	Pharmacy Discounts	(1,416)	10	4
5	Non-Allowable Expense	(498,562)	43	5
6	Building Co - Bank Fees	(5)	21	6
7	Building Co - Filing Fees	(75)	20	7
8	Building Co - Title Fees	(2,783)	20	8
9	Building Co - Accounting Fees	(2,826)	19	9
10	Building Co - Legal Fees	(23,368)	19	10
11	Building Co - Management Fees	(146,679)	17	11
12	Building Co - Loan Fees	(33,928)	19	12
13	Additional R&M	1,588	06	13
14	PAC Dues	(12,942)	20	14
15	Non-Allowable Legal	(18,881)	19	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(798,282)		49

STATE OF ILLINOIS

Grove Of Lagrange Park

ID# 0053884

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 Lagrange Park # 0053884 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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			880									880	1
2	Food Purchase	(16,662)		15									(16,647)	2
3	Housekeeping			1,383									1,383	3
4	Laundry			9						(2,266)			(2,257)	4
5	Heat and Other Utilities	(6,122)				823							(5,299)	5
6	Maintenance	1,588		6,906		1,107		(536)					9,065	6
7	Other (specify):*													7
8	**TOTAL General Services**	(21,196)		9,193		1,930		(536)		(2,266)			(12,875)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(3,658)		56,669			(178)						52,833	10
10a	Therapy													10a
11	Activities			55									55	11
12	Social Services			3,424									3,424	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				6,306								6,306	15
16	**TOTAL Health Care and Programs**	(3,658)		60,147	6,306		(178)						62,618	16
	C. General Administration													
17	Administrative	(146,679)	146,679	72,823									72,823	17
18	Directors Fees													18
19	Professional Services	(79,003)	60,123	8,853		34			(1,389)				(11,382)	19
20	Fees, Subscriptions & Promotions	(43,552)	2,858	504		1							(40,190)	20
21	Clerical & General Office Expenses	(260,429)	5	304,671		271							44,517	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			2,413									2,413	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			4,099		317							4,416	26
27	Other (specify):*			46,148									46,148	27
28	**TOTAL General Administration**	(529,662)	209,664	439,510		623			(1,389)				118,745	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(554,516)	209,664	508,850	6,306	2,553	(178)	(536)	(1,389)	(2,266)			168,488	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Grove Of Lagrange Park # 0053884 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	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	90,680	84,154										174,834	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(19,128)	650,570	27		3,919							635,388	32
33	Real Estate Taxes		(22,371)			3,730							(18,641)	33
34	Rent-Facility & Grounds		(1,014,819)	34,012		(33,886)							(1,014,693)	34
35	Rent-Equipment & Vehicles				3,292								3,292	35
36	Other (specify):*													36
37	**TOTAL Ownership**	71,552	(302,466)	34,039	3,292	(26,237)							(219,820)	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):*	(498,562)											(498,562)	43
44	**TOTAL Special Cost Centers**	(498,562)											(498,562)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(981,526)	(92,802)	542,889	9,598	(23,685)	(178)	(536)	(1,389)	(2,266)			(549,894)	45

Facility Name & ID Number Grove Of Lagrange Park # 0053884 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	Rental Income	$ 1,014,819	Grove of LaGrange Healthcare Properties LLC		$	$ (1,014,819)	1
2	V	32	Interest		Grove of LaGrange Healthcare Properties LLC		650,570	650,570	2
3	V	21	Bank Fees		Grove of LaGrange Healthcare Properties LLC		5	5	3
4	V	20	Filing Fees		Grove of LaGrange Healthcare Properties LLC		75	75	4
5	V	20	Title Fees		Grove of LaGrange Healthcare Properties LLC		2,783	2,783	5
6	V	19	Accounting		Grove of LaGrange Healthcare Properties LLC		2,826	2,826	6
7	V	19	Legal		Grove of LaGrange Healthcare Properties LLC		23,368	23,368	7
8	V	19	Loan Fees		Grove of LaGrange Healthcare Properties LLC		33,928	33,928	8
9	V	17	Property Management Fees		Grove of LaGrange Healthcare Properties LLC		146,679	146,679	9
10	V	33	Real Estate Taxes	22,371	Grove of LaGrange Healthcare Properties LLC			(22,371)	10
11	V	30	Depreciation		Grove of LaGrange Healthcare Properties LLC		84,154	84,154	11
12	V								12
13	V								13
14	Total			$ 1,037,190			$ 944,388	$ * (92,802)	14

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

Facility Name & ID Number Grove Of Lagrange Park # 0053884 Report Period Beginning: 01/01/18 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		$ 829	$ 829	15
16	V	01	DIETARY SUPPLIES		Legacy Healthcare Financial Services		51	51	16
17	V	02	FOOD		Legacy Healthcare Financial Services		15	15	17
18	V	03	HOUSEKEEPING		Legacy Healthcare Financial Services		1,383	1,383	18
19	V	04	LINEN REPLACEMENT		Legacy Healthcare Financial Services		9	9	19
20	V	06	MAINTENANCE SALARY		Legacy Healthcare Financial Services		5,881	5,881	20
21	V	06	REPAIRS AND MAINTENANCE		Legacy Healthcare Financial Services		1,025	1,025	21
22	V	10	NURSING SALARY		Legacy Healthcare Financial Services		54,379	54,379	22
23	V	10	NURSE CONSULTANT		Legacy Healthcare Financial Services		2,227	2,227	23
24	V	10	MEDICAL SUPPLIES		Legacy Healthcare Financial Services		62	62	24
25	V	12	SOCIAL SERVICE SALARY		Legacy Healthcare Financial Services		3,404	3,404	25
26	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services		55	55	26
27	V	12	SOCIAL SERVICE CONSULTANT		Legacy Healthcare Financial Services		20	20	27
28	V	17	CFO/ADMINISTRATIVE SALARY		Legacy Healthcare Financial Services		72,823	72,823	28
29	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services		8,853	8,853	29
30	V	20	DUES/LICENSE/PERMITS		Legacy Healthcare Financial Services		504	504	30
31	V	21	CLERICAL AND GENERAL WAGES		Legacy Healthcare Financial Services		296,106	296,106	31
32	V	21	CLERICAL AND OFFICE EXPENSE		Legacy Healthcare Financial Services		8,565	8,565	32
33	V	24	EDUCATION AND SEMINARS		Legacy Healthcare Financial Services		2,413	2,413	33
34	V	26	INSURANCE- GENERAL		Legacy Healthcare Financial Services		4,099	4,099	34
35	V	27	NON-NURSING PAYROLL TAXES/BENEFITS		Legacy Healthcare Financial Services		46,148	46,148	35
36	V	32	INTEREST		Legacy Healthcare Financial Services		27	27	36
37	V	34	RENT		Legacy Healthcare Financial Services		33,886	33,886	37
38	V	34	OFFSITE STORAGE/PARKING		Legacy Healthcare Financial Services		126	126	38
39	Total			$			$ 542,889	$ * 542,889	39

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

Facility Name & ID Number Grove Of Lagrange Park # 0053884 Report Period Beginning: 01/01/18 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services		177	$ 177	15
16	V	35	AUTO RENTAL		Legacy Healthcare Financial Services		3,115	3,115	16
17	V	15	NURSING PAYROLL TAXES/BENEFITS		Legacy Healthcare Financial Services		6,306	6,306	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			$			$ 9,598	$ * 9,598	39

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

Facility Name & ID Number Grove Of Lagrange Park # 0053884 Report Period Beginning: 01/01/18 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		$ 823	$ 823	15
16	V	6	REPAIRS & MAINTENANCE		CF St. Louis LLC		1,107	1,107	16
17	V	19	PROFESSIONAL FEES		CF St. Louis LLC		34	34	17
18	V	20	DUES & SUBSCRIPTIONS		CF St. Louis LLC		1	1	18
19	V	21	OFFICE EXPENSE		CF St. Louis LLC		271	271	19
20	V	26	INSURANCE		CF St. Louis LLC		317	317	20
21	V	32	INTEREST EXPENSE		CF St. Louis LLC		3,919	3,919	21
22	V	33	REAL ESTATE TAXES		CF St. Louis LLC		3,730	3,730	22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	33,886	CF St. Louis LLC			(33,886)	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			$ 33,886			$ 10,201	$ * (23,685)	39

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

Facility Name & ID Number Grove Of Lagrange Park # 0053884 Report Period Beginning: 01/01/18 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Medical Supplies	$ 6,188	ReMED Services		$ 6,010	$ (178)	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			$ 6,188			$ 6,010	$ * (178)	39

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

Facility Name & ID Number Grove Of Lagrange Park # 0053884 Report Period Beginning: 01/01/18 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance	$ 7,200	ML Group Design and Development		$ 6,664	$ (536)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 7,200			$ 6,664	$ * (536)	39

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

Facility Name & ID Number Grove Of Lagrange Park # 0053884 Report Period Beginning: 01/01/18 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Processing	$ 5,304	ProPay HR LLC		$ 3,915	$ (1,389)	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			$ 5,304			$ 3,915	$ * (1,389)	39

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

Facility Name & ID Number Grove Of Lagrange Park # 0053884 Report Period Beginning: 01/01/18 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	04	Laundry Services	$ 97,252	EcoBrite Linen		$ 94,986	$ (2,266)	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			$ 97,252			$ 94,986	$ * (2,266)	39

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

Facility Name & ID Number Grove Of Lagrange Park # 0053884 Report Period Beginning: 01/01/18 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Grove Of Lagrange Park # 0053884 Report Period Beginning: 01/01/18 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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.

STATE OF ILLINOIS

Facility Name & ID Number Grove Of Lagrange Park # 0053884 **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	GROVE OF LAGRANGE HEALTHCARE PROPERTIES LLC		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			ELMBROOK SKILLED NURSING FACILITY LLC	ELMHURST				13
14			EVANSTON SKILLED NURSING FACILITY LLC	EVANSTON				14
15			GROVE AT THE LAKE SKILLED NURSING FACILITY LLC	ZION				15
16			GROVE OF FOX VALLEY	AURORA				16
17			GROVE OF ST. CHARLES	ST. CHARLES				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 Lagrange Park # 0053884 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 Lagrange Park # 0053884 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	
					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	
	Name	Title	Function	Ownership Interest		Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Grove Of Lagrange Park # 0053884 Report Period Beginning: 01/01/18 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]

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

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

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

Facility Name & ID Number Grove Of Lagrange Park # 0053884 Report Period Beginning: 01/01/18 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 [ ]

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

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

	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	47,815	$ 829	1
2	01	DIETARY SUPPLIES	AVAIL. BED DAYS	1,918,919	34	2,031		47,815	51	2
3	02	FOOD	AVAIL. BED DAYS	1,918,919	34	595		47,815	15	3
4	03	HOUSEKEEPING	AVAIL. BED DAYS	1,918,919	34	55,512		47,815	1,383	4
5	04	LINEN REPLACEMENT	AVAIL. BED DAYS	1,918,919	34	343		47,815	9	5
6	06	MAINTENANCE SALARY	AVAIL. BED DAYS	1,918,919	34	235,999	235,999	47,815	5,881	6
7	06	REPAIRS AND MAINTENANCE	AVAIL. BED DAYS	1,918,919	34	41,154		47,815	1,025	7
8	10	NURSING SALARY	AVAIL. BED DAYS	1,918,919	34	2,182,345	2,182,345	47,815	54,379	8
9	10	NURSE CONSULTANT	AVAIL. BED DAYS	1,918,919	34	89,384		47,815	2,227	9
10	10	MEDICAL SUPPLIES	AVAIL. BED DAYS	1,918,919	34	2,503		47,815	62	10
11	12	SOCIAL SERVICE SALARY	AVAIL. BED DAYS	1,918,919	34	136,611	136,611	47,815	3,404	11
12	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,918,919	34	2,204		47,815	55	12
13	12	SOCIAL SERVICE CONSULTAN	AVAIL. BED DAYS	1,918,919	34	800		47,815	20	13
14	17	CFO/ADMINISTRATIVE SALAR	AVAIL. BED DAYS	1,918,919	34	2,922,553	2,922,553	47,815	72,823	14
15	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,918,919	34	355,302		47,815	8,853	15
16	20	DUES/LICENSE/PERMITS	AVAIL. BED DAYS	1,918,919	34	20,207		47,815	504	16
17	21	CLERICAL AND GENERAL WA	AVAIL. BED DAYS	1,918,919	34	11,883,371	11,883,371	47,815	296,106	17
18	21	CLERICAL AND OFFICE EXPE	AVAIL. BED DAYS	1,918,919	34	343,715		47,815	8,565	18
19	24	EDUCATION AND SEMINARS	AVAIL. BED DAYS	1,918,919	34	96,819		47,815	2,413	19
20	26	INSURANCE- GENERAL	AVAIL. BED DAYS	1,918,919	34	164,496		47,815	4,099	20
21	27	NON-NURSING PAYROLL TAX	AVAIL. BED DAYS	1,918,919	34	1,852,008		47,815	46,148	21
22	32	INTEREST	AVAIL. BED DAYS	1,918,919	34	1,074		47,815	27	22
23	34	RENT	AVAIL. BED DAYS	1,918,919	34	1,359,900		47,815	33,886	23
24	34	OFFSITE STORAGE/PARKING	AVAIL. BED DAYS	1,918,919	34	5,072		47,815	126	24
25	TOTALS					$ 21,787,253	$ 17,394,136		$ 542,889	25

Facility Name & ID Number Grove Of Lagrange Park # 0053884 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 [ ]

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

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

	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		47,815	177	1
2	35	AUTO RENTAL	AVAIL. BED DAYS	1,918,919	34	125,028		47,815	3,115	2
3	15	NURSING PAYROLL TAXES/BE	AVAIL. BED DAYS	1,918,919	34	253,092		47,815	6,306	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	$		$ 9,598	25

Facility Name & ID Number Grove Of Lagrange Park # 0053884 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 [ ]

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

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

	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	$	47,815	$ 823	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,916,917	34	44,396		47,815	1,107	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,916,917	34	1,378		47,815	34	3
4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,916,917	34	23		47,815	1	4
5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,916,917	34	10,860		47,815	271	5
6	26	INSURANCE	AVAIL. BED DAYS	1,916,917	34	12,721		47,815	317	6
7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,916,917	34	157,106		47,815	3,919	7
8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,916,917	34	149,528		47,815	3,730	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	$		$ 10,201	25

Facility Name & ID Number Grove Of Lagrange Park # 0053884 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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: ( )

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.

	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			$	$		$ 6,010	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					$	$		$ 6,010	25

Facility Name & ID Number Grove Of Lagrange Park # 0053884 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 [ ]

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: ( )

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

	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			$	$		$ 6,664	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					$	$		$ 6,664	25

Facility Name & ID Number Grove Of Lagrange Park # 0053884 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, IL 60202
Phone Number: (847) 905-3268
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct			$	$		$ 3,915	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 3,915	25

Facility Name & ID Number Grove Of Lagrange Park # 0053884 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 [ ]

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: ( )

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

	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			$	$		$ 94,986	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					$	$		$ 94,986	25

Facility Name & ID Number Grove Of Lagrange Park # 0053884 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 Lagrange Park # 0053884 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 Lagrange Park** # **0053884** 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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	The Private Bank		X	Mortgage			$	$ 10,115,748			$ 650,570	1
2	The Private Bank		X	Note Payable				1,061,378			80,556	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 11,177,126			$ 731,126	9
	B. Non-Facility Related*											
10	Interest Income										(19,128)	10
11	Allocated from Legacy HC Financial		X								27	11
12	Allocated from CF St Louis		X								3,919	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (15,182)	14
15	TOTALS (line 9+line14)						$	$ 11,177,126			$ 715,944	15

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

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

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

Facility Name & ID Number Grove Of Lagrange Park # 0053884 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Description		Amount	Line
1. Real Estate Tax accrual used on 2017 report.	$	307,219	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.)	$	288,577	2
3. Under or (over) accrual (line 2 minus line 1).	$	(18,642)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	293,393	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.	$	274,751	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		Amount	Line
	2013	247,456	8
	2014	264,044	9
	2015	268,157	10
	2016	298,270	11
	2017	284,847	12

2018 Accrual - $284,847 x 1.02 = $290,523 (Rounded)

*Beginning Accrual Adjusted

Allocated CF St Louis = $3,730

	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 Lagrange Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053884

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.	15-33-128-010-0000	Long Term Care Property	$ 114,241.91	$ 114,241.91
2.	15-33-128-011-0000	Long Term Care Property	$ 170,605.17	$ 170,605.17
3.	10-23-406-034-0000	Home Office Allocation	$ 492,481.94	$ 3,729.78
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 777,329.02	$ 288,576.86

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 Lagrange Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053884

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.

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	43,000	2015	$ 750,000	1
2	Allocated from CF St. Louis			4,923	2
3	TOTALS			$ 754,923	3

Facility Name & ID Number Grove Of Lagrange Park # 0053884 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	131		2015	1975	$ 3,282,000	$ 84,154	39	$ 84,154	$ (0)	$ 606,610	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2009	327,624		20	32,762	32,762	327,624	9
10	Various			2010	115,636		20	11,564	11,564	104,073	10
11	Various			2011	157,995		20	15,800	15,800	126,396	11
12	Various			2012	37,487		20	3,749	3,749	26,241	12
13	Various			2013	344,818		20	34,482	34,482	206,891	13
14	Various			2014	132,299		20	13,230	13,230	66,150	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Grove Of Lagrange Park # 0053884 Report Period Beginning: 01/01/18 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)		195,095			9,187	9,187	27,350	68
69	Financial Statement Depreciation			133,331			(133,331)		69
70	TOTAL (lines 4 thru 69)		$ 4,592,955	$ 217,485		$ 204,927	$ (12,558)	$ 1,491,334	70

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

Facility Name & ID Number Grove Of Lagrange Park # 0053884 Report Period Beginning: 01/01/18 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		$ 4,592,955	$ 217,485		$ 204,927	$ (12,558)	$ 1,491,334	1
2	Hvac Repair	2017	2,655		20	310	310	620	2
3	Flooring In Common Areas	2017	55,646		20	8,347	8,347	16,694	3
4	Roam Alert System	2017	12,000		20	1,600	1,600	3,200	4
5	Wall Sconces For 1St Floor	2017	5,438		20	272	272	544	5
6	New Vinyl, Drywall, And Tiles In Resident Rooms	2017	33,781		20	1,689	1,689	3,378	6
7	3 Pole 100 Amp Circuit Breaker For Elevator	2017	2,942		20	147	147	294	7
8	New Kitchen Flooring	2017	7,600		20	380	380	760	8
9	Electrical Work 1St Floor Rooms	2017	3,500		20	175	175	350	9
10	Repaired Boiler	2017	12,668		20	633	633	1,267	10
11	Bathroom - Tiling And Walls/Drywall	2017	3,355		20	168	168	336	11
12	6" Wilkins Double Detector For Sprinkler	2017	7,298		20	365	365	730	12
13	2Nd/3Rd Flr Bathrooms-New Door Knobs, Installation Of New Mir	2018	3,841		20	346	346	346	13
14	Pipe Insulation, Lever Handle Passage Locks	2018	3,394		20	306	306	306	14
15	Fence/Sign Installation,Fixed Light Pole,Fire Rated Damper	2018	4,026		20	254	254	254	15
16	Lower Level Door Controls	2018	5,739		20	886	886	886	16
17	Boiler Installation	2018	2,699		20	202	202	202	17
18	3Rd Flr - Intall New Sheet Metal Panels On P-Tac	2018	2,916		20	263	263	263	18
19	Conference Rm-Flooring,Baseboards,Painting,Mirrors	2018	26,102		20	1,305	1,305	1,305	19
20	Roof Repair - Wooden Soffit,Facia Boards,Paint,Light Fixture Bulb	2018	2,638		20	132	132	132	20
21	Install New Piping, Repair 2" Elbow Leaking - Domestic Water Boi	2018	6,294		20	315	315	315	21
22	2 Garage Heaters - Replace Motor And Blade ($2,612)	2018	2,417		20	121	121	121	22
23	Domestic Hot Water Heater Replacements	2018	15,624		20	781	781	781	23
24	Oversight Of Installation Of Door Graphics/Cabinets - 1St Flr/Base	2018	7,709		20	385	385	385	24
25	Mirror Installation	2018	2,928		20	146	146	146	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,826,165	$ 217,485		$ 224,455	$ 6,970	$ 1,524,949	34

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

Facility Name & ID Number Grove Of Lagrange Park # 0053884 Report Period Beginning: 01/01/18 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		$ 4,826,165	$ 217,485		$ 224,455	$ 6,970	$ 1,524,949	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)		$ 4,826,165	$ 217,485		$ 224,455	$ 6,970	$ 1,524,949	34

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

Facility Name & ID Number Grove Of Lagrange Park # 0053884 Report Period Beginning: 01/01/18 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		$ 4,826,165	$ 217,485		$ 224,455	$ 6,970	$ 1,524,949	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		$ 4,826,165	$ 217,485		$ 224,455	$ 6,970	$ 1,524,949	34

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

Facility Name & ID Number Grove Of Lagrange Park # 0053884 Report Period Beginning: 01/01/18 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		$ 4,826,165	$ 217,485		$ 224,455	$ 6,970	$ 1,524,949	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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16									16
17									17
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19									19
20									20
21									21
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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)		$ 4,826,165	$ 217,485		$ 224,455	$ 6,970	$ 1,524,949	34

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

Facility Name & ID Number Grove Of Lagrange Park # 0053884 Report Period Beginning: 01/01/18 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 Lagrange Park # 0053884 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
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number **Grove Of Lagrange Park** # **0053884** Report Period Beginning: **01/01/18** 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	26,507		35	757	757	2,272	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	164,572		20	8,229	8,229	24,686	9
10	Allocated from CF St. Louis, LLC	2017	3,820		20	191	191	382	10
11									11
12									12
13	Allocated from Legacy HC	2018	196		20	10	10	10	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)		$ 195,095	$		$ 9,187	$ 9,187	$ 27,350	34

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

Facility Name & ID Number Grove Of Lagrange Park # 0053884 Report Period Beginning: 01/01/18 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		$ 195,095	$		$ 9,187	$ 9,187	$ 27,350	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 195,095	$		$ 9,187	$ 9,187	$ 27,350	34

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

Facility Name & ID Number Grove Of Lagrange Park # 0053884 Report Period Beginning: 01/01/18 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	$ 826,068	$	$ 82,562	$ 82,562	10	$ 564,010	71
72	Current Year Purchases	13,453		1,148	1,148	10	1,148	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 839,520	$	$ 83,710	$ 83,710		$ 565,158	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,420,609	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 217,485	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 308,165	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 90,680	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,090,107	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	CIP	$ 19,751	92
93			93
94			94
95		$ 19,751	95

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

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

Facility Name & ID Number Grove Of Lagrange Park # 0053884 Report Period Beginning: 01/01/18 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 HC Financial				126			5
6								6
7	TOTAL				$ 126 **			7

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

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

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

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

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

16. Rental Amount for movable equipment: $ 4,972 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Toyota Corolla	$ 222.00	$ 4,895	17
18	Allocated Legacy HC Financial			3,115	18
19					19
20					20
21	TOTAL		$ 222.00	$ 8,010	21

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

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

Facility Name & ID Number Grove Of Lagrange Park # 0053884 Report Period Beginning: 01/01/18 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 Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 238,121	$		$ 238,121	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			161,313			161,313	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			267,289			267,289	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				196,198		196,198	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					39,858	113,736		153,594	13
14	TOTAL			$		$ 706,581	$ 309,934		$ 1,016,515	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.

Facility Name & ID Number Grove Of Lagrange Park # 0053884 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	$	$ 3,101	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,527,519	1,527,519	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,941	29,941	6
7	Other Prepaid Expenses	11,294	28,042	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	313,509	681,344	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,882,263	$ 2,269,947	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		750,000	13
14	Buildings, at Historical Cost		3,282,000	14
15	Leasehold Improvements, at Historical Cost	611,704	611,704	15
16	Equipment, at Historical Cost	371,087	371,087	16
17	Accumulated Depreciation (book methods)	(279,771)	(886,380)	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	972,597	4,990,892	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,675,617	$ 9,119,303	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,557,880	$ 11,389,250	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 265,027	$ 267,478	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,061,378	1,061,378	29
30	Accrued Salaries Payable	223,805	223,805	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,542	7,542	31
32	Accrued Real Estate Taxes(Sch.IX-B)		293,393	32
33	Accrued Interest Payable		56,003	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	196,599	222,867	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,754,351	$ 2,132,466	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,115,748	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	1,475,152	676,080	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,475,152	$ 10,791,828	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,229,503	$ 12,924,294	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 328,377	$ (1,535,044)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,557,880	$ 11,389,250	48

*(See instructions.)

Facility Name & ID Number Grove Of Lagrange Park # 0053884 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**	$ 434,801	1
2	Restatements (describe):		2
3	Prior Year Depreciation	(93,211)	3
4	Prior Year Bad Debt	(121,126)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 220,464	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	107,913	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)**	$ 107,913	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)**	$ 328,377	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	$ 12,091,162	1
2	Discounts and Allowances for all Levels	(4,985,763)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,105,399	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,618,509	6
7	Oxygen	61	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,618,570	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	201,787	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	34,946	19
20	Radiology and X-Ray		20
21	Other Medical Services	11,826	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 248,559	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	19,128	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 19,128	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	18,581	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 18,581	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,010,237	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,407,890	31
32	Health Care	3,325,047	32
33	General Administration	1,838,707	33
	B. Capital Expense		
34	Ownership	1,531,788	34
	C. Ancillary Expense		
35	Special Cost Centers	1,515,077	35
36	Provider Participation Fee	283,815	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,902,324	40
41	**Income before Income Taxes (line 30 minus line 40)****	107,913	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 107,913	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,545,610	44
45	Private Pay - Net Inpatient Revenue	394,860	45
46	Medicare - Net Inpatient Revenue	550,046	46
47	Other-(specify) Insurance	78,063	47
48	Other-(specify) Veterans	536,820	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,105,399	49

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,032	2,080	$ 104,912	$ 50.44	1
2	Assistant Director of Nursing	1,872	2,140	89,073	41.62	2
3	Registered Nurses	19,602	24,122	821,411	34.05	3
4	Licensed Practical Nurses	27,286	29,125	814,625	27.97	4
5	CNAs & Orderlies	51,310	55,224	844,408	15.29	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,936	5,836	156,234	26.77	8
9	Activity Director	2,008	2,096	38,120	18.19	9
10	Activity Assistants	6,538	7,195	87,043	12.10	10
11	Social Service Workers	6,521	7,168	149,971	20.92	11
12	Dietician					12
13	Food Service Supervisor	1,976	2,210	54,867	24.83	13
14	Head Cook	5,183	5,467	87,614	16.03	14
15	Cook Helpers/Assistants	12,943	14,368	174,911	12.17	15
16	Dishwashers					16
17	Maintenance Workers	3,968	4,220	103,522	24.53	17
18	Housekeepers	13,261	14,930	181,015	12.12	18
19	Laundry	2,899	3,478	54,045	15.54	19
20	Administrator	1,840	2,088	135,575	64.93	20
21	Assistant Administrator	1,960	2,120	54,676	25.79	21
22	Other Administrative					22
23	Office Manager	1,760	1,944	24,187	12.44	23
24	Clerical	4,568	5,015	82,748	16.50	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,992	2,080	39,666	19.07	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	174,455	192,906	$ 4,098,623 *	$ 21.25	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	59,199	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	9,172	10-03	38
39	Pharmacist Consultant	Monthly	10,771	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,816	11-03	44
45	Social Service Consultant	55	3,360	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	55	$ 85,318		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	128	3,205	10-03	52
53	TOTAL (lines 50 - 52)	128	$ 3,205		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Marie H. Derzsy	Administrator	0	$ 135,575
Jennifer LaBella	Assistant Admin	0	54,676
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 190,251

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
Paycor	Payroll Service	$ 5,304
Compliance Resources Inc.	Compliance Audit	169
See Attached	Legal Fees	125,894
Marcum LLP	Accounting Fees	28,677
Achieve Accreditation	Accreditation Services	2,820
IIT/Sourcetech	Data Processing	1,690
Integra Scripts LLC	Pharmacy Mgmt Services	500
MTS Consulting	Tax Consultant	4,039
Prospect Resources	Energy Procurement	2,000
Personnel Planners	Unemployment Consultant	2,044
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 173,137

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 102,978
Unemployment Compensation Insurance	46,879
FICA Taxes	306,419
Employee Health Insurance	206,126
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	27,270
Employee Benefits	8,310
401K Expense	6,387
Voluntary Benefit Contribution	2,863
Employee Physical Exams	12,859
TOTAL (agree to Schedule V, line 22, col.8)	$ 720,091

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	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed 145)	1,453
Patient Background Checks 180	1,798
Dues & Subscriptions	20,432
Licenses & Permits	7,962
Allocated from Legacy HC Financial	504
Allocated from CF St Louis	1
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 34,140

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	160
Allocated from Legacy HC Financial	2,413
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,573

**See instructions.

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 - $19,755, IHCA - $9,617**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **29,927** 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. $ **283,815**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

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

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

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

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