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: 0053835

Facility Name: Grove Of Skokie

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 11/6/2015

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

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

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 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	98	Skilled (SNF)	98	35,770	1
2		Skilled Pediatric (SNF/PED)			2
3	51	Intermediate (ICF)	51	18,615	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	149	TOTALS	149	54,385	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	28,802	1,235	3,986	34,023	8
9	SNF/PED					9
10	ICF	16,039	517	411	16,967	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,841	1,752	4,397	50,990	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.76%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 9/1/2008

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 98 and days of care provided 3,986

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Grove Of Skokie # 0053835 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	480,995	30,728	16,814	528,537		528,537	1,001	529,538			1
2	Food Purchase		364,695		364,695		364,695	(9,504)	355,191			2
3	Housekeeping	182,404	53,395	1,395	237,194		237,194	1,573	238,767			3
4	Laundry	43,837	21,577		65,414		65,414	10	65,424			4
5	Heat and Other Utilities			106,023	106,023		106,023	(6,938)	99,085			5
6	Maintenance	109,282	23,385	133,194	265,861		265,861	7,166	273,027			6
7	Other (specify):*											7
8	**TOTAL General Services**	816,518	493,780	257,426	1,567,724		1,567,724	(6,692)	1,561,032			8
	B. Health Care and Programs											
9	Medical Director			63,732	63,732		63,732		63,732			9
10	Nursing and Medical Records	2,959,786	65,897	27,837	3,053,520		3,053,520	61,491	3,115,011			10
10a	Therapy	186,045			186,045		186,045		186,045			10a
11	Activities	199,031	12,992	832	212,855		212,855	62	212,917			11
12	Social Services	215,355		1,264	216,619		216,619	3,894	220,513			12
13	CNA Training											13
14	Program Transportation			15,860	15,860		15,860		15,860			14
15	Other (specify):*							7,173	7,173			15
16	**TOTAL Health Care and Programs**	3,560,217	78,889	109,525	3,748,631		3,748,631	72,621	3,821,252			16
	C. General Administration											
17	Administrative	95,079			95,079		95,079	82,829	177,908			17
18	Directors Fees											18
19	Professional Services			88,684	88,684	(2,500)	86,184	(15,963)	70,221			19
20	Dues, Fees, Subscriptions & Promotions			90,624	90,624		90,624	(50,308)	40,316			20
21	Clerical & General Office Expenses	110,359	5,847	355,597	471,803		471,803	75,014	546,817			21
22	Employee Benefits & Payroll Taxes			720,160	720,160		720,160		720,160			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,682	3,682		3,682	2,744	6,426			24
25	Other Admin. Staff Transportation			499	499		499		499			25
26	Insurance-Prop.Liab.Malpractice			164,469	164,469		164,469	5,023	169,492			26
27	Other (specify):*							52,489	52,489			27
28	**TOTAL General Administration**	205,438	5,847	1,423,715	1,635,000	(2,500)	1,632,500	151,827	1,784,327			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,582,173	578,516	1,790,666	6,951,355	(2,500)	6,948,855	217,756	7,166,611			29

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

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

Facility Name & ID Number Grove Of Skokie #0053835 Report Period Beginning: 01/01/18 Ending: 12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			51,209	51,209		51,209	961,090	1,012,299			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							846,325	846,325			32
33	Real Estate Taxes			474,996	474,996	2,500	477,496	4,242	481,738			33
34	Rent-Facility & Grounds			1,369,058	1,369,058		1,369,058	(1,368,914)	144			34
35	Rent-Equipment & Vehicles			9,801	9,801		9,801	3,744	13,545			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,905,064	1,905,064	2,500	1,907,564	446,487	2,354,051			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		228,872	701,555	930,427		930,427		930,427			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			362,066	362,066		362,066		362,066			42
43	Other (specify):*			548,310	548,310		548,310	(548,310)				43
44	**TOTAL Special Cost Centers**		228,872	1,611,931	1,840,803		1,840,803	(548,310)	1,292,493			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,582,173	807,388	5,307,661	10,697,222		10,697,222	115,934	10,813,156			45

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

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(7,874)	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	961,090	30		9
10	Interest and Other Investment Income	(36,276)	32		10
11	Discounts, Allowances, Rebates & Refunds	(9,396)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(125)	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	(410)	21		18
19	Entertainment				19
20	Contributions	(10,500)	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	(226,023)	21		24
25	Fund Raising, Advertising and Promotional	(31,674)	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	(861,819)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (223,007)		$	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)	338,941		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 338,941		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 115,934		37

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

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

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

Grove Of Skokie

ID# 0053835

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Personal Items	$ (1,965)	10	1
2	Meals & Entertainment	(3,059)	21	2
3	Bank Charges	(442)	21	3
4	Sequestration Expense	(41,894)	21	4
5	PAC Dues	(7,997)	20	5
6	Non-allowable Legal	(23,994)	19	6
7	Additional R&M	1,588	06	7
8	Capitalized R&M	(2,900)	06	8
9	Non-allowable Expenses	(548,310)	43	9
10	Entertainment Expenses	(711)	20	10
11	Bldg Co - Bank Fees	(5)	21	11
12	Bldg Co - Title Fees	(2,118)	21	12
13	Bldg Co - Legal	(8,610)	19	13
14	Bldg Co - Accounting	(3,839)	19	14
15	Bldg Co - Loan	(45,980)	19	15
16	Bldg Co - Property Management Fees	(170,718)	17	16
17	Pharmacy Discounts	(866)	10	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**	(861,819)		49

Grove Of Skokie

ID# 0053835

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 Skokie # 0053835 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			1,001									1,001	1
2	Food Purchase	(9,521)		17									(9,504)	2
3	Housekeeping			1,573									1,573	3
4	Laundry			10									10	4
5	Heat and Other Utilities	(7,874)				936							(6,938)	5
6	Maintenance	(1,312)		7,855		1,260	(636)						7,166	6
7	Other (specify):*													7
8	**TOTAL General Services**	(18,707)		10,456		2,195	(636)						(6,692)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,831)		64,455					(133)				61,491	10
10a	Therapy													10a
11	Activities			62									62	11
12	Social Services			3,894									3,894	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				7,173								7,173	15
16	**TOTAL Health Care and Programs**	(2,831)		68,412	7,173				(133)				72,621	16
	C. General Administration													
17	Administrative	(170,718)	170,718	82,829									82,829	17
18	Directors Fees													18
19	Professional Services	(82,423)	58,429	10,070		39		(2,078)					(15,963)	19
20	Fees, Subscriptions & Promotions	(50,882)		573		1							(50,308)	20
21	Clerical & General Office Expenses	(273,951)	2,123	346,534		308							75,014	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			2,744									2,744	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			4,662		361							5,023	26
27	Other (specify):*			52,489									52,489	27
28	**TOTAL General Administration**	(577,973)	231,270	499,900		709		(2,078)					151,827	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(599,511)	231,270	578,768	7,173	2,904	(636)	(2,078)	(133)				217,756	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Grove Of Skokie # 0053835 **Report Period Beginning:** 01/01/18 **Ending:** 12/31/18

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	961,090											961,090	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(36,276)	878,113	30		4,457							846,325	32
33	Real Estate Taxes					4,242							4,242	33
34	Rent-Facility & Grounds		(1,369,058)	38,686		(38,542)							(1,368,914)	34
35	Rent-Equipment & Vehicles				3,744								3,744	35
36	Other (specify):*													36
37	**TOTAL Ownership**	924,814	(490,945)	38,716	3,744	(29,842)							446,487	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):*	(548,310)											(548,310)	43
44	**TOTAL Special Cost Centers**	(548,310)											(548,310)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(223,007)	(259,675)	617,484	10,917	(26,938)	(636)	(2,078)	(133)				115,934	45

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,369,058	Grove HC Properties		$	$ (1,369,058)	1
2	V	21	Bank Fees		Grove HC Properties		5	5	2
3	V	21	Title Fees		Grove HC Properties		2,118	2,118	3
4	V	19	Professional Fees - Legal		Grove HC Properties		8,610	8,610	4
5	V	19	Professional Fees - Accounting		Grove HC Properties		3,839	3,839	5
6	V	19	Professional Fees - Loan		Grove HC Properties		45,980	45,980	6
7	V	17	Property Management Fees		Grove HC Properties		170,718	170,718	7
8	V	32	Interest Expense - Mortgage A		Grove HC Properties		878,113	878,113	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,369,058			$ 1,109,383	$ * (259,675)	14

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

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 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		$ 943	$ 943	15
16	V	01	DIETARY SUPPLIES		Legacy Healthcare Financial Services		58	58	16
17	V	02	FOOD		Legacy Healthcare Financial Services		17	17	17
18	V	03	HOUSEKEEPING		Legacy Healthcare Financial Services		1,573	1,573	18
19	V	04	LINEN REPLACEMENT		Legacy Healthcare Financial Services		10	10	19
20	V	06	MAINTENANCE SALARY		Legacy Healthcare Financial Services		6,689	6,689	20
21	V	06	REPAIRS AND MAINTENANCE		Legacy Healthcare Financial Services		1,166	1,166	21
22	V	10	NURSING SALARY		Legacy Healthcare Financial Services		61,851	61,851	22
23	V	10	NURSE CONSULTANT		Legacy Healthcare Financial Services		2,533	2,533	23
24	V	10	MEDICAL SUPPLIES		Legacy Healthcare Financial Services		71	71	24
25	V	12	SOCIAL SERVICE SALARY		Legacy Healthcare Financial Services		3,872	3,872	25
26	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services		62	62	26
27	V	12	SOCIAL SERVICE CONSULTANT		Legacy Healthcare Financial Services		23	23	27
28	V	17	CFO/ADMINISTRATIVE SALARY		Legacy Healthcare Financial Services		82,829	82,829	28
29	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services		10,070	10,070	29
30	V	20	DUES/LICENSE/PERMITS		Legacy Healthcare Financial Services		573	573	30
31	V	21	CLERICAL AND GENERAL WAGES		Legacy Healthcare Financial Services		336,792	336,792	31
32	V	21	CLERICAL AND OFFICE EXPENSE		Legacy Healthcare Financial Services		9,741	9,741	32
33	V	24	EDUCATION AND SEMINARS		Legacy Healthcare Financial Services		2,744	2,744	33
34	V	26	INSURANCE- GENERAL		Legacy Healthcare Financial Services		4,662	4,662	34
35	V	27	NON-NURSING PAYROLL TAXES/BENEFITS		Legacy Healthcare Financial Services		52,489	52,489	35
36	V	32	INTEREST		Legacy Healthcare Financial Services		30	30	36
37	V	34	RENT		Legacy Healthcare Financial Services		38,542	38,542	37
38	V	34	OFFSITE STORAGE/PARKING		Legacy Healthcare Financial Services		144	144	38
39	Total			$			$ 617,484	$ * 617,484	39

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

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services		201	$ 201	15
16	V	35	AUTO RENTAL		Legacy Healthcare Financial Services		3,543	3,543	16
17	V	15	NURSING PAYROLL TAXES/BENEFITS		Legacy Healthcare Financial Services		7,173	7,173	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			$			$ 10,917	$ * 10,917	39

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

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 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		$ 936	$ 936	15
16	V	6	REPAIRS & MAINTENANCE		CF St. Louis LLC		1,260	1,260	16
17	V	19	PROFESSIONAL FEES		CF St. Louis LLC		39	39	17
18	V	20	DUES & SUBSCRIPTIONS		CF St. Louis LLC		1	1	18
19	V	21	OFFICE EXPENSE		CF St. Louis LLC		308	308	19
20	V	26	INSURANCE		CF St. Louis LLC		361	361	20
21	V	32	INTEREST EXPENSE		CF St. Louis LLC		4,457	4,457	21
22	V	33	REAL ESTATE TAXES		CF St. Louis LLC		4,242	4,242	22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	38,542	CF St. Louis LLC			(38,542)	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			$ 38,542			$ 11,604	$ * (26,938)	39

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

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance	$ 8,550	ML Group Design and Development		$ 7,914	$ (636)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 8,550			$ 7,914	$ * (636)	39

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

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	$ 7,937	ProPay		$ 5,859	$ (2,078)	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			$ 7,937			$ 5,859	$ * (2,078)	39

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

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Medical Supplies	$ 4,602	ReMed Services		$ 4,469	$ (133)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,602			$ 4,469	$ * (133)	39

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

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Grove Of Skokie # 0053835 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 HC PROPERTIES	SKOKIE	BUILDING CO	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			LAGRANGE SKILLED NURSING FACILITY LLC	LAGRANGE PARK				18
19			LAKEFRONT SKILLED NURSING FACILITY LLC	CHICAGO				19
20			LINCOLN PARK SKILLED NURSING FACILITY LLC	CHICAGO				20
21			LINCOLNSHIRE LIVING & REHAB CENTER LLC	LINCOLNSHIRE				21
22			NORTHBROOK SKILLED NURSING FACILITY LLC	NORTHBROOK				22
23			PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO				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 Skokie # 0053835 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 Skokie # 0053835 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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$		13

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

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

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Legacy Healthcare Financial Services
Street Address: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 679-9797
Fax Number: (847) 683-2900

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETICIAN SALARY	AVAIL. BED DAYS	1,918,919	34	$ 33,257	$ 33,257	54,385	$ 943	1
2	01	DIETARY SUPPLIES	AVAIL. BED DAYS	1,918,919	34	2,031		54,385	58	2
3	02	FOOD	AVAIL. BED DAYS	1,918,919	34	595		54,385	17	3
4	03	HOUSEKEEPING	AVAIL. BED DAYS	1,918,919	34	55,512		54,385	1,573	4
5	04	LINEN REPLACEMENT	AVAIL. BED DAYS	1,918,919	34	343		54,385	10	5
6	06	MAINTENANCE SALARY	AVAIL. BED DAYS	1,918,919	34	235,999	235,999	54,385	6,689	6
7	06	REPAIRS AND MAINTENANCE	AVAIL. BED DAYS	1,918,919	34	41,154		54,385	1,166	7
8	10	NURSING SALARY	AVAIL. BED DAYS	1,918,919	34	2,182,345	2,182,345	54,385	61,851	8
9	10	NURSE CONSULTANT	AVAIL. BED DAYS	1,918,919	34	89,384		54,385	2,533	9
10	10	MEDICAL SUPPLIES	AVAIL. BED DAYS	1,918,919	34	2,503		54,385	71	10
11	12	SOCIAL SERVICE SALARY	AVAIL. BED DAYS	1,918,919	34	136,611	136,611	54,385	3,872	11
12	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,918,919	34	2,204		54,385	62	12
13	12	SOCIAL SERVICE CONSULTAN	AVAIL. BED DAYS	1,918,919	34	800		54,385	23	13
14	17	CFO/ADMINISTRATIVE SALAR	AVAIL. BED DAYS	1,918,919	34	2,922,553	2,922,553	54,385	82,829	14
15	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,918,919	34	355,302		54,385	10,070	15
16	20	DUES/LICENSE/PERMITS	AVAIL. BED DAYS	1,918,919	34	20,207		54,385	573	16
17	21	CLERICAL AND GENERAL WA	AVAIL. BED DAYS	1,918,919	34	11,883,371	11,883,371	54,385	336,792	17
18	21	CLERICAL AND OFFICE EXPEI	AVAIL. BED DAYS	1,918,919	34	343,715		54,385	9,741	18
19	24	EDUCATION AND SEMINARS	AVAIL. BED DAYS	1,918,919	34	96,819		54,385	2,744	19
20	26	INSURANCE- GENERAL	AVAIL. BED DAYS	1,918,919	34	164,496		54,385	4,662	20
21	27	NON-NURSING PAYROLL TAXI	AVAIL. BED DAYS	1,918,919	34	1,852,008		54,385	52,489	21
22	32	INTEREST	AVAIL. BED DAYS	1,918,919	34	1,074		54,385	30	22
23	34	RENT	AVAIL. BED DAYS	1,918,919	34	1,359,900		54,385	38,542	23
24	34	OFFSITE STORAGE/PARKING	AVAIL. BED DAYS	1,918,919	34	5,072		54,385	144	24
25	TOTALS					$ 21,787,253	$ 17,394,136		$ 617,484	25

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Legacy Healthcare Financial Services
Street Address: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 679-9797
Fax Number: (847) 683-2900

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,918,919	34	7,088		54,385	201	1
2	35	AUTO RENTAL	AVAIL. BED DAYS	1,918,919	34	125,028		54,385	3,543	2
3	15	NURSING PAYROLL TAXES/BE	AVAIL. BED DAYS	1,918,919	34	253,092		54,385	7,173	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	$		$ 10,917	25

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: CF St. Louis LLC
Street Address: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 676-5300
Fax Number: (847) 676-5348

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. BED DAYS	1,916,917	34	$ 32,982	$	54,385	$ 936	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,916,917	34	44,396		54,385	1,260	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,916,917	34	1,378		54,385	39	3
4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,916,917	34	23		54,385	1	4
5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,916,917	34	10,860		54,385	308	5
6	26	INSURANCE	AVAIL. BED DAYS	1,916,917	34	12,721		54,385	361	6
7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,916,917	34	157,106		54,385	4,457	7
8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,916,917	34	149,528		54,385	4,242	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	$		$ 11,604	25

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Grove Of Skokie # 0053835 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				$	$		$ 5,859	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					$	$		$ 5,859	25

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Medical Supplies	Direct			$	$		$ 4,469	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					$	$		$ 4,469	25

Facility Name & ID Number Grove Of Skokie # 0053835 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 Skokie # 0053835 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 Skokie # 0053835 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 Skokie # 0053835 Report Period Beginning: 01/01/18 Ending: 12/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	The Private Bank		X	Mortgage			$	$ 13,713,098			$ 878,113	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 13,713,098			$ 878,113	9
	B. Non-Facility Related*											
10	Interest Income		X								(36,276)	10
11	Allocated from Legacy HC Financial		X								30	11
12	Allocated from CF St. Louis, LLC		X								4,457	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (31,789)	14
15	TOTALS (line 9+line14)						$	$ 13,713,098			$ 846,325	15

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

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

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

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 465,676	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.)		$ 513,300	2
3. Under or (over) accrual (line 2 minus line 1).		$ 47,624	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 431,615	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 2,500	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.		$ 481,739	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2013		8
2014	396,320	9
2015	405,789	10
2016	452,113	11
2017	509,057	12

2018 Accruals = $509,057 x 0.85 = $431,615
Allocated from CF. St. Louis, LLC $4,242
Beginning accrual adjusted

	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 Skokie COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053835

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.	10-16-411-017-0000	Long Term Care Property	$ 406,130.48	$ 406,130.48
2.	10-16-411-018-0000	Long Term Care Property	$ 102,926.92	$ 102,926.92
3.	10-23-406-034-0000	Home Office Allocation	$ 492,481.94	$ 4,242.27
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,001,539.34	$ 513,299.67

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.

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 Skokie COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053835

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Allocated from CF St. Louis			$ 5,599	1
2	Facility			830,000	2
3	TOTALS			$ 835,599	3

Facility Name & ID Number Grove Of Skokie # 0053835 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	149		2015	1976	$ 16,829,101	$	35	$ 480,831	$ 480,831	$ 1,923,326	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2009	826,392		20	41,320	41,320	413,196	9
10	Various			2010	18,355		20	918	918	8,260	10
11	Various			2011	38,602		20	1,930	1,930	15,441	11
12	Various			2012	24,021		20	1,201	1,201	8,407	12
13	Various			2013	504,886		20	25,244	25,244	151,466	13
14	Various			2014	168,871		20	8,444	8,444	42,218	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 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)		76,478			3,824	3,824	45,243	67
68	Related Party Allocations (Pages 12H & 12I)		221,902			10,449	10,449	31,108	68
69	Financial Statement Depreciation			51,209			(51,209)		69
70	TOTAL (lines 4 thru 69)		$ 18,708,607	$ 51,209		$ 574,161	$ 522,952	$ 2,638,664	70

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

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 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		$ 18,708,607	$ 51,209		$ 574,161	$ 522,952	$ 2,638,664	1
2	Power Receptacles Throughout The Facility	2015	4,846		20	242	242	969	2
3	110 Lighting Units Throughout The Facility	2015	5,228		20	261	261	1,046	3
4	Concrete Work Outside Patio	2015	2,675		20	134	134	535	4
5	Replace Kitchen Exhaust Fan Motor, Capacitor, Belt,	2015	2,690		20	135	135	538	5
6	Replace 2 Water Meters In Boiler Room	2015			20				6
7	Install Autolock On Dining Room Door, Replace Fire Door In	2015	3,575		20	179	179	715	7
8	Kitch, And Seal Fireplace Gas Pipe	2015			20				8
9	Architecture Fees	2015	18,048		20	902	902	3,610	9
10	Repair Heating Pipe Leak In Kitchen, Service Boiler	2015	2,789		20	139	139	558	10
11	Carpet Installation In Office	2017	5,115		20	256	256	512	11
12	Install New Piping For Commercial Boiler	2017	15,964		20	333	333	665	12
13	Walk-In Cooler (Kitchen) Repair	2017	2,750		20	46	46	92	13
14	Elevator Repair	2017	3,794		20	95	95	190	14
15	Repair Leaking Heating Line In Mechanical Room	2017	7,846		20	262	262	523	15
16	Air Handler Repairs	2017	3,018		20	503	503	1,006	16
17	Replacement Of Both Bearings On Air Handler Unit	2017	4,347		20	725	725	1,449	17
18	Replaced Condensing Unit For Walk In Freezer, Rewire Controls	2017	4,050		20	540	540	1,080	18
19	Repaired 2Nd Floor Nursing Station	2017	2,500		20	125	125	250	19
20	Installed New Exhaust Fan	2017	3,500		20	175	175	350	20
21	Repaired Storage Tank And Circulation Pump	2017	8,145		20	407	407	815	21
22	Installed Mount Speaker And Amps	2017	4,376		20	219	219	438	22
23	Repair Leak On Chiller Pipe	2017	5,365		20	268	268	537	23
24	Insulation Boards (8,282)	2018	7,666		20	828	828	828	24
25	Insulation Kits (3,795)	2018	3,513		20	316	316	316	25
26	Faucet Exchange (3,950)	2018	3,656		20	329	329	329	26
27	Unit Heaters (11,000)	2018	10,182		20	2,200	2,200	2,200	27
28	Copper Tubing (6,220)	2018	5,757		20	622	622	622	28
29	Replaced Leaking Hot Water Heating Piping (21,757)	2018	20,138		20	1,007	1,007	1,007	29
30	Insulation Of Replacement Piping Above Driveway Ceiling (4,818)	2018	4,460		20	223	223	223	30
31	Repair Leaking Heating Piping And Rear Boiler (10,112)	2018	9,360		20	468	468	468	31
32	Repair Leaking Piping And Installed Compensators On Chilled / H	2018	14,156		20	708	708	708	32
33	Pipes And Tiles Repairs, And Rebuilt Outdoor Support Structure F	2018	3,888		20	194	194	194	33
34	TOTAL (lines 1 thru 33)		$ 18,902,004	$ 51,209		$ 587,001	$ 535,792	$ 2,661,434	34

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

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 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		$ 18,902,004	$ 51,209		$ 587,001	$ 535,792	$ 2,661,434	1
2	Patch & Paint Rehab And Elevator Rooms, Kitchen Area, And Part	2018	5,183		20	259	259	259	2
3	Building Heating And Chilled Water Furnishings And Installations	2018	215,109		20	10,755	10,755	10,755	3
4	Water Supply Installation (4,485)	2018	4,151		20	208	208	208	4
5	Parking Lot Ceiling Pipe Leaks Repair (3,328)	2018	3,080		20	154	154	154	5
6	New Temperature Controller (2,900)	2018	2,684		20	134	134	145	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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 19,132,212	$ 51,209		$ 598,511	$ 547,302	$ 2,672,955	34

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

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 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		$ 19,132,212	$ 51,209		$ 598,511	$ 547,302	$ 2,672,955	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 19,132,212	$ 51,209		$ 598,511	$ 547,302	$ 2,672,955	34

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

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 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		$ 19,132,212	$ 51,209		$ 598,511	$ 547,302	$ 2,672,955	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 19,132,212	$ 51,209		$ 598,511	$ 547,302	$ 2,672,955	34

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

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 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	Allocated from Grove HC Properties	2008	60,573		20	3,029	3,029	35,108	9
10	Allocated from Grove HC Properties	2010	15,905		20	795	795	10,135	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 76,478	$		$ 3,824	$ 3,824	$ 45,243	34

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

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 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		$ 76,478	$		$ 3,824	$ 3,824	$ 45,243	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 76,478	$		$ 3,824	$	$ 45,243	34

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

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 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	30,149		35	861	861	2,584	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	187,184		20	9,359	9,359	28,078	9
10	Allocated from CF St. Louis, LLC	2017	4,345		20	217	217	434	10
11									11
12									12
13	Allocated from Legacy HC	2018	223		20	11	11	11	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)		$ 221,902	$		$ 10,449	$ 10,449	$ 31,108	34

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

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 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		$ 221,902	$		$ 10,449	$ 10,449	$ 31,108	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 221,902	$		$ 10,449	$ 10,449	$ 31,108	34

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

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 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	$ 4,117,559	$	$ 406,434	$ 406,434	10	$ 1,699,334	71
72	Current Year Purchases	71,268		7,354	7,354	10	7,354	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 4,188,827	$	$ 413,788	$ 413,788		$ 1,706,688	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)	$ 24,156,638	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 51,209	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 1,012,299	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 961,090	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,379,643	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	$ 945	92
93			93
94			94
95		$ 945	95

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

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

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 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				144			5
6								6
7	TOTAL				$ 144 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

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

16. Rental Amount for movable equipment: $ 6,388 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Toyota	$ 249.00	$ 3,614	17
18	Allocated from Legacy HC Financial			3,543	18
19					19
20					20
21	TOTAL		$ 249.00	$ 7,157	21

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

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

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 268,582	$		$ 268,582	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			108,743			108,743	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			285,171			285,171	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				122,194		122,194	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					39,059	106,678		145,737	13
14	TOTAL			$		$ 701,555	$ 228,872		$ 930,427	14

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

STATE OF ILLINOIS

Facility Name & ID Number Grove Of Skokie # 0053835 Report Period Beginning: 01/01/18 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	$ 589	$ 4,450	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,098,149	2,591,127	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(12,722)	(12,722)	6
7	Other Prepaid Expenses	12,832	159,609	7
8	Accounts Receivable (owners or related parties)		123,500	8
9	Other(specify): See Attached Schedule	86,016	86,016	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,184,864	$ 2,951,980	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		938,650	13
14	Buildings, at Historical Cost	2,138	8,301,875	14
15	Leasehold Improvements, at Historical Cost	437,975	1,901,278	15
16	Equipment, at Historical Cost	190,380	1,594,838	16
17	Accumulated Depreciation (book methods)	(93,942)	(1,364,577)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	1,174,823	2,544,948	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,711,374	$ 13,917,012	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,896,238	$ 16,868,992	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 755,349	$ 755,350	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	277,148	277,148	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,730	9,730	31
32	Accrued Real Estate Taxes(Sch.IX-B)		431,615	32
33	Accrued Interest Payable		75,591	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	97,584	97,584	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,139,811	$ 1,647,018	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,713,098	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	1,697,212	1,697,212	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,697,212	$ 15,410,310	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,837,023	$ 17,057,328	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,059,215	$ (188,336)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,896,238	$ 16,868,992	48

*(See instructions.)

Facility Name & ID Number Grove Of Skokie # 0053835 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**	$ 779,971	1	
2	Restatements (describe):		2	
3	**Prior Year Depreciation**	(27,881)	3	
4	**Prior Year Bank Charges**	(15,752)	4	
5	**Prior Year R&M**	(1,392)	5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 734,946	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	324,269	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)**	$ 324,269	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)**	$ 1,059,215	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	$ 15,746,189	1
2	Discounts and Allowances for all Levels	(7,597,190)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,148,999	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,654,892	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,654,892	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	132,374	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,154	19
20	Radiology and X-Ray		20
21	Other Medical Services	8,237	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 157,765	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	36,276	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 36,276	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	23,559	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 23,559	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,021,491	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,567,724	31
32	Health Care	3,748,631	32
33	General Administration	1,635,000	33
	B. Capital Expense		
34	Ownership	1,905,064	34
	C. Ancillary Expense		
35	Special Cost Centers	1,478,737	35
36	Provider Participation Fee	362,066	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,697,222	40
41	**Income before Income Taxes (line 30 minus line 40)****	324,269	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 324,269	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,881,853	44
45	Private Pay - Net Inpatient Revenue	251,840	45
46	Medicare - Net Inpatient Revenue	20,217	46
47	Other-(specify) Insurance Contractual Adjustments	(4,911)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,148,999	49

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,880	2,080	$ 139,935	$ 67.28	1
2	Assistant Director of Nursing	1,920	2,080	88,347	42.47	2
3	Registered Nurses	24,839	27,339	933,646	34.15	3
4	Licensed Practical Nurses	20,070	21,853	618,295	28.29	4
5	CNAs & Orderlies	79,185	84,764	1,179,563	13.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,721	8,517	186,045	21.84	8
9	Activity Director	1,848	2,085	58,875	28.24	9
10	Activity Assistants	10,143	10,961	140,156	12.79	10
11	Social Service Workers	8,079	8,651	215,355	24.89	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,160	43,768	20.26	13
14	Head Cook	10,918	12,158	184,952	15.21	14
15	Cook Helpers/Assistants	18,229	19,690	252,275	12.81	15
16	Dishwashers					16
17	Maintenance Workers	5,965	6,429	109,282	17.00	17
18	Housekeepers	14,384	15,566	182,404	11.72	18
19	Laundry	3,154	3,706	43,837	11.83	19
20	Administrator	1,976	2,176	95,079	43.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,491	7,092	110,359	15.56	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	218,802	237,307	$ 4,582,173 *	$ 19.31	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	358	$ 16,814	01-03	35
36	Medical Director	Monthly	63,732	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	13,691	10-03	38
39	Pharmacist Consultant	Monthly	14,146	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	832	11-03	44
45	Social Service Consultant	21	1,264	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	378	$ 110,479		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rehman, Hina	Administrator	0	$ 42,938
Simpson, Katherine	Administrator	0	52,141
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 95,079

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See attached	Legal Fees	$ 46,766
Marcum LLP	Accounting Fees	24,608
PRoPay HR	Payroll Processing	7,937
Achieve Accreditation LLC	Joint Commission Consult	2,153
Adam Zollinger Interiors	Interior Design	1,501
Telemedicine Solutions LLC	Software solutions	256
IIT/Sourcetech	Data Processing	1,914
Integra Scripts LLC	Pharma Management Services	500
MTS Consulting	Tax Consulting	910
Partner Engineering & Science	Engineering/Environmental Con	500
Personnel Planners	Unemployment Tax Consult	840
See Supplemental Schedule		800
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 88,685

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 71,642
Unemployment Compensation Insurance	31,106
FICA Taxes	344,767
Employee Health Insurance	180,053
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	43,688
Employee Benefits	16,242
401K Expense	14,861
Voluntary Benefit Contributions	3,120
Employee Physical Exams	14,681
TOTAL (agree to Schedule V, line 22, col.8)	$ 720,160

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	$ 1,769
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 148.6)	1,486
Patient Background Checks 272.2	2,722
Dues and Subscriptions	24,304
Licenses and Permits	9,461
Allocated from Legacy HC Financial	573
Allocated from CF St. Louis, LLC	1
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 40,315

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,682
Allocated from Legacy HC Financial	2,744
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,426

**See instructions.

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI - $12,784.20; IHCA - $5,036.20**

(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. $ **38,021** 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. $ **362,066**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

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

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

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

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