FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0053876

Facility Name: GROVE OF EVANSTON L & R

Address: 500 Asbury Street (Number) Evanston (City) 60202 (Zip Code)

County: Cook

Telephone Number: (847)316-3320 **Fax #** (847)316-3320

HFS ID Number:

Date of Initial License for Current Owners: 7/1/2010

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/17 to 12/31/17 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

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

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	124	Skilled (SNF)	124	45,260	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	124	TOTALS	124	45,260	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	3,693	545	11,453	15,691	8
9	SNF/PED					9
10	ICF	20,131	1,934		22,065	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,824	2,479	11,453	37,756	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.42%

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 07/01/2010

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/2010 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 124 and days of care provided 8,942

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	336,773	22,167		358,940		358,940		358,940			1
2	Food Purchase		238,626		238,626		238,626	(35,857)	202,769			2
3	Housekeeping	161,315	19,431		180,746		180,746	165	180,911			3
4	Laundry	10,930	23,214	125,082	159,226		159,226	4	159,230			4
5	Heat and Other Utilities			130,182	130,182		130,182	(10,157)	120,025			5
6	Maintenance	70,247	15,325	111,845	197,417		197,417	38,101	235,518			6
7	Other (specify):*											7
8	TOTAL General Services	579,265	318,763	367,109	1,265,137		1,265,137	(7,744)	1,257,393			8
	B. Health Care and Programs											
9	Medical Director			46,770	46,770		46,770	506	47,276			9
10	Nursing and Medical Records	2,602,473	93,873	79,587	2,775,933		2,775,933	80,275	2,856,208			10
10a	Therapy	123,338	8,950		132,288		132,288	(25,767)	106,521			10a
11	Activities	111,069	4,198	2,016	117,283		117,283	3,845	121,128			11
12	Social Services	166,653		2,144	168,797		168,797	1,381	170,178			12
13	CNA Training											13
14	Program Transportation			60,252	60,252		60,252		60,252			14
15	Other (specify):*							13,194	13,194			15
16	TOTAL Health Care and Programs	3,003,533	107,021	190,769	3,301,323		3,301,323	73,432	3,374,755			16
	C. General Administration											
17	Administrative	120,874			120,874		120,874	132,199	253,073			17
18	Directors Fees											18
19	Professional Services			126,970	126,970	(177)	126,793	(3,534)	123,259			19
20	Dues, Fees, Subscriptions & Promotions			74,669	74,669		74,669	(31,294)	43,375			20
21	Clerical & General Office Expenses	129,842	3,794	520,218	653,854		653,854	(267,771)	386,083			21
22	Employee Benefits & Payroll Taxes			560,977	560,977		560,977		560,977			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,439	2,439		2,439	1,525	3,964			24
25	Other Admin. Staff Transportation			4,276	4,276		4,276		4,276			25
26	Insurance-Prop.Liab.Malpractice			123,142	123,142		123,142	2,811	125,953			26
27	Other (specify):*							55,331	55,331			27
28	TOTAL General Administration	250,716	3,794	1,412,691	1,667,201	(177)	1,667,024	(110,734)	1,556,290			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,833,514	429,578	1,970,569	6,233,661	(177)	6,233,484	(45,045)	6,188,439			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 EVANSTON L & R #0053876 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation							392,404	392,404			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			64,047	64,047		64,047	914,299	978,346			32
33	Real Estate Taxes			402,000	402,000	177	402,177	3,559	405,736			33
34	Rent-Facility & Grounds			2,032,881	2,032,881		2,032,881	(2,032,166)	715			34
35	Rent-Equipment & Vehicles			10,577	10,577		10,577	3,501	14,078			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,509,505	2,509,505	177	2,509,682	(718,403)	1,791,279			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		491,533	1,373,272	1,864,805		1,864,805		1,864,805			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			232,472	232,472		232,472		232,472			42
43	Other (specify):*			628,961	628,961		628,961	(628,961)				43
44	**TOTAL Special Cost Centers**		491,533	2,234,705	2,726,238		2,726,238	(628,961)	2,097,277			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,833,514	921,111	6,714,779	11,469,404		11,469,404	(1,392,409)	10,076,995			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 EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(11,118)	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	391,766	30		9
10	Interest and Other Investment Income	(7,501)	32		10
11	Discounts, Allowances, Rebates & Refunds	(35,751)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(157)	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	(7,143)	21		18
19	Entertainment	(1,887)	21		19
20	Contributions	(2,500)	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	(284,435)	21		24
25	Fund Raising, Advertising and Promotional	(19,891)	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	(1,288,200)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,266,817)		$	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)	(125,593)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (125,593)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,392,410)		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 EVANSTON L & R

ID# 0053876

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Personal Items	$ (4,241)	10	1
2	Bank Charges	(21,284)	21	2
3	Sequestration	(115,731)	21	3
4	Therapy Discount	(25,767)	10A	4
5	Non Allowable Legal	(13,630)	19	5
6	PAC Dues	(9,718)	20	6
7	Building Co - Tax Extension Fee	(16,500)	19	7
8	Building Co - Filing Fees	(250)	20	8
9	Building Co - Title Fees	(3,627)	20	9
10	Building Co - Accounting	(688)	19	10
11	Building Co - Legal	(11,322)	19	11
12	Building Co - Loan	(60,466)	21	12
13	Building Co - Management Fees	(376,013)	21	13
14	Non Allowable Expense	(628,961)	43	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
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**	(1,288,200)		49

GROVE OF EVANSTON L & R

ID# 0053876

Report Period Beginning: 01/01/17

Ending: 12/31/17

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(35,908)		37	14								(35,857)	2
3	Housekeeping			165									165	3
4	Laundry			4									4	4
5	Heat and Other Utilities	(11,118)				961							(10,157)	5
6	Maintenance			2,225	34,660	1,215							38,101	6
7	Other (specify):*													7
8	**TOTAL General Services**	(47,026)		2,431	34,674	2,176							(7,744)	8
	B. Health Care and Programs													
9	Medical Director			506									506	9
10	Nursing and Medical Records	(4,241)		31	84,899		(414)						80,275	10
10a	Therapy	(25,767)											(25,767)	10a
11	Activities			3,830	15								3,845	11
12	Social Services			60	1,320								1,381	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				13,194								13,194	15
16	**TOTAL Health Care and Programs**	(30,009)		4,428	99,427		(414)						73,432	16
	C. General Administration													
17	Administrative			17,410	114,789								132,199	17
18	Directors Fees													18
19	Professional Services	(42,141)	28,510	11,828	290	242			(2,263)				(3,534)	19
20	Fees, Subscriptions & Promotions	(35,986)	3,877	673	141	2							(31,294)	20
21	Clerical & General Office Expenses	(866,959)	436,479	138,119	24,589	1							(267,771)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			889	636								1,525	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			746	1,816	249							2,811	26
27	Other (specify):*			28,341	26,990								55,331	27
28	**TOTAL General Administration**	(945,086)	468,866	198,005	169,251	493			(2,263)				(110,734)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,022,121)	468,866	204,865	303,352	2,670	(414)		(2,263)				(45,045)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	391,766			638								392,404	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(7,501)	917,443	14		4,343							914,299	32
33	Real Estate Taxes					3,559							3,559	33
34	Rent-Facility & Grounds		(2,032,288)	34,463	49	(34,391)							(2,032,166)	34
35	Rent-Equipment & Vehicles			2,524	977								3,501	35
36	Other (specify):*													36
37	TOTAL Ownership	384,265	(1,114,845)	37,001	1,664	(26,489)							(718,403)	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):*	(628,961)											(628,961)	43
44	TOTAL Special Cost Centers	(628,961)											(628,961)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,266,817)	(645,979)	241,866	305,017	(23,819)	(414)		(2,263)				(1,392,409)	45

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 2,032,288	Grove of Evanston Realty	100.00%	$	$ (2,032,288)	1
2	V	32	Interest	84,471	Grove of Evanston Realty	100.00%	1,001,914	917,443	2
3	V	19	Tax Extension Fee		Grove of Evanston Realty	100.00%	16,500	16,500	3
4	V	20	Filing Fees		Grove of Evanston Realty	100.00%	250	250	4
5	V	20	Title Fees		Grove of Evanston Realty	100.00%	3,627	3,627	5
6	V	19	Accounting Fees		Grove of Evanston Realty	100.00%	688	688	6
7	V	19	Legal Fees		Grove of Evanston Realty	100.00%	11,322	11,322	7
8	V	21	Loan Fees		Grove of Evanston Realty	100.00%	60,466	60,466	8
9	V	21	Property Management Fees		Grove of Evanston Realty	100.00%	376,013	376,013	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,116,759			$ 1,470,780	$ * (645,979)	14

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	FOOD	$	Legacy Healthcare Financial Services	100.00%	$ 37	$ 37	15
16	V	3	HOUSEKEEPING SUPPLIES		Legacy Healthcare Financial Services	100.00%	165	165	16
17	V	4	LINEN REPLACEMENT		Legacy Healthcare Financial Services	100.00%	4	4	17
18	V	6	UTILITIES		Legacy Healthcare Financial Services	100.00%	9	9	18
19	V	6	GROUNDS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	2,216	2,216	19
20	V	9	MEDICAL DIRECTOR CONSULTANT		Legacy Healthcare Financial Services	100.00%	506	506	20
21	V	10	MEDICAL SUPPLIES		Legacy Healthcare Financial Services	100.00%	31	31	21
22	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services	100.00%	3,830	3,830	22
23	V	12	SOCIAL SERVICE CONSULTANT		Legacy Healthcare Financial Services	100.00%	60	60	23
24	V	17	ADMINISTRATIVE SALARY		Legacy Healthcare Financial Services	100.00%	17,410	17,410	24
25	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	11,828	11,828	25
26	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	673	673	26
27	V	21	CLERICAL & GENERAL WAGES		Legacy Healthcare Financial Services	100.00%	134,405	134,405	27
28	V	21	CLERICAL & GENERAL OTHER COSTS		Legacy Healthcare Financial Services	100.00%	3,714	3,714	28
29	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	889	889	29
30	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	746	746	30
31	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	28,341	28,341	31
32	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	14	14	32
33	V	34	RENT		Legacy Healthcare Financial Services	100.00%	34,391	34,391	33
34	V	34	STORAGE		Legacy Healthcare Financial Services	100.00%	72	72	34
35	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services	100.00%	18	18	35
36	V	35	AUTO RENTAL		Legacy Healthcare Financial Services	100.00%	2,506	2,506	36
37	V								37
38	V								38
39	Total			$			$ 241,866	$ * 241,866	39

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	FOOD	$	Progressive Healthcare Consulting	100.00%	$ 14	$ 14	15
16	V	6	MAINTENANCE SALARY		Progressive Healthcare Consulting	100.00%	34,557	34,557	16
17	V	6	BUILDING MAINTENANCE AND R&M		Progressive Healthcare Consulting	100.00%	103	103	17
18	V	10	NURSING SALARIES		Progressive Healthcare Consulting	100.00%	84,899	84,899	18
19	V	11	ACTIVITIES PROGRAM		Progressive Healthcare Consulting	100.00%	15	15	19
20	V	12	CLERGY CONSULTANT		Progressive Healthcare Consulting	100.00%	1,317	1,317	20
21	V	12	SOCIAL SERVICE		Progressive Healthcare Consulting	100.00%	3	3	21
22	V	15	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	13,194	13,194	22
23	V	17	ADMIN SALARY- NON OWNER		Progressive Healthcare Consulting	100.00%	114,789	114,789	23
24	V	19	PROFESSIONAL FEES		Progressive Healthcare Consulting	100.00%	290	290	24
25	V	20	DUES, SUBSCRIPTIONS, LICENSES		Progressive Healthcare Consulting	100.00%	141	141	25
26	V	21	CLERICAL WAGES		Progressive Healthcare Consulting	100.00%	24,329	24,329	26
27	V	21	CLERICAL & GENERAL - OTHER		Progressive Healthcare Consulting	100.00%	259	259	27
28	V	24	SEMINARS		Progressive Healthcare Consulting	100.00%	636	636	28
29	V	27	EMP. BEN.-NON-NURSING		Progressive Healthcare Consulting	100.00%	26,990	26,990	29
30	V	26	INSURANCE		Progressive Healthcare Consulting	100.00%	1,816	1,816	30
31	V	30	DEPRECIATION		Progressive Healthcare Consulting	100.00%	638	638	31
32	V	34	STORAGE RENTAL		Progressive Healthcare Consulting	100.00%	49	49	32
33	V	35	AUTO RENTAL		Progressive Healthcare Consulting	100.00%	977	977	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 305,017	$ * 305,017	39

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	CF ST. LOUIS, LLC	100.00%	$ 961	$ 961	15
16	V	6	REPAIRS & MAINTENANCE		CF ST. LOUIS, LLC	100.00%	1,215	1,215	16
17	V	19	PROFESSIONAL FEES		CF ST. LOUIS, LLC	100.00%	242	242	17
18	V	20	DUES & SUBSCRIPTIONS		CF ST. LOUIS, LLC	100.00%	2	2	18
19	V	21	OFFICE EXPENSE		CF ST. LOUIS, LLC	100.00%	1	1	19
20	V	26	INSURANCE		CF ST. LOUIS, LLC	100.00%	249	249	20
21	V	32	INTEREST EXPENSE		CF ST. LOUIS, LLC	100.00%	4,343	4,343	21
22	V	33	REAL ESTATE TAXES		CF ST. LOUIS, LLC	100.00%	3,559	3,559	22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	34,391	CF ST. LOUIS, LLC	100.00%		(34,391)	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			$ 34,391			$ 10,572	$ * (23,819)	39

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Medical Supplies	$ 10,163	ReMED Services		$ 9,749	$ (414)	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			$ 10,163			$ 9,749	$ * (414)	39

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	$ 9,430	ProPay HR LLC	24.00%	$ 7,167	$ (2,263)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,430			$ 7,167	$ * (2,263)	39

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	GPN Family Trust	50.00%	ASTORIA PLACE SKILLED NURSING FACILITY LLC	CHICAGO	GROVE OF EVANSTON REALTY		BUILDING CO	1
2	Doros Generation Trust	50.00%	AVANTARA LONG GROVE	LONG GROVE	LEGACY HC & FINANCIAL SER	LINCOLNWOOD	HOME OFFICE/BOOKKEEPI	2
3			AVANTARA PARK RIDGE	PARK RIDGE	PROGRESSIVE HC	LINCOLNWOOD	NURSE CONSULTANT	3
4			AZRIA MIDTOWN	OMAHA, NE	ML GROUP DESIGN & DEV	SKOKIE	ASSET MANAGEMENT	4
5			AZRIA MONTCLAIR	OMAHA, NE	REMED SERVICES LLC	LINCOLNWOOD	NURSING EQUIPMENT	5
6			AZRIA OLATHE	OLATHE, KS	AURORA SUPPORTIVE LIVING	AURORA	SUPPORTIVE LIVING	6
7			BETHANY TERRACE	MORTON GROVE	TERRACE GARDENS	MORTON GROVE	ASSISTED LIVING	7
8			CARLTON SKILLED NURSING FACILITY LLC	CHICAGO	LINCOLNSHIRE ASSISTED LIVI	LINCOLNSHIRE	ASSISTED LIVING	8
9			CEDAR SKILLED NURSING FACILITY	CEDAR CITY, UT	CF ST. LOUIS LLC	SKOKIE	BUILDING COMPANY	9
10			CHALET SKILLED NURSING FACILITY LLC	CHICAGO	PROPAY HR	EVANSTON	PAYROLL PROCESSING	10
11			CLARK SKILLED NURSING FACILITY	CHICAGO				11
12			ELMBROOK SKILLED NURSING FACILITY LLC	ELMHURST				12
13			GROVE AT THE LAKE SKILLED NURSING FACILITY LLC	ZION				13
14			GROVE OF FOX VALLEY	AURORA				14
15			LAGRANGE SKILLED NURSING FACILITY LLC	LAGRANGE PARK				15
16			LAKEFRONT SKILLED NURSING FACILITY LLC	CHICAGO				16
17			LINCOLN PARK SKILLED NURSING FACILITY LLC	CHICAGO				17
18			LINCOLNSHIRE LIVING & REHAB CENTER LLC	LINCOLNSHIRE				18
19			NORTHBROOK SKILLED NURSING FACILITY LLC	NORTHBROOK				19
20			PARKER SKILLED NURSING FACILITY LLC	PARKER, CO				20
21			PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO				21
22			SKOKIE SKILLED NURSING FACILITY LLC	SKOKIE				22
23			ST. GEORGE SKILLED NURSING FACILITY	ST. GEORGE, UT				23
24			WARREN BARR LIVING AND REHAB	CHICAGO				24
25			WARREN BARR NORTH SHORE	HIGHLAND PARK				25
26			WARREN BARR SOUTH LOOP	CHICAGO				26
27								27
28								28
29								29
30								30

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	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 EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	FOOD	AVAIL. BED DAYS	1,789,215	30	$ 1,460	$	45,260	$ 37	1
2	3	HOUSEKEEPING SUPPLIES	AVAIL. BED DAYS	1,789,215	30	6,519		45,260	165	2
3	4	LINEN REPLACEMENT	AVAIL. BED DAYS	1,789,215	30	171		45,260	4	3
4	6	UTILITIES	AVAIL. BED DAYS	1,789,215	30	372		45,260	9	4
5	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	1,789,215	30	87,596		45,260	2,216	5
6	9	MEDICAL DIRECTOR CONSU	AVAIL. BED DAYS	1,789,215	30	20,000		45,260	506	6
7	10	MEDICAL SUPPLIES	AVAIL. BED DAYS	1,789,215	30	1,237		45,260	31	7
8	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,789,215	30	151,405		45,260	3,830	8
9	12	SOCIAL SERVICE CONSULTA	AVAIL. BED DAYS	1,789,215	30	2,392		45,260	60	9
10	17	ADMINISTRATIVE SALARY	AVAIL. BED DAYS	1,789,215	30	688,242	688,242	45,260	17,410	10
11	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,789,215	30	467,580		45,260	11,828	11
12	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,789,215	30	26,590		45,260	673	12
13	21	CLERICAL & GENERAL WAG	AVAIL. BED DAYS	1,789,215	30	5,313,296	5,313,296	45,260	134,405	13
14	21	CLERICAL & GENERAL OTH	AVAIL. BED DAYS	1,789,215	30	146,833		45,260	3,714	14
15	24	SEMINARS	AVAIL. BED DAYS	1,789,215	30	35,138		45,260	889	15
16	26	INSURANCE	AVAIL. BED DAYS	1,789,215	30	29,475		45,260	746	16
17	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	1,789,215	30	1,120,380		45,260	28,341	17
18	32	INTEREST	AVAIL. BED DAYS	1,789,215	30	561		45,260	14	18
19	34	RENT	AVAIL. BED DAYS	1,789,215	30	1,359,562		45,260	34,391	19
20	34	STORAGE	AVAIL. BED DAYS	1,789,215	30	2,842		45,260	72	20
21	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,789,215	30	694		45,260	18	21
22	35	AUTO RENTAL	AVAIL. BED DAYS	1,789,215	30	99,069		45,260	2,506	22
23										23
24										24
25	TOTALS					$ 9,561,416	$ 6,001,539		$ 241,866	25

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	FOOD	AVAIL. BED DAYS	1,374,590	21	$ 432	$	45,260	$ 14	1
2	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,374,590	21	1,049,531	1,049,531	45,260	34,557	2
3	6	BUILDING MAINTENANCE AI	AVAIL. BED DAYS	1,374,590	21	3,133		45,260	103	3
4	10	NURSING SALARIES	AVAIL. BED DAYS	1,374,590	21	2,578,462	2,578,462	45,260	84,899	4
5	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,374,590	21	443		45,260	15	5
6	12	CLERGY CONSULTANT	AVAIL. BED DAYS	1,374,590	21	39,998		45,260	1,317	6
7	12	SOCIAL SERVICE	AVAIL. BED DAYS	1,374,590	21	95		45,260	3	7
8	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,374,590	21	400,703		45,260	13,194	8
9	17	ADMIN SALARY- NON OWNE	AVAIL. BED DAYS	1,374,590	21	3,486,246	3,486,246	45,260	114,789	9
10	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,374,590	21	8,800		45,260	290	10
11	20	DUES, SUBSCRIPTIONS, LICE	AVAIL. BED DAYS	1,374,590	21	4,293		45,260	141	11
12	21	CLERICAL WAGES	AVAIL. BED DAYS	1,374,590	21	738,904	738,904	45,260	24,329	12
13	21	CLERICAL & GENERAL - OTI	AVAIL. BED DAYS	1,374,590	21	7,880		45,260	259	13
14	24	SEMINARS	AVAIL. BED DAYS	1,374,590	21	19,314		45,260	636	14
15	27	EMP. BEN.-NON-NURSING	AVAIL. BED DAYS	1,374,590	21	819,705		45,260	26,990	15
16	26	INSURANCE	AVAIL. BED DAYS	1,374,590	21	55,168		45,260	1,816	16
17	30	DEPRECIATION	AVAIL. BED DAYS	1,374,590	21	19,384		45,260	638	17
18	34	STORAGE RENTAL	AVAIL. BED DAYS	1,374,590	21	1,500		45,260	49	18
19	35	AUTO RENTAL	AVAIL. BED DAYS	1,374,590	21	29,674		45,260	977	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 9,263,664	$ 7,853,142		$ 305,017	25

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. BED DAYS	1,789,215	30	$ 37,998	$	45,260	$ 961	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,789,215	30	48,042		45,260	1,215	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,789,215	30	9,551		45,260	242	3
4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,789,215	30	76		45,260	2	4
5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,789,215	30	32		45,260	1	5
6	26	INSURANCE	AVAIL. BED DAYS	1,789,215	30	9,839		45,260	249	6
7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,789,215	30	171,679		45,260	4,343	7
8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,789,215	30	140,710		45,260	3,559	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 417,927	$		$ 10,572	25

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Medical Supplies	Direct			$	$		$ 9,749	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					$	$		$ 9,749	25

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Direct			$	$		$ 17,100	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 17,100	25

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: ProPay HR LLC
Street Address: 2201 W Main St
City / State / Zip Code: Evantson, IL 60202
Phone Number: (847) 905-3268
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct			$	$		$ 7,167	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					$	$		$ 7,167	25

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	The Private Bank		X	Mortgage			$	$ 18,484,500			$ 1,001,914	1
2												2
3												3
4												4
5												5
	Working Capital											
6	The Private Bank		X	Line of Credit				393,404			64,047	6
7												7
8												8
9	TOTAL Facility Related						$	$ 18,877,904			$ 1,065,961	9
	B. Non-Facility Related*											
10	Interest Income		X								(7,501)	10
11	Interest Income - Bldg Co		X								(84,471)	11
12	Allocated Legacy HC Fin		X								14	12
13	See Supplemental Schedule										4,343	13
14	TOTAL Non-Facility Related						$	$			$ (87,615)	14
15	TOTALS (line 9+line14)						$	$ 18,877,904			$ 978,346	15

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

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

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	348,531	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.)	$	382,765	2
3. Under or (over) accrual (line 2 minus line 1).	$	34,234	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	371,325	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.)**	$	177	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.	$	405,736	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	292,350	8
	2013	321,166	9
	2014	328,758	10
	2015	331,938	11
	2016	379,206	12

Beginning Accrual Adjusted
Allocated CF St Louis = $3559
2017 Accrual = 348,531 x 1.065 (rounded)

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GROVE OF EVANSTON L & R COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053876

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2016 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-24-431-035-0000	Long Term Care Property	$ 6,334.51	$ 6,334.51
2.	10-24-431-036-0000	Long Term Care Property	$ 372,871.29	$ 372,871.29
3.	10-23-406-034-0000	Home Office Allocation	$ 463,439.48	$ 3,559.40
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 842,645.28	$ 382,765.20

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

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

IMPORTANT NOTICE

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

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

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

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

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GROVE OF EVANSTON L & R COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053876

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2016 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2016.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,712 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

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

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

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

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

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

None

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	51,712		$ 869,565	1
2	Allocated CF St Louis			16,442	2
3	TOTALS	51,712		$ 886,007	3

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	124		2010	1961	$ 6,411,594	$	39	$ 164,400	$ 164,400	$ 777,143	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2010	87,650		20	2,863	2,863	71,883	9
10	Various			2011	817,830		20	43,388	43,388	303,213	10
11	Various			2012	176,181		20	7,712	7,712	48,294	11
12	Various			2013	32,732		20	2,956	2,956	14,561	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		22,435			1,122	1,122	7,854	67
68	Related Party Allocations (Pages 12H & 12I)		197,651			9,307	9,307	18,420	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 7,746,074	$		$ 231,749	$ 231,749	$ 1,241,368	70

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,746,074	$		$ 231,749	$ 231,749	$ 1,241,368	1
2	New Wallpaper	2014	3,534		20	589	589	1,826	2
3	Elevator Repair Work	2014	4,200		20	175	175	718	3
4	3Rd Floor Hallway Wallcoverings/Paint Frames	2015	5,500		20	275	275	825	4
5	Installed Poplar Beams On Ceiling	2015	4,550		20	228	228	683	5
6	Repaired/Paint Brick Wall, Drywall/Installed Window	2015	3,450		20	173	173	518	6
7	Shower Room - Demo/Masonry/Carpentry/Electric	2015	53,500		20	2,675	2,675	8,025	7
8	Repaired Roof	2015	8,900		20	445	445	1,335	8
9	Repaired Sewer/Installed Concrete Blocks	2015	4,860		20	243	243	729	9
10	Installed 2 Passenger Elevator Pit Ladders	2015	2,500		20	125	125	375	10
11	Painted 15 Guest Rooms Ceiling Walls	2016	5,940		20	297	297	297	11
12	Painted 15 Guest Rooms Ceiling Walls	2016	5,940		20	297	297	297	12
13	Air Conditioner Through Wall	2016	2,799		20	140	140	140	13
14	Carpeting For 1St Floor	2016	12,435		20	622	622	622	14
15	1St Floor Flooring In Rooms	2016	14,500		20	1,450	1,450	1,450	15
16	Cubicle Curtains	2016	3,633		20	363	363	363	16
17	Installed New Boiler	2016	10,753		20	1,075	1,075	1,075	17
18	1St Floor Carpeting	2016	7,484		20	748	748	748	18
19	Installed Multiple Signs - Parking Lot, Main Doors, Awning	2017	30,941		20	1,547	1,547	1,547	19
20	1St Floor Removed Tile, Installed Rubber Floor, Molding	2017	2,536		20	127	127	127	20
21	Installed Pressure Gauges On All Floors & Sprinkler Head In Sho	2017	2,603		20	108	108	108	21
22	Custom Flooring For Lower Level Rehab Wing	2017	6,042		20	504	504	504	22
23	Wallpaper For Hallway Lower Level	2017	3,323		20	166	166	166	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)		$ 7,945,995	$		$ 244,120	$ 244,120	$ 1,263,845	34

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 7,945,995	$		$ 244,120	$ 244,120	$ 1,263,845	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
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19									19
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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)		$ 7,945,995	$		$ 244,120	$ 244,120	$ 1,263,845	34

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 7,945,995	$		$ 244,120	$ 244,120	$ 1,263,845	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
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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)		$ 7,945,995	$		$ 244,120	$ 244,120	$ 1,263,845	34

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 7,945,995	$		$ 244,120	$ 244,120	$ 1,263,845	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
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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)		$ 7,945,995	$		$ 244,120	$ 244,120	$ 1,263,845	34

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Installed Duplex Outlets, Disconnected & Capped off Scones	2010	2,825		20	141	141	987	9
10	Landscape Restoration	2010	12,110		20	606	606	4,242	10
11	Landscape Irrigation System - Installation	2010	7,500		20	375	375	2,625	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)		$ 22,435	$		$ 1,122	$ 1,122	$ 7,854	34

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 22,435	$		$ 1,122	$	$ 7,854	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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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)		$ 22,435	$		$ 1,122	$	$ 7,854	34

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from CF St. Louis LLC	2016	26,881		35	768	768	1,536	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis LLC	2016	166,896		20	8,345	8,345	16,690	9
10	Allocated from CF St. Louis LLC	2017	3,874		20	194	194	194	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)		$ 197,651	$		$ 9,307	$ 9,307	$ 18,420	34

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 197,651	$		$ 9,307	$ 9,307	$ 18,420	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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21									21
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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)		$ 197,651	$		$ 9,307	$ 9,307	$ 18,420	34

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,307,995	$ 638	$ 142,649	$ 142,011	10	$ 873,881	71
72	Current Year Purchases	65,327		5,635	5,635	10	5,635	72
73	Fully Depreciated Assets	1,202,122				10	1,202,122	73
74								74
75	TOTALS	$ 2,575,443	$ 638	$ 148,284	$ 147,646		$ 2,081,637	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)	$ 11,407,445	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 638	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 392,404	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 391,766	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,345,482	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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	Offsite Storage				593			5
6	Alloc LegacyHC/Progressive Cons				121			6
7	TOTAL				$ 714 **			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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 10,596 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	Allocated Legacy HC Financial		$	$ 2,506	17
18	Allocated Progressive Consulting			977	18
19					19
20					20
21	TOTAL		$	$ 3,483	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 EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		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	$		$ 515,075	$		$ 515,075	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			164,300			164,300	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			608,342			608,342	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				360,497		360,497	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					85,555	131,036		216,591	13
14	TOTAL			$		$ 1,373,272	$ 491,533		$ 1,864,805	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 EVANSTON L & R **#** 0053876 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 17,831	$ 22,623	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,866,782	2,866,782	3
4	Supply Inventory (priced at)	207	207	4
5	Short-Term Investments			5
6	Prepaid Insurance	96,137	96,137	6
7	Other Prepaid Expenses	18,752	232,430	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	552,462	1,015,363	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,552,171	$ 4,233,542	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		824,151	13
14	Buildings, at Historical Cost	30,941	3,311,903	14
15	Leasehold Improvements, at Historical Cost	21,193	501,307	15
16	Equipment, at Historical Cost	178,440	199,945	16
17	Accumulated Depreciation (book methods)	(9,100)	(717,776)	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	1,143,289	6,918,283	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,364,763	$ 11,037,813	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,916,934	$ 15,271,355	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 921,808	$ 921,808	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	393,404	836,675	29
30	Accrued Salaries Payable	247,343	247,343	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,333	7,333	31
32	Accrued Real Estate Taxes(Sch.IX-B)		371,325	32
33	Accrued Interest Payable		91,649	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	378,825	600,735	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,948,713	$ 3,076,868	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		18,041,229	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	1,492,329	1,492,329	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,492,329	$ 19,533,558	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,441,042	$ 22,610,426	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,475,892	$ (7,339,071)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,916,934	$ 15,271,355	48

***(See instructions.)**

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 349,110	1
2	Restatements (describe):		2
3	Equity Restatement	(62,746)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 286,364	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,189,528	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)**	$ 1,189,528	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)**	$ 1,475,892	24 *

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,887,260	1
2	Discounts and Allowances for all Levels	(7,526,952)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,360,308	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,795,926	6
7	Oxygen	30	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 6,795,956	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	347,720	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	54,100	19
20	Radiology and X-Ray		20
21	Other Medical Services	21,163	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 422,983	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,501	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,501	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	72,184	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 72,184	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,658,932	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,265,137	31
32	Health Care	3,301,323	32
33	General Administration	1,667,201	33
	B. Capital Expense		
34	Ownership	2,509,505	34
	C. Ancillary Expense		
35	Special Cost Centers	2,493,766	35
36	Provider Participation Fee	232,472	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,469,404	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,189,528	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,189,528	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,775,905	44
45	Private Pay - Net Inpatient Revenue	579,810	45
46	Medicare - Net Inpatient Revenue	1,544,273	46
47	Other-(specify) Insurance	460,320	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,360,308	49

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

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

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

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,022	2,198	$ 106,376	$ 48.40	1
2	Assistant Director of Nursing	1,979	2,151	86,986	40.44	2
3	Registered Nurses	18,520	20,131	632,176	31.40	3
4	Licensed Practical Nurses	25,845	28,092	781,964	27.84	4
5	CNAs & Orderlies	66,433	72,210	964,801	13.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,728	5,139	123,338	24.00	8
9	Activity Director	2,310	2,510	35,696	14.22	9
10	Activity Assistants	5,678	6,171	75,373	12.21	10
11	Social Service Workers	5,817	6,323	166,653	26.36	11
12	Dietician	941	1,022	24,872	24.34	12
13	Food Service Supervisor					13
14	Head Cook	9,206	10,006	160,987	16.09	14
15	Cook Helpers/Assistants	11,621	12,632	150,914	11.95	15
16	Dishwashers					16
17	Maintenance Workers	2,046	2,224	70,247	31.59	17
18	Housekeepers	13,052	14,187	161,315	11.37	18
19	Laundry	906	985	10,930	11.10	19
20	Administrator	1,867	2,029	120,874	59.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,854	7,450	129,842	17.43	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	1,535	1,668	30,170	18.09	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	181,360	197,128	$ 3,833,514 *	$ 19.45	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		$		35
36	Medical Director	Monthly	46,770	09-03	36
37	Medical Records Consultant	Monthly	2,800	10-03	37
38	Nurse Consultant	Monthly	19,238	10-03	38
39	Pharmacist Consultant	Monthly	9,549	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,016	11-03	44
45	Social Service Consultant	35	2,144	12-03	45
46	Other(specify)				46
47	Physicians Consultant	Monthly	48,000	10-03	47
48					48
49	TOTAL (lines 35 - 48)	35	$ 130,517		49

C. CONTRACT NURSES

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

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Etan Bleichman	Administrator	0.00	$ 62,954
Shilpi Chona	Administrator	0.00	57,921
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 120,875

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
Marcum LLP	Accounting Fees	$ 27,265
See Attached	Legal Fees	76,817
Achieve Accreditation, LLC	Joint Commission Consult	4,444
Propay	Payroll Services	9,430
Prospect Resources Inc	Natural Gas Procurement	800
BlueOrange Compliance	Compliance	1,021
IIT/Sourcetech	Data Processing	1,790
Lexisnexis Risk Solutions	Data Processing	38
MTS Consulting	WOTC Services	4,299
Personnel Planners	Unemployment Tax Consult	1,050
Strauss Data Consulting	Consulting Services	16
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 126,970

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,709
Unemployment Compensation Insurance	20,536
FICA Taxes	289,726
Employee Health Insurance	138,793
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	23,265
401K Expense	10,252
Voluntary Benefits Contributions	16,863
Employee Physical Exams	7,580
Employee Benefits	12,253
TOTAL (agree to Schedule V, line 22, col.8)	$ 560,977

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	189
Health Care Worker Background Check	5,576
(Indicate # of checks performed 558)	
Patient Background Checks 231	2,309
Dues & Subscriptions	17,476
Licenses & Permits	17,009
Allocated Legacy HC Financial	673
Allocated Progressive Consulting	141
See Supplemental Schedule	2
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 43,375

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,439
Allocated Legacy Healthcare	889
Allocated Progressive Consulting	636
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,964

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GROVE OF EVANSTON L & R # 0053876 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC: $15,599; IHCA: $6,386**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **29,796** 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 **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
The Grove of Evanston, IDPH License #0050948

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **232,472**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

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

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

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

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