

Facility Name & ID Number Grove At The Lake Living And Rehabilitation

0053926 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	244	Skilled (SNF)	244	89,060	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	244	TOTALS	244	89,060	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	50,898	3,139	6,511	60,548	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	50,898	3,139	6,511	60,548	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.99%

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 10/10/1982

J. Was the facility purchased or leased after January 1, 1978?

YES Date 10/10/1982 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 244 and days of care provided 5,002

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES 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 At The Lake Living And Rehabilitation # 0053926 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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	417,450	35,135	18,492	471,077		471,077	1,544	472,621		1
2	Food Purchase		390,029		390,029		390,029	(18,627)	371,402		2
3	Housekeeping	267,987	62,199	2,531	332,717		332,717	2,429	335,146		3
4	Laundry	90,805	29,674		120,479		120,479	15	120,494		4
5	Heat and Other Utilities			221,093	221,093		221,093	(13,798)	207,295		5
6	Maintenance	196,968	30,020	182,667	409,655		409,655	15,211	424,866		6
7	Other (specify):*										7
8	TOTAL General Services	973,210	547,057	424,783	1,945,050		1,945,050	(13,226)	1,931,824		8
	B. Health Care and Programs										
9	Medical Director			37,008	37,008		37,008		37,008		9
10	Nursing and Medical Records	3,637,814	163,897	30,660	3,832,371		3,832,371	87,902	3,920,273		10
10a	Therapy	207,924	2,340		210,264		210,264		210,264		10a
11	Activities	257,547	14,032	5,025	276,604		276,604	96	276,700		11
12	Social Services	234,166		19,432	253,598		253,598	6,012	259,610		12
13	CNA Training										13
14	Program Transportation			16,745	16,745		16,745		16,745		14
15	Other (specify):*							11,072	11,072		15
16	TOTAL Health Care and Programs	4,337,451	180,269	108,870	4,626,590		4,626,590	105,083	4,731,673		16
	C. General Administration										
17	Administrative	163,955			163,955		163,955	127,858	291,813		17
18	Directors Fees										18
19	Professional Services			161,034	161,034	(5,542)	155,492	(8,030)	147,462		19
20	Dues, Fees, Subscriptions & Promotions			149,563	149,563		149,563	(104,728)	44,835		20
21	Clerical & General Office Expenses	219,353	5,312	423,348	648,013		648,013	211,254	859,267		21
22	Employee Benefits & Payroll Taxes			1,102,194	1,102,194		1,102,194	(9,665)	1,092,529		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,805	3,805		3,805	4,236	8,041		24
25	Other Admin. Staff Transportation			72	72		72		72		25
26	Insurance-Prop.Liab.Malpractice			260,235	260,235		260,235	7,754	267,989		26
27	Other (specify):*							81,023	81,023		27
28	TOTAL General Administration	383,308	5,312	2,100,251	2,488,871	(5,542)	2,483,329	309,701	2,793,030		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,693,969	732,638	2,633,904	9,060,511	(5,542)	9,054,969	401,558	9,456,527		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 At The Lake Living And Rehabilitation

#0053926

Report Period Beginning:

01/01/18

Ending:

12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			114,686	114,686		114,686	494,729	609,415			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			25,117	25,117		25,117	1,071,443	1,096,560			32
33	Real Estate Taxes			386,691	386,691	5,542	392,233	14,891	407,124			33
34	Rent-Facility & Grounds			1,706,741	1,706,741		1,706,741	(1,701,496)	5,245			34
35	Rent-Equipment & Vehicles			11,539	11,539		11,539	5,780	17,319			35
36	Other (specify):*											36
37	TOTAL Ownership			2,244,774	2,244,774	5,542	2,250,316	(114,652)	2,135,664			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	319,033	517,999	971,815	1,808,847		1,808,847		1,808,847			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			503,641	503,641		503,641		503,641			42
43	Other (specify):*			745,895	745,895		745,895	(745,895)				43
44	TOTAL Special Cost Centers	319,033	517,999	2,221,351	3,058,383		3,058,383	(745,895)	2,312,488			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,013,002	1,250,637	7,100,029	14,363,668		14,363,668	(458,989)	13,904,679			45

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

Grove At The Lake Living And RehabilitationID# 0053926Report Period Beginning: 01/01/18Ending: 12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Patient Personal Items	\$ (4,967)	10	1
2	Bank Charges	(682)	21	2
3	Sequestration Expense	(69,510)	21	3
4	Pharmacy Discounts	(6,398)	10	4
5	Miscellaneous Income	(1,271)	21	5
6	Non-Allowable Expense	(745,895)	43	6
7	Building Co. - Title Fees	(4,440)	20	7
8	Building Co. - Accounting Fees	(2,799)	19	8
9	Building Co. - Legal Fees	(10,649)	19	9
10	Building Co. - Loan Fees	(56,871)	21	10
11	Building Co. - Property Management Fees	(233,071)	21	11
12	Building Co. - Filing Fees	(75)	21	12
13	Additional R&M	1,588	06	13
14	PAC Dues	(17,529)	20	14
15	Non-Allowable Legal	(21,653)	19	15
16	Executive Insurance	(9,665)	22	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,183,887)		49

Grove At The Lake Living And Rehabilitation

Report Period Beginning: ID# 0053926
 Ending: 01/01/18
 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 At The Lake Living And Rehabilitation# 0053926

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			1,544									1,544	1
2	Food Purchase	(18,653)		26									(18,627)	2
3	Housekeeping			2,429									2,429	3
4	Laundry			15									15	4
5	Heat and Other Utilities	(15,242)				1,444							(13,798)	5
6	Maintenance	1,588		12,125		1,944		(446)					15,211	6
7	Other (specify):*													7
8	TOTAL General Services	(32,307)		16,139		3,389		(446)					(13,226)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(11,365)		99,494			(227)						87,902	10
10a	Therapy													10a
11	Activities			96									96	11
12	Social Services			6,012									6,012	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				11,072								11,072	15
16	TOTAL Health Care and Programs	(11,365)		105,602	11,072		(227)						105,083	16
	C. General Administration													
17	Administrative			127,858									127,858	17
18	Directors Fees													18
19	Professional Services	(35,101)	13,448	15,544		60			(1,981)				(8,030)	19
20	Fees, Subscriptions & Promotions	(110,053)	4,440	884		1							(104,728)	20
21	Clerical & General Office Expenses	(614,156)	290,017	534,918		476							211,254	21
22	Employee Benefits & Payroll Taxes	(9,665)											(9,665)	22
23	Inservice Training & Education													23
24	Travel and Seminar			4,236									4,236	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			7,196		557							7,754	26
27	Other (specify):*			81,023									81,023	27
28	TOTAL General Administration	(768,975)	307,905	771,658		1,094			(1,981)				309,701	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(812,647)	307,905	893,399	11,072	4,482	(227)	(446)	(1,981)				401,558	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Grove At The Lake Living And Rehabilitation # 0053926 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	77,215	417,514										494,729	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(27,279)	1,091,795	47		6,880							1,071,443	32
33	Real Estate Taxes		8,343			6,548							14,891	33
34	Rent-Facility & Grounds		(1,701,718)	59,716		(59,494)							(1,701,496)	34
35	Rent-Equipment & Vehicles				5,780								5,780	35
36	Other (specify):*													36
37	TOTAL Ownership	49,936	(184,066)	59,763	5,780	(46,065)							(114,652)	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):*	(745,895)											(745,895)	43
44	TOTAL Special Cost Centers	(745,895)											(745,895)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,508,606)	123,839	953,162	16,852	(41,583)	(227)	(446)	(1,981)				(458,989)	45

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. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rental Income	\$ 1,701,718	Grove at the Lake Realty		\$	\$ (1,701,718)	1
2	V	21 Filing Fees		Grove at the Lake Realty		75	75	2
3	V	20 Title Fees		Grove at the Lake Realty		4,440	4,440	3
4	V	19 Accounting Fees		Grove at the Lake Realty		2,799	2,799	4
5	V	19 Legal Fees		Grove at the Lake Realty		10,649	10,649	5
6	V	21 Loan Fees		Grove at the Lake Realty		56,871	56,871	6
7	V	21 Property Management Fees		Grove at the Lake Realty		233,071	233,071	7
8	V	32 Interest Expense		Grove at the Lake Realty		1,091,795	1,091,795	8
9	V	33 Real Estate Taxes		Grove at the Lake Realty		8,343	8,343	9
10	V	30 Depreciation		Grove at the Lake Realty		417,514	417,514	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,701,718			\$ 1,825,557	\$ * 123,839	14

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

Facility Name & ID Number Grove At The Lake Living And Rehabilitation

0053926

Report Period Beginning: 01/01/18

Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	01	DIETICIAN SALARY	\$	Legacy Healthcare Financial Services		\$ 1,455	\$ 1,455	15
16	V	01	DIETARY SUPPLIES		Legacy Healthcare Financial Services		89	89	16
17	V	02	FOOD		Legacy Healthcare Financial Services		26	26	17
18	V	03	HOUSEKEEPING		Legacy Healthcare Financial Services		2,429	2,429	18
19	V	04	LINEN REPLACEMENT		Legacy Healthcare Financial Services		15	15	19
20	V	06	MAINTENANCE SALARY		Legacy Healthcare Financial Services		10,325	10,325	20
21	V	06	REPAIRS AND MAINTENANCE		Legacy Healthcare Financial Services		1,800	1,800	21
22	V	10	NURSING SALARY		Legacy Healthcare Financial Services		95,475	95,475	22
23	V	10	NURSE CONSULTANT		Legacy Healthcare Financial Services		3,910	3,910	23
24	V	10	MEDICAL SUPPLIES		Legacy Healthcare Financial Services		109	109	24
25	V	12	SOCIAL SERVICE SALARY		Legacy Healthcare Financial Services		5,977	5,977	25
26	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services		96	96	26
27	V	12	SOCIAL SERVICE CONSULTANT		Legacy Healthcare Financial Services		35	35	27
28	V	17	CFO/ADMINISTRATIVE SALARY		Legacy Healthcare Financial Services		127,858	127,858	28
29	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services		15,544	15,544	29
30	V	20	DUES/LICENSE/PERMITS		Legacy Healthcare Financial Services		884	884	30
31	V	21	CLERICAL AND GENERAL WAGES		Legacy Healthcare Financial Services		519,881	519,881	31
32	V	21	CLERICAL AND OFFICE EXPENSE		Legacy Healthcare Financial Services		15,037	15,037	32
33	V	24	EDUCATION AND SEMINARS		Legacy Healthcare Financial Services		4,236	4,236	33
34	V	26	INSURANCE- GENERAL		Legacy Healthcare Financial Services		7,196	7,196	34
35	V	27	NON-NURSING PAYROLL TAXES/BENEFITS		Legacy Healthcare Financial Services		81,023	81,023	35
36	V	32	INTEREST		Legacy Healthcare Financial Services		47	47	36
37	V	34	RENT		Legacy Healthcare Financial Services		59,494	59,494	37
38	V	34	OFFSITE STORAGE/PARKING		Legacy Healthcare Financial Services		222	222	38
39	Total			\$			\$ 953,162	\$ * 953,162	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	35 EQUIPMENT RENTAL		Legacy Healthcare Financial Services		310	\$	310	15
16	V	35 AUTO RENTAL		Legacy Healthcare Financial Services		5,470		5,470	16
17	V	15 NURSING PAYROLL TAXES/BENEFITS		Legacy Healthcare Financial Services		11,072		11,072	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		\$			\$ 16,852	\$ *	16,852	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	CF St. Louis LLC		\$ 1,444	\$ 1,444
16	V	6 REPAIRS & MAINTENANCE		CF St. Louis LLC		1,944	1,944
17	V	19 PROFESSIONAL FEES		CF St. Louis LLC		60	60
18	V	20 DUES & SUBSCRIPTIONS		CF St. Louis LLC		1	1
19	V	21 OFFICE EXPENSE		CF St. Louis LLC		476	476
20	V	26 INSURANCE		CF St. Louis LLC		557	557
21	V	32 INTEREST EXPENSE		CF St. Louis LLC		6,880	6,880
22	V	33 REAL ESTATE TAXES		CF St. Louis LLC		6,548	6,548
23	V						
24	V						
25	V						
26	V	34 RENT	59,494	CF St. Louis LLC			(59,494)
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 59,494			\$ 17,911	\$ * (41,583)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 Medical Supplies	\$ 7,875	ReMED Services		\$ 7,648	\$ (227)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 7,875			\$ 7,648	\$ * (227)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06 Maintenance	\$ 6,000	ML Group Design and Development		\$ 5,554	\$ (446)	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 6,000			\$ 5,554	\$ * (446)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Payroll Processing	\$ 7,567	ProPay HR LLC		\$ 5,586	\$ (1,981)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 7,567			\$ 5,586	\$ * (1,981)

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

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Grove At The Lake Living And Rehabilitatic # 0053926 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Grove At The Lake Living And Rehabilitation

0053926

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 At The Lake Living And Rehabilitation

0053926

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

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	DIETICIAN SALARY	AVAIL. BED DAYS	1,918,919	34	\$ 33,257	\$ 83,950	\$ 1,455	1
2	01	DIETARY SUPPLIES	AVAIL. BED DAYS	1,918,919	34	2,031	83,950	89	2
3	02	FOOD	AVAIL. BED DAYS	1,918,919	34	595	83,950	26	3
4	03	HOUSEKEEPING	AVAIL. BED DAYS	1,918,919	34	55,512	83,950	2,429	4
5	04	LINEN REPLACEMENT	AVAIL. BED DAYS	1,918,919	34	343	83,950	15	5
6	06	MAINTENANCE SALARY	AVAIL. BED DAYS	1,918,919	34	235,999	83,950	10,325	6
7	06	REPAIRS AND MAINTENANCE	AVAIL. BED DAYS	1,918,919	34	41,154	83,950	1,800	7
8	10	NURSING SALARY	AVAIL. BED DAYS	1,918,919	34	2,182,345	83,950	95,475	8
9	10	NURSE CONSULTANT	AVAIL. BED DAYS	1,918,919	34	89,384	83,950	3,910	9
10	10	MEDICAL SUPPLIES	AVAIL. BED DAYS	1,918,919	34	2,503	83,950	109	10
11	12	SOCIAL SERVICE SALARY	AVAIL. BED DAYS	1,918,919	34	136,611	83,950	5,977	11
12	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,918,919	34	2,204	83,950	96	12
13	12	SOCIAL SERVICE CONSULTANT	AVAIL. BED DAYS	1,918,919	34	800	83,950	35	13
14	17	CFO/ADMINISTRATIVE SALARY	AVAIL. BED DAYS	1,918,919	34	2,922,553	83,950	127,858	14
15	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,918,919	34	355,302	83,950	15,544	15
16	20	DUES/LICENSE/PERMITS	AVAIL. BED DAYS	1,918,919	34	20,207	83,950	884	16
17	21	CLERICAL AND GENERAL WAGES	AVAIL. BED DAYS	1,918,919	34	11,883,371	83,950	519,881	17
18	21	CLERICAL AND OFFICE EXPENSE	AVAIL. BED DAYS	1,918,919	34	343,715	83,950	15,037	18
19	24	EDUCATION AND SEMINARS	AVAIL. BED DAYS	1,918,919	34	96,819	83,950	4,236	19
20	26	INSURANCE- GENERAL	AVAIL. BED DAYS	1,918,919	34	164,496	83,950	7,196	20
21	27	NON-NURSING PAYROLL TAX	AVAIL. BED DAYS	1,918,919	34	1,852,008	83,950	81,023	21
22	32	INTEREST	AVAIL. BED DAYS	1,918,919	34	1,074	83,950	47	22
23	34	RENT	AVAIL. BED DAYS	1,918,919	34	1,359,900	83,950	59,494	23
24	34	OFFSITE STORAGE/PARKING	AVAIL. BED DAYS	1,918,919	34	5,072	83,950	222	24
25	TOTALS					\$ 21,787,253	\$ 17,394,136	\$ 953,162	25

Facility Name & ID Number Grove At The Lake Living And Rehabilitation

0053926

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

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,918,919	34	7,088	83,950	310	1
2	35	AUTO RENTAL	AVAIL. BED DAYS	1,918,919	34	125,028	83,950	5,470	2
3	15	NURSING PAYROLL TAXES/BE	AVAIL. BED DAYS	1,918,919	34	253,092	83,950	11,072	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	\$		\$ 16,852	25

Facility Name & ID Number Grove At The Lake Living And Rehabilitation

0053926

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

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. BED DAYS	1,916,917	34	\$ 32,982	\$ 83,950	\$ 1,444	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,916,917	34	44,396	83,950	1,944	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,916,917	34	1,378	83,950	60	3
4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,916,917	34	23	83,950	1	4
5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,916,917	34	10,860	83,950	476	5
6	26	INSURANCE	AVAIL. BED DAYS	1,916,917	34	12,721	83,950	557	6
7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,916,917	34	157,106	83,950	6,880	7
8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,916,917	34	149,528	83,950	6,548	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	\$	\$ 17,911	25

Facility Name & ID Number Grove At The Lake Living And Rehabilitation

0053926

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

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

()

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	Medical Supplies	Direct		\$	\$		\$ 7,648	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				\$	\$		\$ 7,648	25

Facility Name & ID Number Grove At The Lake Living And Rehabilitation

0053926

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

ML Group Design and Development

Street Address

3424 Oakton Street

City / State / Zip Code

Skokie, IL

Phone Number

(847) 676-5300

Fax Number

()

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Direct		\$	\$		5,554	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				\$	\$		5,554	25

Facility Name & ID Number Grove At The Lake Living And Rehabilitation

0053926

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

Name of Related Organization

ProPay HR

Street Address

2201 Maint Street

City / State / Zip Code

Evanston, IL 60202

Phone Number

(847) 905-3268

Fax Number

()

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct		\$	\$		5,586	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				\$	\$		5,586	25

Facility Name & ID Number Grove At The Lake Living And Rehabilitation

0053926

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 At The Lake Living And Rehabilitation

0053926

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 At The Lake Living And Rehabilitation

0053926

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	The Private Bank		X	Mortgage			\$	16,954,746		\$	1,091,795	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	The Private Bank		X	Line of Credit				45,553			25,117	6								
7												7								
8												8								
9	TOTAL Facility Related						\$	17,000,299		\$	1,116,912	9								
B. Non-Facility Related*																				
10	Interest Income		X								(27,279)	10								
11	Allocated from Legacy HC		X								47	11								
12	Allocated from CF St. Louis		X								6,880	12								
13												13								
14	TOTAL Non-Facility Related						\$			\$	(20,352)	14								
15	TOTALS (line 9+line14)						\$	17,000,299		\$	1,096,560	15								

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

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

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

Facility Name & ID Number Grove At The Lake Living And Rehabilitation# 0053926

Report Period Beginning:

01/01/18

Ending:

12/31/18**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2017 report.		\$	<u>367,086</u>	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.)		\$	<u>381,977</u>	2		
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>14,891</u>	3		
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>386,692</u>	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.)		\$	<u>5,542</u>	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.		\$	<u>407,125</u>	7		
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2013	<u>366,143</u>	8			
	2014	<u>327,196</u>	9			
	2015	<u>382,995</u>	10			
	2016	<u>356,394</u>	11			
	2017	<u>375,429</u>	12			
2018 Accrual - \$375,429 x 0.997 = \$374,457 (Rounded)						
*Beginning Accrual Adjusted						
Allocated from CF St. Louis LLC: \$6,548						
				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 At The Lake Living And Rehabilitation COUNTY Lake
 FACILITY IDPH LICENSE NUMBER 0053926
 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) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
1.	<u>04-22-301-007</u>	<u>Long Term Care Property</u>	\$ <u>361,198.14</u>	\$ <u>361,198.14</u>
2.	<u>04-22-301-009</u>	<u>Long Term Care Property</u>	\$ <u>14,230.40</u>	\$ <u>14,230.40</u>
3.	<u>See Attached</u>	<u>Home Office Allocation</u>	\$ <u>492,481.94</u>	\$ <u>6,548.47</u>
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u><u>867,910.48</u></u>	\$ <u><u>381,977.01</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2017 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

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

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Grove At The Lake Living And Rehabilitation COUNTY Lake
 FACILITY IDPH LICENSE NUMBER 0053926
 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) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 83,793 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

C. Does the Operating Entity? (a) Own the Facility (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (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 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>50,091</u>	<u>1990</u>	<u>\$ 28,460</u>	<u>1</u>
2	<u>Allocated from CF St. Louis</u>			<u>8,643</u>	<u>2</u>
3	TOTALS			\$ 37,103	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	244	1990	1975	\$ 5,384,307	\$ 417,514	39	\$ 138,059	\$ (279,455)	\$ 1,278,618	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1980	5,655		20			5,655	9
10	Various		1981	13,906		20			13,906	10
11	Various		1982	1,171		20			1,171	11
12	Various		1983	17,000		20			17,000	12
13	Various		1984	36,737		20			36,737	13
14	Various		1985	135,882		20			135,882	14
15	Various		1986	63,852		20			63,852	15
16	Various		1987	60,439		20			60,439	16
17	Various		1988	24,257		20			24,257	17
18	Various		1989	102,083		20			102,083	18
19	Various		1990	84,998		20			84,998	19
20	Various		1991	10,496		20			10,496	20
21	Various		1992	18,109		20			18,109	21
22	Various		1993	39,981		20			39,981	22
23	Various		1994	123,996		20	70	70	122,744	23
24	Various		1995	157,007		20			157,007	24
25	Various		1996	210,423		20			210,423	25
26	Various		1997	97,938		20			97,938	26
27	Various		1998	76,538		20	3,827	3,827	76,538	27
28	Various		1999	232,757		20	11,638	11,638	221,405	28
29	Various		2000	88,771		20	4,439	4,439	79,894	29
30	Various		2001	147,900		20	7,395	7,395	122,515	30
31	Various		2002	156,984		20	7,849	7,849	125,588	31
32	Various		2003	473,434		20	23,672	23,672	353,881	32
33	Various		2004	276,659		20	13,833	13,833	193,661	33
34	Various		2005	89,356		20	4,468	4,468	58,081	34
35	Various		2006	90,306		20	4,515	4,515	54,183	35
36	Various		2007	115,795		20	5,790	5,790	63,687	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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Various	2008	\$ 117,156	\$	20	\$ 5,858	\$ 5,858	\$ 58,578	37
38	Various	2009	186,177		20	9,309	9,309	83,780	38
39	Various	2010	425,373		20	21,269	21,269	170,149	39
40	Various	2011	172,439		20	8,622	8,622	60,354	40
41	Various	2012	39,393		20	1,970	1,970	11,818	41
42	Various	2013	313,912		20	15,696	15,696	78,478	42
43	Various	2014	152,332		20	7,617	7,617	30,466	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)		2,192,019			109,602	109,602	761,588	67
68	Related Party Allocations (Pages 12H & 12I)		342,533			16,129	16,129	48,018	68
69	Financial Statement Depreciation			114,686			(114,686)		69
70	TOTAL (lines 4 thru 69)		\$ 12,278,071	\$ 532,200		\$ 421,624	\$ (110,576)	\$ 5,133,959	70

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

Facility Name & ID Number Grove At The Lake Living And Rehabilitation

0053926

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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 12,278,071	\$ 532,200		\$ 421,624	\$ (110,576)	\$ 5,133,959	1
2	Interior Pain & Wallpaper - Penthouse Hallway	2017	3,489		20	174	174	349	2
3	Flooring, Vinyl Base And Planks	2017	3,518		20	147	147	294	3
4	Installation Of Wireless Vent Alarm System	2017	29,760		20	3,968	3,968	7,936	4
5	Replacing Condensing Unit	2017	2,904		20	73	73	146	5
6	Penthouse Ac Unit Repair	2017	15,203		20	1,520	1,520	3,040	6
7	Repaired Condensing Unit For Penthouse Unit	2017	22,313		20	2,231	2,231	4,462	7
8	Flooring, Cove Base	2017	4,771		20	875	875	1,750	8
9	Replaced Valves On Cooling System	2017	3,155		20	79	79	158	9
10	Heat Pump In Dialysis Room	2017	10,897		20	363	363	726	10
11	Repaired Fire Alarm System	2017	4,914		20	125	125	250	11
12	5Th Floor Air Handler	2017	4,788		20	958	958	1,916	12
13	Repaired Sprinkler System On 9Th Floor	2017	3,370		20	618	618	1,236	13
14	Wall Box Water Only, Water Valves	2017	5,822		20	1,067	1,067	2,134	14
15	Mini Split Ac System In Elevator Room	2017	7,288		20	850	850	1,700	15
16	Flooring In Dialysis Unit	2017	4,724		20	236	236	472	16
17	Piston Pump	2017	2,664		20	533	533	1,066	17
18	Hot Water Heater In Kitchen	2017	13,999		20	2,566	2,566	5,132	18
19	Cubicle Curtains	2017	2,642		20	440	440	880	19
20	Sink Pipe Insulation, Door Knob Replacement, Door Frames,Fauce	2018	3,610		20	260	260	260	20
21	Lever Passage Locksets For Doors	2018	6,266		20	967	967	967	21
22	Hot Water Mixing Valve Replacement	2018	3,193		20	240	240	240	22
23	Domestic Hot Water Tank	2018	8,640		20	864	864	864	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)		\$ 12,446,002	\$ 532,200		\$ 440,779	\$ (91,421)	\$ 5,169,937	34

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

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		\$ 12,446,002	\$ 532,200		\$ 440,779	\$ (91,421)	\$ 5,169,937	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)		\$ 12,446,002	\$ 532,200		\$ 440,779	\$ (91,421)	\$ 5,169,937	34

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

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		\$ 12,446,002	\$ 532,200		\$ 440,779	\$ (91,421)	\$ 5,169,937	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)		\$ 12,446,002	\$ 532,200		\$ 440,779	\$ (91,421)	\$ 5,169,937	34

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

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		\$ 12,446,002	\$ 532,200		\$ 440,779	\$ (91,421)	\$ 5,169,937	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)		\$ 12,446,002	\$ 532,200		\$ 440,779	\$ (91,421)	\$ 5,169,937	34

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

Facility Name & ID Number Grove At The Lake Living And Rehabilitation

0053926

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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	4Th Floor Nurse Call System	2012	5,054		20	253	253	1,769	9
10	Framing/Drywall For Nurses Stations	2012	6,000		20	300	300	2,100	10
11	1St Flr Flooring, Masonrv, Doors, Windows, Painting, Electrical	2012	797,114		20	39,856	39,856	278,990	11
12	1St Floor Sas Architect Fees	2012	39,728		20	1,986	1,986	13,905	12
13	Install new framing, drywall, and taping in corridors.	2012	15,375		20	769	769	5,381	13
14	Installation of cable jacks, patching and sanding of sprinkler pipe. N	2012	47,760		20	2,388	2,388	16,716	14
15	Install receptacles for TV in residence bedrooms	2012	6,204		20	310	310	2,172	15
16	Complete installation of Landscape, irrigation system per proposal.	2012	14,500		20	725	725	5,075	16
17	Add additional soffits for nurses stations, patching	2012	9,000		20	450	450	3,150	17
18	Room 313,319,334,405-411-Repair dry wall, new tiles	2012	8,535		20	427	427	2,987	18
19	Remove baseboard and prep for paint, work throughtout guestrooms	2012	45,779		20	2,289	2,289	16,023	19
20	116 VT-Door	2012	31,933		20	1,597	1,597	11,177	20
21	Remove all existing baseboard and prep for paint in guest baths, pr	2012	19,955		20	998	998	6,984	21
22	Complete the framing and installation of drywall for all soffits, rep	2012	30,484		20	1,524	1,524	10,670	22
23	Replace 117 new and four old doors, install seven diving walls, insta	2012	12,658		20	633	633	4,431	23
24	TV plates installed behind the TV's	2012	3,745		20	187	187	1,311	24
25	Provide and install drywall patches and tape due to springler pipe, i	2012	11,830		20	592	592	4,141	25
26	Completed all work throughtout guestrooms, additional drywall and	2012	26,747		20	1,337	1,337	9,361	26
27	Checked existing bx wiring, installed 63 new receptacles	2012	13,058		20	653	653	4,571	27
28	Installed j-box for microwave, steam table outlet, wall light	2012	5,158		20	258	258	1,806	28
29	Install 2 new shrub zones for plantings, electric solenoid valves, shr	2012	3,000		20	150	150	1,050	29
30	Low voltage installations	2012	28,475		20	1,424	1,424	9,966	30
31	81.25 X 59.00 General Suppliers	2012	2,696		20	135	135	943	31
32	Rmored Nurse Station lights; Installed 4 ceiling lights, 1 exit sign, 2	2012	24,185		20	1,209	1,209	8,465	32
33	Triton DVR	2012	14,818		20	741	741	5,187	33
34	TOTAL (lines 1 thru 33)		\$ 1,223,791	\$		\$ 61,191	\$ 61,191	\$ 428,331	34

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

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 1,223,791	\$		\$ 61,191	\$ 61,191	\$ 428,331	1
2	Triton DVR CCTV Sytem with installation and cutover	2012	4,238		20	212	212	1,484	2
3	3rd Floor Corridor & Patient Room-Installed lights, exit signs, sprinkler	2012	12,215		20	611	611	4,275	3
4	3rd & 4th Floor-Framing, drywall & taping; Installed all 2x2 ultima wit	2012	20,000		20	1,000	1,000	7,000	4
5	Building Permit, City of Zion for Interior Remodel- Office Space	2012	8,300		20	415	415	2,905	5
6	Exterior Signage and Lighting	2012	37,709		20	1,885	1,885	13,198	6
7	1st Floor, 2nd Floor, 3rd Floor, and 4th Floor - Fire Sprinklers	2012	211,240		20	10,562	10,562	73,934	7
8	2nd Floor Res Rms, 3rd Floor Rms, Nurse Stations, Bathrooms -								8
9	Removed existing wall tiles, installed new light fixtures, ceramic wall tile								9
10	Removed existing cove base, floor prep, and installed cornices	2012	264,819		20	13,241	13,241	92,687	10
11	Nurse Stations, 2nd-4th Floors Corridors, dining & resid rms, bathrooms								11
12	Light fixtures, floor prep, handrails, wallcoverings, cornices								12
13	cove bases, ceramic tiles, millwork base, and signage	2012	297,229		20	14,861	14,861	104,030	13
14	Therapy Rms, 2nd Flr Rms- new mirror, drop ceilings, sinks, ceiling pan	2012	36,465		20	1,823	1,823	10,940	14
15	3rd Floor dining rms-Removed existing light fixtures and installed 17 ne	2013	6,117		20	306	306	1,835	15
16	3rd Flr Dining area & Rm 231-patching, painting, and installed wallcove	2013	4,230		20	212	212	1,269	16
17	3rd Flr Dining Rm-Installed new 2x2 drop ceilings, sinks, and chair rail	2013	7,625		20	381	381	2,288	17
18	20 loc overhead paging systems	2013	4,747		20	237	237	1,424	18
19	Furnished and installed hot water boiler	2013	14,470		20	724	724	4,341	19
20	Generator repair-Removed and replaced oil filters, cylinder head liners,	2013	28,820		20	1,441	1,441	8,646	20
21	4th Flr Dining Rm-Removed conduit in floor, ceiling fixtures; Installed	2013	4,639		20	232	232	1,392	21
22	Lobby, Laundry Rm and elevators-Installed 4 new receptacles;circuit w	2013	5,365		20	268	268	1,609	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,192,019	\$		\$ 109,602	\$	\$ 761,588	34

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

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	46,539		35	1,330	1,330	3,989	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	288,942		20	14,447	14,447	43,341	9
10	Allocated from CF St. Louis, LLC	2017	6,706		20	335	335	671	10
11									11
12									12
13	Allocated from Legacy HC	2018	345		20	17	17	17	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)		\$ 342,533	\$		\$ 16,129	\$ 16,129	\$ 48,018	34

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

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		\$ 342,533	\$		\$ 16,129	\$ 16,129	\$ 48,018	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)		\$ 342,533	\$		\$ 16,129	\$ 16,129	\$ 48,018	34

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

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	\$ 1,598,407	\$	\$ 161,586	\$ 161,586	10	\$ 1,108,757	71
72	Current Year Purchases	31,627		3,958	3,958	10	3,958	72
73	Fully Depreciated Assets	849,732				10	849,732	73
74								74
75	TOTALS	\$ 2,479,766	\$	\$ 165,544	\$ 165,544		\$ 1,962,447	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		VAN	2008	\$ 15,461	\$	\$ 3,092	\$ 3,092	5	\$ 15,461	76
77										77
78										78
79										79
80	TOTALS			\$ 15,461	\$	\$ 3,092	\$ 3,092		\$ 15,461	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)	\$ 14,978,332	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 532,200	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 609,415	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 77,215	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,147,844	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	LAND - 1994	\$ 199,000	\$	\$	86
87	REMODEL STORAGE ROOM - 1999	4,000			87
88	REMODEL STORAGE RM - 1999	10,000			88
89	REMODEL STORAGE ROOM - 1999	4,300			89
90	DAYCARE CTR ARCHITEC - 2000	787			90
91	TOTALS	\$ 218,087	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$ 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.

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	Storage				5,023			5
6	Allocated from Legacy HC				222			6
7	TOTAL				\$ 5,245			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: \$ 9,185 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	\$ 222.00	\$ 2,664	17
18	Allocated from Legacy HC			5,470	18
19					19
20					20
21	TOTAL		\$ 222.00	\$ 8,134	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 At The Lake Living And Rehabilitation # 0053926 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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost			Units	Cost								
1	Licensed Occupational Therapist	39 - 03	hrs	\$				\$	291,696	\$			\$	291,696	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs						110,494					110,494	2	
3	Licensed Recreational Therapist		hrs												3	
4	Licensed Physical Therapist	39 - 03	hrs						331,682					331,682	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 prescripts							275,967				275,967	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs												10	
11	Academic Education		hrs												11	
12	Other (specify):														12	
13	Other (specify):				319,033				237,943	242,032				799,008	13	
14	TOTAL			\$	319,033			\$	971,815	\$	517,999		\$	1,808,847	14	

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

Facility Name & ID Number Grove At The Lake Living And Rehabilitation

0053926

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	\$	\$ 1,844	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,560,698	2,560,698	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(72,490)	(72,490)	6
7	Other Prepaid Expenses	40,382	255,003	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	159,510	159,797	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,688,100	\$ 2,904,852	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,000,000	13
14	Buildings, at Historical Cost		8,124,904	14
15	Leasehold Improvements, at Historical Cost	230,005	3,028,116	15
16	Equipment, at Historical Cost	502,514	948,779	16
17	Accumulated Depreciation (book methods)	(216,793)	(3,342,410)	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	635,277	1,131,463	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,151,003	\$ 10,890,852	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,839,103	\$ 13,795,704	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 670,441	\$ 670,442	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		1	29
30	Accrued Salaries Payable	377,362	377,362	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,733	11,733	31
32	Accrued Real Estate Taxes(Sch.IX-B)		386,692	32
33	Accrued Interest Payable		93,985	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	242,941	242,941	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,302,477	\$ 1,783,156	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	45,553	45,553	39
40	Mortgage Payable		16,954,746	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	1,124,952	377,130	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,170,505	\$ 17,377,429	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,472,982	\$ 19,160,585	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,366,121	\$ (5,364,881)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,839,103	\$ 13,795,704	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 895,607	1
2	Restatements (describe):		2
3	Prior Year Bad Debt Expense	(82,757)	3
4	Additional Prior Year Bad Debt Expense	(56,683)	4
5	Prior Year Legal/Office Expense	2,324	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 758,491	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	607,630	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)	\$ 607,630	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)	\$ 1,366,121	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Grove At The Lake Living And Rehabilitation

0053926

Report Period Beginning: 01/01/18

Ending: 12/31/18

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

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 19,018,003	1
2	Discounts and Allowances for all Levels	(7,347,259)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,670,744	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,907,277	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,907,277	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	283,309	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	36,180	19
20	Radiology and X-Ray	55	20
21	Other Medical Services	20,334	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 339,878	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	27,279	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 27,279	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	26,120	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 26,120	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,971,298	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,945,050	31
32	Health Care	4,626,590	32
33	General Administration	2,488,871	33
B. Capital Expense			
34	Ownership	2,244,774	34
C. Ancillary Expense			
35	Special Cost Centers	2,554,742	35
36	Provider Participation Fee	503,641	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,363,668	40
41	Income before Income Taxes (line 30 minus line 40)**	607,630	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 607,630	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 9,980,769	44
45	Private Pay - Net Inpatient Revenue	461,915	45
46	Medicare - Net Inpatient Revenue	1,034,904	46
47	Other-(specify) <u>Insurance</u>	193,156	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,670,744	49

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

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

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

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

Facility Name & ID Number Grove At The Lake Living And Rehabilitation

0053926

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,768	1,904	\$ 104,565	\$ 54.92	1
2	Assistant Director of Nursing	1,321	1,345	54,972	40.87	2
3	Registered Nurses	15,354	16,771	571,319	34.07	3
4	Licensed Practical Nurses	47,071	51,505	1,577,751	30.63	4
5	CNAs & Orderlies	80,308	87,003	1,256,595	14.44	5
6	CNA Trainees					6
7	Licensed Therapist	10,114	10,916	319,033	29.23	7
8	Rehab/Therapy Aides	8,449	9,397	207,924	22.13	8
9	Activity Director	3,570	4,202	89,896	21.39	9
10	Activity Assistants	12,482	13,385	167,651	12.53	10
11	Social Service Workers	9,918	10,701	234,166	21.88	11
12	Dietician	1,744	1,824	40,750	22.34	12
13	Food Service Supervisor	2,016	2,080	46,221	22.22	13
14	Head Cook	6,672	7,347	95,272	12.97	14
15	Cook Helpers/Assistants	17,481	19,084	235,207	12.32	15
16	Dishwashers					16
17	Maintenance Workers	8,745	9,700	196,968	20.31	17
18	Housekeepers	20,540	22,308	267,987	12.01	18
19	Laundry	6,011	6,460	90,805	14.06	19
20	Administrator	1,984	2,080	131,310	63.13	20
21	Assistant Administrator	776	800	32,645	40.81	21
22	Other Administrative					22
23	Office Manager	600	711	24,495	34.45	23
24	Clerical	10,405	11,407	194,858	17.08	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,849	2,027	45,079	22.24	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	1,917	2,148	27,533	12.82	33
34	TOTAL (lines 1 - 33)	271,095	295,105	\$ 6,013,002 *	\$ 20.38	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 18,492	01-03	35
36	Medical Director	Monthly	37,008	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	13,174	10-03	38
39	Pharmacist Consultant	Monthly	17,486	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	5,025	11-03	44
45	Social Service Consultant	Monthly	6,047	12-03	45
46	Other(specify)				46
47	<u>Consultant - Psychiatric</u>	Monthly	13,385	12-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 110,617		49

C. CONTRACT NURSES

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

Facility Name & ID Number Grove At The Lake Living And Rehabilitation# 0053926

Report Period Beginning:

01/01/18Ending: 12/31/18**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 - \$35,059
- (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. \$ 54,976 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. \$ 503,641
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 benefit on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ No
- (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