

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

I. IDPH License ID Number: 0053876 Facility Name: The Grove of Evanston L R Address: 500 Asbury Avenue Evanston 60202 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 ☐ Charitable Corp. ☐ Trust IRS Exemption Code ☒ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☒ Limited Liability Co. ☐ Trust ☐ Other ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other
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In the event there are further questions about this report, please contact:

Name: Steven N. Lavenda

Telephone Number: (847) 282-6300

Email Address:

#	0053876	Report Period Beginning:	01/01/20	Ending:	12/31/20
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D. How many bed reserve days during this year were paid by the Department?

None (Do not include bed reserve days in Section B.)

N/A

None

Yes

YES ☐ NO ☒

YES ☐ NO ☒

Date started 07/01/2010

YES ☒ Date 07/01/2010 NO ☐

YES ☒ NO ☐ If YES, enter number
of beds certified 124 and days of care provided 7,656

IV. ACCOUNTING BASIS

Is your fiscal year identical to your tax year? YES ☒ NO ☐

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

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) **76.32%**

76.32%

Facility Name & ID Number The Grove of Evanston L R # 0053876 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	56,591	4,671	854,819	916,081		916,081	2,340	918,421			1
2	Food Purchase		2,388		2,388		2,388	4,453	6,841			2
3	Housekeeping		3,203	287,729	290,932		290,932	1,518	292,450			3
4	Laundry	27,895	25,443	105,691	159,029		159,029	103	159,132			4
5	Heat and Other Utilities			111,838	111,838		111,838	(10,514)	101,324			5
6	Maintenance	54,080	7,930	167,335	229,345		229,345	962	230,307			6
7	Other (specify):*											7
8	TOTAL General Services	138,566	43,635	1,527,412	1,709,613		1,709,613	(1,139)	1,708,474			8
	B. Health Care and Programs											
9	Medical Director			51,400	51,400		51,400		51,400			9
10	Nursing and Medical Records	3,237,114	230,812	47,899	3,515,825		3,515,825	66,083	3,581,908			10
10a	Therapy	150,493			150,493		150,493		150,493			10a
11	Activities	131,088	7,201	2,296	140,585		140,585	6	140,591			11
12	Social Services	155,903		2,519	158,422		158,422	4,066	162,488			12
13	CNA Training											13
14	Program Transportation			69,945	69,945		69,945		69,945			14
15	Other (specify):*							4,217	4,217			15
16	TOTAL Health Care and Programs	3,674,598	238,013	174,059	4,086,670		4,086,670	74,372	4,161,042			16
	C. General Administration											
17	Administrative	201,272			201,272		201,272	45,258	246,530			17
18	Directors Fees											18
19	Professional Services			224,042	224,042	(50,671)	173,371	(4,430)	168,941			19
20	Dues, Fees, Subscriptions & Promotions			83,236	83,236		83,236	(37,245)	45,991			20
21	Clerical & General Office Expenses	126,375	1,551	501,268	629,194		629,194	(203,518)	425,676			21
22	Employee Benefits & Payroll Taxes			645,937	645,937		645,937		645,937			22
23	Inservice Training & Education											23
24	Travel and Seminar			692	692		692	101	793			24
25	Other Admin. Staff Transportation			242	242		242	3,383	3,625			25
26	Insurance-Prop.Liab.Malpractice			268,636	268,636		268,636	9,354	277,990			26
27	Other (specify):*							18,140	18,140			27
28	TOTAL General Administration	327,647	1,551	1,724,053	2,053,251	(50,671)	2,002,580	(168,957)	1,833,623			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,140,811	283,199	3,425,524	7,849,534	(50,671)	7,798,863	(95,724)	7,703,139			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							375,034	375,034			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			29,740	29,740		29,740	725,873	755,613			32
33	Real Estate Taxes			326,828	326,828	50,671	377,499	392,142	769,641			33
34	Rent-Facility & Grounds			1,524,360	1,524,360		1,524,360	(1,523,101)	1,259			34
35	Rent-Equipment & Vehicles			7,406	7,406		7,406	3,287	10,693			35
36	Other (specify):*							107,138	107,138			36
37	TOTAL Ownership			1,888,334	1,888,334	50,671	1,939,005	80,372	2,019,377			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		439,628	1,242,678	1,682,306		1,682,306	(58,024)	1,624,282			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			225,441	225,441		225,441		225,441			42
43	Other (specify):*			553,044	553,044		553,044	(553,044)				43
44	TOTAL Special Cost Centers		439,628	2,021,163	2,460,791		2,460,791	(611,068)	1,849,723			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,140,811	722,827	7,335,021	12,198,659		12,198,659	(626,420)	11,572,239			45

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

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	(11,306)	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	260,518	30		9
10	Interest and Other Investment Income	(17,161)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		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	(4,241)	21		18
19	Entertainment	(1,748)	21		19
20	Contributions	(12,213)	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	(334,650)	21		24
25	Fund Raising, Advertising and Promotional	(13,305)	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	(782,178)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (916,284)		\$	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)	289,864		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 289,864		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (626,420)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non Allowable Expense	\$ (553,044)	43	1
2	Rebates	(840)	10	2
3	Patient Personal Items	(8,193)	10	3
4	Bank Charges	(6,992)	21	4
5	Sequestration	(51,994)	21	5
6	Therapy Discount	(37,565)	39	6
7	Bldg Co - Processing Fees	(1,500)	21	7
8	Bldg Co - Accounting	(16,978)	19	8
9	Bldg Co - Legal Fees	(65,360)	19	9
10	Bldg Co - Amortization	(4,692)	36	10
11	Capitalized R&M	(6,576)	06	11
12	Marketing License	(777)	20	12
13	PAC Dues	(12,618)	20	13
14	Non Allowable Legal	(14,180)	19	14
15	Prior Period Dues	(869)	20	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	(782,178)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Grove of Evanston L R

0053876

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			2,340									2,340	1
2	Food Purchase			4,453									4,453	2
3	Housekeeping			1,518									1,518	3
4	Laundry			103									103	4
5	Heat and Other Utilities	(11,306)				792							(10,514)	5
6	Maintenance	(6,576)		7,608		767		(838)					962	6
7	Other (specify):*													7
8	TOTAL General Services	(17,882)		16,022		1,559		(838)					(1,139)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(9,033)		77,829					(2,713)				66,083	10
10a	Therapy													10a
11	Activities			6									6	11
12	Social Services			4,066									4,066	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				4,217								4,217	15
16	TOTAL Health Care and Programs	(9,033)		81,901	4,217				(2,713)				74,372	16
	C. General Administration													
17	Administrative			45,258									45,258	17
18	Directors Fees													18
19	Professional Services	(96,518)	82,338	14,133		333	(4,716)						(4,430)	19
20	Fees, Subscriptions & Promotions	(39,782)		2,537		0							(37,245)	20
21	Clerical & General Office Expenses	(401,125)	1,500	195,923		184							(203,518)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			101									101	24
25	Other Admin. Staff Transportation			3,383									3,383	25
26	Insurance-Prop.Liab.Malpractice		9,066	89		199							9,354	26
27	Other (specify):*			18,140									18,140	27
28	TOTAL General Administration	(537,425)	92,904	279,564		716	(4,716)						(168,957)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(564,340)	92,904	377,487	4,217	2,275	(4,716)	(838)	(2,713)				(95,724)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Grove of Evanston L R # 0053876 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	260,518	109,634			4,882							375,034	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(17,161)	740,290			2,744							725,873	32
33	Real Estate Taxes		389,649			2,493							392,142	33
34	Rent-Facility & Grounds		(1,523,172)	22,975		(22,904)							(1,523,101)	34
35	Rent-Equipment & Vehicles				3,287								3,287	35
36	Other (specify):*	(4,692)	111,830										107,138	36
37	TOTAL Ownership	238,665	(171,769)	22,975	3,287	(12,785)							80,372	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(37,565)									(20,459)		(58,024)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(553,044)											(553,044)	43
44	TOTAL Special Cost Centers	(590,609)									(20,459)		(611,068)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(916,284)	(78,865)	400,461	7,504	(10,510)	(4,716)	(838)	(2,713)		(20,459)		(626,420)	45

VII. RELATED PARTIES

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

[illegible]

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 1,523,172	Grove of Evanston Realty		\$	(1,523,172)	1
2	V	32	Interest	25,357	Grove of Evanston Realty		765,647	740,290	2
3	V	33	RE Taxes		Grove of Evanston Realty		389,649	389,649	3
4	V	26	Property Insurance		Grove of Evanston Realty		9,066	9,066	4
5	V	36	MIP Expense		Grove of Evanston Realty		107,138	107,138	5
6	V	21	Processing Fees		Grove of Evanston Realty		1,500	1,500	6
7	V	19	Accounting		Grove of Evanston Realty		16,978	16,978	7
8	V	19	Legal Fees		Grove of Evanston Realty		65,360	65,360	8
9	V	30	Depreciation		Grove of Evanston Realty		109,634	109,634	9
10	V	36	Amortization		Grove of Evanston Realty		4,692	4,692	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,548,529			\$ 1,469,664	\$ * (78,865)	14

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

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 Company	1
2	Doros Generation Trust	50.00 %	Avantara Arlington	Arlington, SD	Legacy HC & Financial Services	Lincolnwood	Home Office/Bookkeeping	2
3			Avantara Armour	Armour, SD	CF St. Louis LLC	Skokie	Building Company	3
4			Avantara Arrowhead	Rapid City, SD	ML Group Design & Development	Skokie	Asset Management	4
5			Avantara Aurora	Aurora	ReMED Services LLC	Lincolnwood	Nursing Equipment	5
6			Avantara Billings	Billings, MT	Propay HR	Evanston	Payroll Processing	6
7			Avantara Clark	Clark, SD	Ecobrite Linen	Skokie	Laundry Supplies	7
8			Avantara Elgin	Elgin	Aurora Supportive Living	Aurora	Supportive Living	8
9			Avantara Evergreen Park	Evergreen Park	Terrace Gardens	Morton Grove	Assisted Living	9
10			Avantara Groton	Groton, SD	Lincolnshire Assisted Living Center	Lincolnshire	Assisted Living	10
11			Avantara Huron	Huron, SD	Wellshire Park Place	Milbank, SD	Assisted Living	11
12			Avantara Ipswich	Ipswich, SD	Wellshire Huron	Huron, SD	Assisted Living	12
13			Avantara Lake Norden	Lake Norden, SD	Lifescan Labs of Illinois	Skokie	Laboratory	13
14			Avantara Long Grove	Long Grove				14
15			Avantara Milbank	Milbank, SD				15
16			Avantara Mountainview	Rapid City, SD				16
17			Avantara North	Rapid City, SD				17
18			Avantara Norton	Sioux Falls, SD				18
19			Avantara Park Ridge	Park Ridge				19
20			Avantara Pierre	Pierre, SD				20
21			Avantara Redfield	Redfield, SD				21
22			Avantara Salem	Salem, SD				22
23			Avantara St. Cloud	Rapid City, SD				23
24			Avantara Watertown	Watertown, SD				24
25			Bella Terra Streamwood	Streamwood				25
26			Bella Terra Wheeling	Wheeling				26
27			Bethany Terrace	Morton Grove				27
28			Carlton Skilled Nursing Facility LLC	Chicago				28
29			Chalet Skilled Nursing Facility LLC	Chicago				29
30			Clark Skilled Nursing Facility	Chicago				30

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			Elmbrook Skilled Nursing Facility LLC	Elmhurst				1
2			Grove at the Lake Skilled Nursing Facility LLC	Zion				2
3			Grove of Berwyn	Berwyn				3
4			Grove of Fox Valley	Aurora				4
5			Grove of St. Charles	St. Charles				5
6			Lagrange Skilled Nursing Facility LLC	Lagrange Park				6
7			Lakefront Skilled Nursing Facility LLC	Chicago				7
8			Lincoln Park Skilled Nursing Facility LLC	Chicago				8
9			Lincolnshire Living & Rehab Center LLC	Lincolnshire				9
10			Northbrook Skilled Nursing Facility LLC	Northbrook				10
11			Peterson Park Associates Limited Partnership	Chicago				11
12			Skokie Skilled Nursing Facility LLC	Skokie				12
13			Valley Skilled Nursing Facility	Billings, MT				13
14			Warren Barr Living And Rehab	Chicago				14
15			Warren Barr North Shore	Highland Park				15
16			Warren Barr South Loop	Chicago				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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietician Salary	\$	Legacy Healthcare Financial Services		\$ 2,328	\$ 2,328	15
16	V	01	Dietary Supplies		Legacy Healthcare Financial Services		12	12	16
17	V	02	Food		Legacy Healthcare Financial Services		4,453	4,453	17
18	V	03	Housekeeping		Legacy Healthcare Financial Services		1,518	1,518	18
19	V	04	Linen Replacement		Legacy Healthcare Financial Services		103	103	19
20	V	06	Maintenance Salary		Legacy Healthcare Financial Services		7,182	7,182	20
21	V	06	Repairs & Maintenance		Legacy Healthcare Financial Services		426	426	21
22	V	10	Nursing Salary		Legacy Healthcare Financial Services		59,447	59,447	22
23	V	10	Nurse/Medical Director Consultant		Legacy Healthcare Financial Services		5,611	5,611	23
24	V	10	Medical Supplies		Legacy Healthcare Financial Services		12,772	12,772	24
25	V	12	Social Service Salary		Legacy Healthcare Financial Services		4,050	4,050	25
26	V	11	Activities Program		Legacy Healthcare Financial Services		6	6	26
27	V	12	Social Service Consultant		Legacy Healthcare Financial Services		16	16	27
28	V	17	COO / Administrative Salary		Legacy Healthcare Financial Services		45,258	45,258	28
29	V	19	Professional Fees	725	Legacy Healthcare Financial Services		14,858	14,133	29
30	V	20	Dues / Licenses / Permits		Legacy Healthcare Financial Services		2,537	2,537	30
31	V	21	Clerical & General Wages		Legacy Healthcare Financial Services		182,607	182,607	31
32	V	21	Clerical & Office Expense		Legacy Healthcare Financial Services		13,316	13,316	32
33	V	24	Education & Seminars		Legacy Healthcare Financial Services		101	101	33
34	V	25	Travel		Legacy Healthcare Financial Services		3,383	3,383	34
35	V	26	Insurance - General		Legacy Healthcare Financial Services		89	89	35
36	V	27	Non-Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		18,140	18,140	36
37	V	34	Rent		Legacy Healthcare Financial Services		22,904	22,904	37
38	V	34	Offsite Storage / Parking		Legacy Healthcare Financial Services		71	71	38
39	Total			\$ 725			\$ 401,186	\$ * 400,461	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Equipment Rental		Legacy Healthcare Financial Services		306	\$	306
16	V	35	Auto Rental		Legacy Healthcare Financial Services		2,981		2,981
17	V	15	Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		4,217		4,217
18	V								
19	V								
20	V								
21	V								
22	V								
23	V								
24	V								
25	V								
26	V								
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$			7,504	\$ *	7,504

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	\$	CF St. Louis LLC		\$ 792	\$ 792	15
16	V	6	Repairs & Maintenance		CF St. Louis LLC		767	767	16
17	V	19	Property Valuation Fee		CF St. Louis LLC		271	271	17
18	V	19	Accounting Fees		CF St. Louis LLC		62	62	18
19	V	20	Dues & Subscriptions		CF St. Louis LLC		0	0	19
20	V	21	Office Expense		CF St. Louis LLC		184	184	20
21	V	26	Insurance		CF St. Louis LLC		199	199	21
22	V	30	Depreciation		CF St. Louis LLC		4,882	4,882	22
23	V	32	Interest Expense		CF St. Louis LLC		2,744	2,744	23
24	V	33	Real Estate Taxes		CF St. Louis LLC		2,493	2,493	24
25	V								25
26	V	34	Rent	22,904	CF St. Louis LLC			(22,904)	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			\$ 22,904			\$ 12,394	\$ * (10,510)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	\$ 20,586	ProPay HR		\$ 15,870	\$ (4,716)	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			\$ 20,586			\$ 15,870	\$ * (4,716)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance	\$ 34,200	ML Group Design & Development		\$ 33,362	\$ (838)	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			\$ 34,200			\$ 33,362	\$ * (838)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Medical Supplies	\$ 9,000	ReMED Services		\$ 6,287	\$ (2,713)	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			\$ 9,000			\$ 6,287	\$ * (2,713)	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	04	Laundry Services	\$ 105,691	EcoBrite Linen		\$ 105,691	\$	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			\$ 105,691			\$ 105,691	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Laboratory	\$ 50,267	Lifescan Labs of Illinois		\$ 29,808	\$ (20,459)	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			\$ 50,267			\$ 29,808	\$ * (20,459)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

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

Ending: 12/31/20**Fax Number**

NO ☒

Facility Name & ID Number The Grove of Evanston L R# 0053876

Report Period Beginning:

01/01/20Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Legacy Healthcare Financial Services

Street Address

3450 Oakton Street

City / State / Zip Code

Skokie, IL 60076

Phone Number

(847) 679-9797

Fax Number

(847) 683-2900

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietician Salary	Available Bed Days	2,540,133	53	\$ 130,303	\$ 130,303	45,384	\$ 2,328	1
2	01	Dietary Supplies	Available Bed Days	2,540,133	53	697		45,384	12	2
3	02	Food	Available Bed Days	2,540,133	53	249,220		45,384	4,453	3
4	03	Housekeeping	Available Bed Days	2,540,133	53	84,952		45,384	1,518	4
5	04	Linen Replacement	Available Bed Days	2,540,133	53	5,771		45,384	103	5
6	06	Maintenance Salary	Available Bed Days	2,540,133	53	401,986	401,986	45,384	7,182	6
7	06	Repairs & Maintenance	Available Bed Days	2,540,133	53	23,857		45,384	426	7
8	10	Nursing Salary	Available Bed Days	2,540,133	53	3,327,223	3,327,223	45,384	59,447	8
9	10	Nurse/Medical Director Consultant	Available Bed Days	2,540,133	53	314,035		45,384	5,611	9
10	10	Medical Supplies	Available Bed Days	2,540,133	53	714,824		45,384	12,772	10
11	12	Social Service Salary	Available Bed Days	2,540,133	53	226,662	226,662	45,384	4,050	11
12	11	Activities Program	Available Bed Days	2,540,133	53	335		45,384	6	12
13	12	Social Service Consultant	Available Bed Days	2,540,133	53	893		45,384	16	13
14	17	COO / Administrative Salary	Available Bed Days	2,540,133	53	2,533,078	2,533,078	45,384	45,258	14
15	19	Professional Fees	Available Bed Days	2,540,133	53	831,592		45,384	14,858	15
16	20	Dues / Licenses / Permits	Available Bed Days	2,540,133	53	141,983		45,384	2,537	16
17	21	Clerical & General Wages	Available Bed Days	2,540,133	53	10,220,453	10,220,453	45,384	182,607	17
18	21	Clerical & Office Expense	Available Bed Days	2,540,133	53	745,293		45,384	13,316	18
19	24	Education & Seminars	Available Bed Days	2,540,133	53	5,655		45,384	101	19
20	25	Travel	Available Bed Days	2,540,133	53	189,364		45,384	3,383	20
21	26	Insurance - General	Available Bed Days	2,540,133	53	4,997		45,384	89	21
22	27	Non-Nursing Payroll Taxes / Bene	Available Bed Days	2,540,133	53	1,015,274		45,384	18,140	22
23	34	Rent	Available Bed Days	2,540,133	53	1,281,940		45,384	22,904	23
24	34	Offsite Storage / Parking	Available Bed Days	2,540,133	53	3,949		45,384	71	24
25	TOTALS					\$ 22,454,338	\$ 16,839,706		\$ 401,186	25

Ending: 12/31/20

(847) 683-2900

IL478-2471

Ending: 12/31/20

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

IL478-2471

Ending: 12/31/20

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

IL478-2471

Ending: 12/31/20

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IL478-2471

Ending: 12/31/20

IL478-2471

Ending: 12/31/20

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IL478-2471

Ending: 12/31/20

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IL478-2471

Ending: 12/31/20

IL478-2471

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	CIBC		X	Mortgage			\$	18,342,629			\$	765,647	1
2													2
3													3
4													4
5													5
	Working Capital												
6	CIBC		X	Line of Credit								29,740	6
7													7
8													8
9	TOTAL Facility Related						\$	18,342,629			\$	795,387	9
	B. Non-Facility Related*												
10	Interest Income		X									(17,161)	10
11	Interest Income - Bldg Co		X									(25,357)	11
12	Allocated from CF St. Louis	X										2,744	12
13													13
14	TOTAL Non-Facility Related						\$				\$	(39,774)	14
15	TOTALS (line 9+line14)						\$	18,342,629			\$	755,613	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 107,138 Line # 36

* 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 The Grove of Evanston L R COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053876

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ()

Enter the tax index number and real estate tax assessed for 2019 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 2019.

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: 2019 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 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Grove of Evanston L R COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053876

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	51,712		\$ 869,565	1
2	Allocated from CF St. Louis, LLC			3,526	2
3	TOTALS	51,712		\$ 873,091	3

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	11,220	67
68	Related Party Allocations (Pages 12H & 12I)		165,953	4,501		7,891	3,390	35,301	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		\$ 7,810,381	\$ 114,135		\$ 233,932	\$ 119,797	\$ 1,916,449	70

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

Facility Name & ID Number The Grove of Evanston L R

0053876

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,810,381	\$ 114,135		\$ 233,932	\$ 119,797	\$ 1,916,449	1
2	Installed Multiple Signs - Parking Lot, Main Doors, Awning	2017	30,941		20	1,547	1,547	6,188	2
3	1St Floor Removed Tile, Installed Rubber Floor, Molding	2017	2,536		20	127	127	507	3
4	Installed Pressure Gauges On All Floors & Sprinkler Head In Sho	2017	2,603		20	130	130	476	4
5	Custom Flooring For Lower Level Rehab Wing	2017	6,042		20	302	302	1,612	5
6	Wallpaper For Hallway Lower Level	2017	3,323		20	166	166	665	6
7	1St-3Rd Resident Room/Bathrooms - New Door Handles/Insulator	2018	2,750		20	138	138	527	7
8	Installed 109 Passage Locks And Insulator Kits-Resident Rooms/B	2018	4,645		20	232	232	891	8
9	Replaced Air Filter, Fuel Tank, Gasket For Heater	2018	9,287		20	464	464	1,703	9
10	Remodel Of Basement Room-Flooring/Wallpaper/Painting (17,900	2018	16,568		20	828	828	2,552	10
11	Carpet And Wallpaper - Rehab Room (9015)	2018	8,344		20	417	417	1,585	11
12	Drapes And Blinds (2970)	2018	2,749		20	137	137	424	12
13	Repaired Float/Conveyor Drive For Wash Tank	2018	2,658		20	133	133	510	13
14	Carpet Installation - Conference Room (4153)	2018	3,844		20	192	192	384	14
15	Paint And Installation Of 80Ft Baseboard Covers (5485)	2018	5,077		20	254	254	508	15
16	Wallpaper - Graphics (5820)	2018	5,387		20	269	269	539	16
17	Ceiling Mounted Walking Track (3300)	2018	3,054		20	153	153	305	17
18	Install Front Door & Keypad With Siren (\$4,304)	2019	4,171		20	209	209	823	18
19	Flooring In Office Area And Therapy Room (\$3,350)	2019	3,246		20	162	162	293	19
20	Lower Lvl Plumbing Work,Replace Ejector Pump In Boiler Rm (\$	2019	67,774		20	3,389	3,389	7,468	20
21	Carpeting (\$5,673)	2019	5,498		20	275	275	748	21
22	Basement Rehab Rm Flooring, Build Closet For Pump Room (\$15	2019	14,896		20	745	745	1,513	22
23	Repair Wall Cracks-Top Flr To Basement,Repair Stairway&Lock	2019	2,883		20	144	144	268	23
24	Install New Hot Water Tank In Kitchen (\$9,200)	2019	8,916		20	446	446	1,366	24
25	1St Flr Ac-Installed New Compressor & Condenser Fan Motor (\$3	2019	3,683		20	184	184	342	25
26	Basement - Installed 2 New Pumps And Control Panel (\$14,735)	2019	14,280		20	714	714	1,123	26
27	Repair Door Mag Locks - W. Stair,2Nd & 3Rd Floor (\$2,661)	2019	2,579		20	129	129	262	27
28	Repair Door Mag Locks - 1St Flr Stairwell, Back Door (\$2,979)	2019	2,887		20	144	144	293	28
29	Window Repair (2,560)	2019	2,497		20	125	125	125	29
30	Repair Front Entrance Elevator (6,700)	2020	6,536		20	327	327	327	30
31	Run New Electric Line For Booster (2,680)	2020	2,614		20	131	131	131	31
32	Security Camera System (2,936)	2020	2,864		20	143	143	143	32
33	Repair 15 Toilets (3,325)	2020	3,244		20	162	162	162	33
34	TOTAL (lines 1 thru 33)		\$ 8,068,757	\$ 114,135		\$ 246,851	\$ 132,716	\$ 1,951,213	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 8,068,757	\$ 114,135		\$ 246,851	\$ 132,716	\$ 1,951,213	1
2 Repair Light Fixtures In Basement & 3Rd Fl (2,884)	2020	2,813		20	141	141	141	2
3 Domestic Pumps (3,692)	2020	3,602		20	180	180	180	3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 8,075,172	\$ 114,135		\$ 247,172	\$ 133,037	\$ 1,951,533	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 8,075,172	\$ 114,135		\$ 247,172	\$ 133,037	\$ 1,951,533	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,075,172	\$ 114,135		\$ 247,172	\$ 133,037	\$ 1,951,533	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 8,075,172	\$ 114,135		\$ 247,172	\$ 133,037	\$ 1,951,533	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,075,172	\$ 114,135		\$ 247,172	\$ 133,037	\$ 1,951,533	34

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

Facility Name & ID Number The Grove of Evanston L R

0053876

Report Period Beginning:

01/01/20

Ending:

12/31/20

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	1,410	9
10	Landscape Restoration	2010	12,110		20	606	606	6,060	10
11	Landscape Irrigation System - Installation	2010	7,500		20	375	375	3,750	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	\$ 11,220	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 22,435	\$		\$ 1,122	\$ 1,122	\$ 11,220	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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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	\$ 11,220	34

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

Facility Name & ID Number The Grove of Evanston L R

0053876

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party								1
2	Buildings:								2
3	Allocated from CF St. Louis, LLC	2016	18,987	882	35	542	(339)	2,712	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	117,880	2,908	20	5,894	2,986	29,470	9
10	Allocated from CF St. Louis, LLC	2017	2,736	67	20	137	69	547	10
11	Allocated from CF St. Louis, LLC	2019	24,799	612	20	1,240	628	2,480	11
12	Allocated from CF St. Louis, LLC	2019	1,304	32	20	65	33	65	12
13									13
14	Allocated from Legacy HC	2018	141		20	7	7	21	14
15	Allocated from Legacy HC	2020	106		20	5	5	5	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)		\$ 165,953	\$ 4,501		\$ 7,891	\$ 3,390	\$ 35,301	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 165,953	\$ 4,501		\$ 7,891	\$ 3,390	\$ 35,301	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 165,953	\$ 4,501		\$ 7,891	\$ 3,390	\$ 35,301	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$2,616,145	\$380	\$122,428	\$122,048	10	\$1,073,848	71
72	Current Year Purchases	26,444	1	2,644	2,643	10	2,644	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$2,642,589	\$381	\$125,073	\$124,692		\$1,076,493	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		2009 Smart Passion Car	2018	\$13,950	\$	\$2,790	\$2,790	5	\$4,185	76
77										77
78										78
79										79
80	TOTALS			\$13,950	\$	\$2,790	\$2,790		\$4,185	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)	\$11,604,802	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$114,516	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$375,035	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$260,518	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,032,211	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Storage				1,188			5
6	Allocated from Legacy Healthcare				71			6
7	TOTAL				\$ 1,259			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 7,712
- Description: See Attached

(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 from Legacy Healthcare		\$	\$ 2,981	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 2,981	21

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. /2021 \$
13. /2022 \$
14. /2023 \$

* 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.

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

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 458,228	\$		\$ 458,228	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			115,076			115,076	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			544,261			544,261	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				330,501		330,501	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					125,113	109,127		234,240	13
14	TOTAL			\$		\$ 1,242,678	\$ 439,628		\$ 1,682,306	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 67,862	\$ 746,100	1
2	Cash-Patient Deposits	28,262	28,262	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,602,802	2,602,802	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,554	1,554	6
7	Other Prepaid Expenses	288,839	334,383	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	229,044	528,519	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,218,363	\$ 4,241,620	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	200,406	680,520	15
16	Equipment, at Historical Cost	294,956	316,461	16
17	Accumulated Depreciation (book methods)	(141,687)	(1,290,800)	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	3,287,478	7,447,490	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,672,094	\$ 11,289,725	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,890,457	\$ 15,531,345	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 892,905	\$ 900,386	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		357,590	29
30	Accrued Salaries Payable	280,068	280,068	30
31	Accrued Taxes Payable (excluding real estate taxes)	187,260	187,260	31
32	Accrued Real Estate Taxes(Sch.IX-B)	130,734	653,399	32
33	Accrued Interest Payable	15,798	(571,396)	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	2,137,196	2,245,825	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,643,961	\$ 4,053,132	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		17,985,039	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	1,530,708	361,960	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,530,708	\$ 18,346,999	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,174,669	\$ 22,400,131	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,715,788	\$ (6,868,786)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,890,457	\$ 15,531,345	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,449,865	1
2	Restatements (describe):		2
3	Bad Debt	647,716	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,097,581	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	6,324	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	(1,388,117)	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)	\$ (1,381,793)	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)	\$ 1,715,788	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **The Grove of Evanston L R**# **0053876**Report Period Beginning: **01/01/20**Ending: **12/31/20****XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**1**

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 11,914,885	1
2	Discounts and Allowances for all Levels	(4,847,630)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,067,255	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,580,757	6
7	Oxygen	213	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,580,970	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	302,502	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	75,100	19
20	Radiology and X-Ray	200	20
21	Other Medical Services	50,234	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 428,036	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	17,161	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17,161	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	1,111,561	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,111,561	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,204,983	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,709,613	31
32	Health Care	4,086,670	32
33	General Administration	2,053,251	33
	B. Capital Expense		
34	Ownership	1,888,334	34
	C. Ancillary Expense		
35	Special Cost Centers	2,235,350	35
36	Provider Participation Fee	225,441	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,198,659	40
41	Income before Income Taxes (line 30 minus line 40)**	6,324	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 6,324	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,928,043	44
45	Private Pay - Net Inpatient Revenue	423,571	45
46	Medicare - Net Inpatient Revenue	2,192,046	46
47	Other-(specify) Insurance	523,595	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,067,255	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,130	2,242	\$ 144,481	\$ 64.44	1
2	Assistant Director of Nursing	1,962	2,080	84,949	40.84	2
3	Registered Nurses	20,410	23,150	863,210	37.29	3
4	Licensed Practical Nurses	20,717	24,396	796,780	32.66	4
5	CNAs & Orderlies	66,939	76,212	1,344,668	17.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,376	5,935	150,493	25.36	8
9	Activity Director	2,626	2,773	56,241	20.28	9
10	Activity Assistants	4,708	5,260	74,847	14.23	10
11	Social Service Workers	4,613	5,033	119,961	23.83	11
12	Dietician	1,984	2,080	56,591	27.21	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,668	1,762	54,080	30.69	17
18	Housekeepers					18
19	Laundry	1,827	1,924	27,895	14.50	19
20	Administrator	1,903	2,100	164,852	78.50	20
21	Assistant Administrator	984	1,080	36,420	33.72	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,155	6,671	126,375	18.94	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	2,119	2,237	38,968	17.42	33
34	TOTAL (lines 1 - 33)	146,121	164,936	\$ 4,140,811 *	\$ 25.11	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 854,819	01-03	35
36	Medical Director	Monthly	51,400	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	43,481	10-03	38
39	Pharmacist Consultant	Monthly	4,418	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	38	2,296	11-03	44
45	Social Service Consultant	42	2,519	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	80	\$ 958,933		49

C. CONTRACT NURSES

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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Louise Dihiansan	Asst. Admin	0	\$ 36,420
Shilpi Chona	Administrator	0	164,852
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 201,272
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	\$	24,000
ProPay HR	Payroll Processing		20,586
Onyx Procurement Solutions	Procurement Services		8,370
Achieve Accreditation	Accreditation Services		9,869
Compligent	Compliance		3,843
Elaton Energy Services	Energy Procurement		1,000
Cortex Health	E.H.R Software		11,435
BaldrigeCoach, Inc.	Performance Consulting		25,110
Hygieneering, Inc.	Hygiene & Safety Consult		917
Language Line Services	Translation Services		1,136
See Attached	Legal		97,787
See Supplemental Schedule			19,990
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 224,043
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance	\$		33,055
Unemployment Compensation Insurance			24,025
FICA Taxes			316,772
Employee Health Insurance			190,790
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Union Pension			24,278
Employee Benefits			26,480
401K Expense			15,313
Voluntary Benefit Contributions			8,285
Employee Physical Exams			6,939
TOTAL (agree to Schedule V, line 22, col.8)			\$ 645,937
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	\$		2,487
Advertising: Employee Recruitment			468
Health Care Worker Background Check (Indicate # of checks performed 78)			785
Patient Background Checks	255		2,551
Dues & Subscriptions			27,911
Licenses & Fees			9,253
See Supplemental Schedule			2,537
Less: Public Relations Expense	(		)
Non-allowable advertising	(		)
Yellow page advertising	(		)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 45,992
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel	\$		
In-State Travel			
Seminar Expense			692
See Supplemental Schedule			101
Entertainment Expense	(		)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	793

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1)

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

Yes

(2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

HCCI \$19,319 ; IHCA \$10,763

(3)

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

Yes
Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
N/A

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
10 Years

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 21,784 Line 10

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
N/A

(9)

Are you presently operating under a sublease agreement?

YES X NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 225,441

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

(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?
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.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ N/A
Indicate the amount. \$

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No
\$ 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?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

No
N/A

(18)

Have all costs which do not relate to the provision of long term care been adjusted out 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.
Attach invoices and a summary of services for all architect and appraisal fees.

Yes