

Facility Name & ID Number Grove Of Evanston

0053876 Report Period Beginning: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>124</u>	Skilled (SNF)	<u>124</u>	<u>45,260</u>	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	<u>124</u>	TOTALS	<u>124</u>	<u>45,260</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>2,849</u>	<u>422</u>	<u>13,289</u>	<u>16,560</u>	8
9	SNF/PED					9
10	ICF	<u>15,529</u>	<u>1,497</u>		<u>17,026</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>18,378</u>	<u>1,919</u>	<u>13,289</u>	<u>33,586</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.21%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 07/01/2010

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 124 and days of care provided 11,576

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number

Grove Of Evanston

0053876

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	314,099	17,624		331,723		331,723		331,723		1
2	Food Purchase		218,714		218,714		218,714	(15,673)	203,041		2
3	Housekeeping	143,099	34,153	686	177,938		177,938	83	178,021		3
4	Laundry		185	142,011	142,196		142,196		142,196		4
5	Heat and Other Utilities			149,840	149,840		149,840	(24,632)	125,208		5
6	Maintenance	55,828		146,465	202,293		202,293	32,244	234,537		6
7	Other (specify):*										7
8	TOTAL General Services	513,026	270,676	439,002	1,222,704		1,222,704	(7,978)	1,214,726		8
	B. Health Care and Programs										
9	Medical Director			145,653	145,653		145,653		145,653		9
10	Nursing and Medical Records	2,396,319	145,721	73,544	2,615,584		2,615,584	(20,641)	2,594,943		10
10a	Therapy	115,521			115,521		115,521		115,521		10a
11	Activities	122,518	6,409		128,927		128,927	168	129,095		11
12	Social Services	186,839		5,649	192,488		192,488	5,908	198,396		12
13	CNA Training										13
14	Program Transportation			98,335	98,335		98,335	(479)	97,856		14
15	Other (specify):*							42	42		15
16	TOTAL Health Care and Programs	2,821,197	152,130	323,181	3,296,508		3,296,508	(15,002)	3,281,506		16
	C. General Administration										
17	Administrative	98,584		1,273	99,857		99,857	(40,662)	59,195		17
18	Directors Fees										18
19	Professional Services			360,575	360,575	(79)	360,496	(210,275)	150,221		19
20	Dues, Fees, Subscriptions & Promotions			181,051	181,051		181,051	(113,743)	67,308		20
21	Clerical & General Office Expenses	246,620	4,288	559,310	810,218		810,218	(408,806)	401,412		21
22	Employee Benefits & Payroll Taxes			674,926	674,926		674,926		674,926		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,488	8,488		8,488	806	9,294		24
25	Other Admin. Staff Transportation			23,112	23,112		23,112		23,112		25
26	Insurance-Prop.Liab.Malpractice			156,056	156,056		156,056	2,931	158,987		26
27	Other (specify):*							13,094	13,094		27
28	TOTAL General Administration	345,204	4,288	1,964,791	2,314,283	(79)	2,314,204	(756,655)	1,557,549		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,679,427	427,094	2,726,974	6,833,495	(79)	6,833,416	(779,635)	6,053,781		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

#0053876

Report Period Beginning:

01/01/15

Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			313,165	313,165		313,165	93,833	406,998			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,699	1,699		1,699	156,861	158,560			32
33	Real Estate Taxes			338,400	338,400	79	338,479	(26,602)	311,876			33
34	Rent-Facility & Grounds			1,193,423	1,193,423		1,193,423	(1,193,423)	0			34
35	Rent-Equipment & Vehicles			10,488	10,488		10,488	(3,488)	7,000			35
36	Other (specify):*			976,000	976,000		976,000	(976,000)				36
37	TOTAL Ownership			2,833,175	2,833,175	79	2,833,254	(1,948,820)	884,434			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		670,413	1,520,013	2,190,426		2,190,426		2,190,426			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			189,583	189,583		189,583		189,583			42
43	Other (specify):*			690,482	690,482		690,482	(690,482)	(0)			43
44	TOTAL Special Cost Centers		670,413	2,400,078	3,070,491		3,070,491	(690,482)	2,380,009			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,679,427	1,097,507	7,960,227	12,737,161		12,737,161	(3,418,937)	9,318,224			45

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

Grove Of Evanston

ID# 0053876
 Report Period Beginning: 01/01/15
 Ending: 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Additional R&M	\$ 31,097	06	1
2	Sequestration	(129,160)	21	2
3	Patient Personal Items	(2,205)	10	3
4	Meals	(8,186)	21	4
5	Bank Charges	(6,143)	21	5
6	Non-Allowable Vehicle	(5,126)	35	6
7	Amortization	(976,000)	36	7
8	PAC Dues	(3,621)	20	8
9	Non-Allowable Expenses	(690,482)	43	9
10	Non-Allowable Legal	(7,473)	19	10
11	Building Co - Legal Fees	(16,725)	19	11
12	Building Co - Loan Fees	(30,297)	26	12
13	Building Co - Non-Allowable Fees	(108,210)	43	13
14	Building Co - Title Fees	(21,128)	21	14
15	Building Co - Accounting Fees	(2,492)	19	15
16	Building Co - Zoning Fees	(3,500)	21	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	(1,979,652)		49

Grove Of Evanston

ID# 0053876
 Report Period Beginning: 01/01/15
 Ending: 12/31/15

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# 0053876

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(16,858)				1,185							(15,673)	2
3	Housekeeping			83									83	3
4	Laundry													4
5	Heat and Other Utilities	(25,526)		894									(24,632)	5
6	Maintenance	31,097		2,040		(893)							32,244	6
7	Other (specify):*													7
8	TOTAL General Services	(11,287)		3,017		292							(7,978)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,205)				(18,436)							(20,641)	10
10a	Therapy													10a
11	Activities			168									168	11
12	Social Services					5,908							5,908	12
13	CNA Training													13
14	Program Transportation						(479)						(479)	14
15	Other (specify):*					42							42	15
16	TOTAL Health Care and Programs	(2,205)		168		(12,486)	(479)						(15,002)	16
	C. General Administration													
17	Administrative			1,272		(41,934)							(40,662)	17
18	Directors Fees													18
19	Professional Services	(26,690)	19,217	(203,198)		396							(210,275)	19
20	Fees, Subscriptions & Promotions	(114,545)		741		61							(113,743)	20
21	Clerical & General Office Expenses	(510,875)	24,628	92,034		(14,592)							(408,806)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			746		60							806	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice	(30,297)	30,297	565		2,366							2,931	26
27	Other (specify):*			23,044		(9,950)							13,094	27
28	TOTAL General Administration	(682,408)	74,142	(84,797)		(63,593)							(756,655)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(695,900)	74,142	(81,612)		(75,786)	(479)						(779,635)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Grove Of Evanston# 0053876

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	(983)	91,890	1,265	1,661								93,833	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,818)	158,770	10	899								156,861	32
33	Real Estate Taxes		(28,200)	1,598									(26,602)	33
34	Rent-Facility & Grounds		(1,193,423)	5,945	(5,945)								(1,193,423)	34
35	Rent-Equipment & Vehicles	(5,126)		1,153		485							(3,488)	35
36	Other (specify):*	(976,000)											(976,000)	36
37	TOTAL Ownership	(984,927)	(970,963)	9,971	(3,385)	485							(1,948,820)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(798,692)	108,210										(690,482)	43
44	TOTAL Special Cost Centers	(798,692)	108,210										(690,482)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(2,479,520)	(788,611)	(71,641)	(3,385)	(75,301)	(479)						(3,418,937)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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 Rent	\$ 1,193,423	Grove of Evanston Realty	100.00%	\$	\$ (1,193,423)	1
2	V	19 Accounting		Grove of Evanston Realty	100.00%	2,492	2,492	2
3	V	30 Depreciation		Grove of Evanston Realty	100.00%	91,890	91,890	3
4	V	32 Interest	20	Grove of Evanston Realty	100.00%	158,790	158,770	4
5	V	19 Legal		Grove of Evanston Realty	100.00%	16,725	16,725	5
6	V	26 Loan Fees		Grove of Evanston Realty	100.00%	30,297	30,297	6
7	V	43 Non-Allowable Fees		Grove of Evanston Realty	100.00%	108,210	108,210	7
8	V	33 Real Estate Taxes	28,200	Grove of Evanston Realty	100.00%		(28,200)	8
9	V	21 Title Fees		Grove of Evanston Realty	100.00%	21,128	21,128	9
10	V	21 Zoning Fees		Grove of Evanston Realty	100.00%	3,500	3,500	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,221,643			\$ 433,032	\$ * (788,611)	14

* 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	3 HOUSEKEEPING SUPPLIES	\$	Legacy Healthcare Financial Services	100.00%	\$ 83	\$	83	15
16	V	5 UTILITIES		Legacy Healthcare Financial Services	100.00%	894		894	16
17	V	6 GROUNDS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	2,040		2,040	17
18	V	11 ACTIVITIES PROGRAM		Legacy Healthcare Financial Services	100.00%	168		168	18
19	V	17 MANAGEMENT FEES - Y. ZUCKERMAN		Legacy Healthcare Financial Services	100.00%	1,272		1,272	19
20	V	19 PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	16,802		16,802	20
21	V	20 FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	741		741	21
22	V	21 CLERICAL & GENERAL WAGES		Legacy Healthcare Financial Services	100.00%	83,549		83,549	22
23	V	21 CLERICAL & GENERAL OTHER COSTS		Legacy Healthcare Financial Services	100.00%	8,485		8,485	23
24	V	24 SEMINARS		Legacy Healthcare Financial Services	100.00%	746		746	24
25	V	26 INSURANCE		Legacy Healthcare Financial Services	100.00%	565		565	25
26	V	27 EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	23,044		23,044	26
27	V	30 DEPRECIATION		Legacy Healthcare Financial Services	100.00%	1,265		1,265	27
28	V	32 INTEREST		Legacy Healthcare Financial Services	100.00%	10		10	28
29	V	33 REAL ESTATE TAXES		Legacy Healthcare Financial Services	100.00%	1,598		1,598	29
30	V	34 RENT		Legacy Healthcare Financial Services	100.00%	5,945		5,945	30
31	V	35 EQUIPMENT RENTAL		Legacy Healthcare Financial Services	100.00%	1,153		1,153	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V	19 BOOKKEEPING FEES	220,000	Legacy Healthcare Financial Services	100.00%			(220,000)	36
37	V								37
38	V								38
39	Total		\$ 220,000			\$ 148,359	\$ *	(71,641)	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	30 DEPRECIATION		Legacy Real Properties	100.00%	1,661	\$	1,661	15
16	V	32 INTEREST EXPENSE		Legacy Real Properties	100.00%	899		899	16
17	V								17
18	V								18
19	V	34 RENT	5,945	Legacy Real Properties	100.00%			(5,945)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 5,945			\$ 2,560	\$ *	(3,385)	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	2	FOOD	Progressive Healthcare Consulting	100.00%	\$ 1,185	\$ 1,185
16	V	6	MAINTENANCE SALARY	Progressive Healthcare Consulting	100.00%	3	3
17	V	6	BUILDING MAINTENANCE AND R&M	Progressive Healthcare Consulting	100.00%	654	654
18	V	10	MEDICAL AND NURSING SUPPLIES	Progressive Healthcare Consulting	100.00%	2	2
19	V	10	NURSING SALARIES	Progressive Healthcare Consulting	100.00%	45,282	45,282
20	V	12	ACTIVITIES PROGRAM	Progressive Healthcare Consulting	100.00%	7	7
21	V	12	CLERGY SALARY	Progressive Healthcare Consulting	100.00%	1,146	1,146
22	V	12	ADMISSIONS SALARY	Progressive Healthcare Consulting	100.00%	52,674	52,674
23	V	15	EMP. BEN.-NURSING	Progressive Healthcare Consulting	100.00%	8,412	8,412
24	V	17	ADMIN SALARY- NON OWNER	Progressive Healthcare Consulting	100.00%	55,608	55,608
25	V	19	PROFESSIONAL FEES	Progressive Healthcare Consulting	100.00%	396	396
26	V	20	FEES, SUBSCRIPTIONS	Progressive Healthcare Consulting	100.00%	61	61
27	V	21	CLERICAL & GENERAL	Progressive Healthcare Consulting	100.00%	785	785
28	V	24	SEMINARS	Progressive Healthcare Consulting	100.00%	60	60
29	V	27	EMP. BEN.-NURSING	Progressive Healthcare Consulting	100.00%	10,543	10,543
30	V	26	INSURANCE	Progressive Healthcare Consulting	100.00%	2,366	2,366
31	V	35	AUTO RENTAL	Progressive Healthcare Consulting	100.00%	485	485
32	V	17	ADMINISTRATOR	Progressive Healthcare Consulting	100.00%		(97,542)
33	V	10	NURSING	Progressive Healthcare Consulting	100.00%		(63,720)
34	V	12	SOCIAL SERVICE	Progressive Healthcare Consulting	100.00%		(47,919)
35	V	06	MAINTENANCE	Progressive Healthcare Consulting	100.00%		(1,549)
36	V	21	CLERICAL	Progressive Healthcare Consulting	100.00%		(15,377)
37	V	15	PAYROLL TAXES - NURSING	Progressive Healthcare Consulting	100.00%		(8,370)
38	V	27	PAYROLL TAXES	Progressive Healthcare Consulting	100.00%		(20,493)
39	Total		\$ 254,970			\$ 179,669	\$ * (75,301)

* 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	14 Ambulance	\$ 6,259	Lifeline Ambulance	100.00%	\$ 5,780	\$ (479)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 6,259			\$ 5,780	\$ * (479)

* 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)

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)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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 # 0053876 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Yair Zuckerman	Owner	Administrative	0.90%	See Attached	1.55	3.88%	Alloc Sal/Fee	\$ 7,752	17-3/17-7	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	\$ 7,752		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

0053876

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Grove Of Evanston

0053876

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 7040 N. Ridgeway
 City / State / Zip Code Lincolnwood, IL 60712
 Phone Number (847) 679-9797
 Fax Number (847) 679-1126

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	3	HOUSEKEEPING SUPPLIES	AVAIL. BED DAYS	1,253,624	23	\$ 2,296	\$ 45,260	\$ 83	1
2	5	UTILITIES	AVAIL. BED DAYS	1,253,624	23	24,766	45,260	894	2
3	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	1,253,624	23	56,504	45,260	2,040	3
4	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,253,624	23	4,642	45,260	168	4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,253,624	23	465,391	45,260	16,802	5
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,253,624	23	20,516	45,260	741	6
7	21	CLERICAL & GENERAL WAG	AVAIL. BED DAYS	1,253,624	23	2,314,153	2,314,153	83,549	7
8	21	CLERICAL & GENERAL OTH	AVAIL. BED DAYS	1,253,624	23	235,020	45,260	8,485	8
9	24	SEMINARS	AVAIL. BED DAYS	1,253,624	23	20,662	45,260	746	9
10	26	INSURANCE	AVAIL. BED DAYS	1,253,624	23	15,655	45,260	565	10
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	1,253,624	23	638,286	45,260	23,044	11
12	30	DEPRECIATION	AVAIL. BED DAYS	1,253,624	23	35,040	45,260	1,265	12
13	32	INTEREST	AVAIL. BED DAYS	1,253,624	23	267	45,260	10	13
14	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,253,624	23	44,250	45,260	1,598	14
15	34	RENT	AVAIL. BED DAYS	1,253,624	23	164,669	45,260	5,945	15
16	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,253,624	23	31,945	45,260	1,153	16
17									17
18	17	MGMT FEES- Y. ZUCKERMAN	AVG HOURS WKD	50	20	32,807	1.94	1,272	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 4,106,869	\$ 2,314,153	\$ 148,359	25

Facility Name & ID Number Grove Of Evanston

0053876

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 Real Properties
 Street Address 7040 N. Ridgeway
 City / State / Zip Code Lincolnwood, IL 60712
 Phone Number (847) 679-9797
 Fax Number (847) 679-1126

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	30	DEPRECIATION	AVAIL. BED DAYS	1,253,624	23	46,013	45,260	1,661	1
2	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,253,624	23	24,899	45,260	899	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					\$ 70,912	\$	\$ 2,560	25

Facility Name & ID Number Grove Of Evanston

0053876

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 Progressive Healthcare Consulting
 Street Address 7040 N. Ridgeway
 City / State / Zip Code Lincolnwood, IL 60712
 Phone Number (847) 679-9797
 Fax Number (847) 679-1126

1	2	3	4	5	6	7	8	9	
Schedule V	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	
Line Reference									
1	2	FOOD	AVAIL. BED DAYS	1,167,679	20	\$ 30,560	\$ 45,260	\$ 1,185	1
2	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,167,679	20	65	45,260	3	2
3	6	BUILDING MAINTENANCE A	AVAIL. BED DAYS	1,167,679	20	16,865	45,260	654	3
4	10	MEDICAL AND NURSING SUP	AVAIL. BED DAYS	1,167,679	20	47	45,260	2	4
5	10	NURSING SALARIES	AVAIL. BED DAYS	1,167,679	20	1,168,252	1,168,252	45,260	45,282
6	12	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,167,679	20	187	45,260	7	6
7	12	CLERGY SALARY	AVAIL. BED DAYS	1,167,679	20	29,559	45,260	1,146	7
8	12	ADMISSIONS SALARY	AVAIL. BED DAYS	1,167,679	20	1,358,960	1,358,960	45,260	52,674
9	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,167,679	20	217,026	45,260	8,412	9
10	17	ADMIN SALARY- NON OWNE	AVAIL. BED DAYS	1,167,679	20	1,434,659	1,434,659	45,260	55,608
11	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,167,679	20	10,207	45,260	396	11
12	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,167,679	20	1,577	45,260	61	12
13	21	CLERICAL & GENERAL	AVAIL. BED DAYS	1,167,679	20	20,243	45,260	785	13
14	24	SEMINARS	AVAIL. BED DAYS	1,167,679	20	1,535	45,260	60	14
15	27	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,167,679	20	272,007	45,260	10,543	15
16	26	INSURANCE	AVAIL. BED DAYS	1,167,679	20	61,041	45,260	2,366	16
17	35	AUTO RENTAL	AVAIL. BED DAYS	1,167,679	20	12,512	45,260	485	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 4,635,301	\$ 3,991,495	\$ 179,669	25

Facility Name & ID Number Grove Of Evanston

0053876

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Lifeline Ambulance LLC
 Street Address 2424 S. Wabash Avenue
 City / State / Zip Code Chicago, IL 60616
 Phone Number (312) 949-9595
 Fax Number (312) 949-9262

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.

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	14	Ambulance	Direct Allocation		\$	\$		\$ 5,780	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 5,780	25

Facility Name & ID Number Grove Of Evanston

0053876

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Grove Of Evanston

0053876

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Grove Of Evanston

0053876

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Grove Of Evanston

0053876 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Grove Of Evanston

0053876

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number

Grove Of Evanston

0053876

Report Period Beginning:

01/01/15

Ending:

12/31/15

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										
										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	Private Bank		X	Mortgage			\$	\$ 24,242,169		\$ 158,790	1								
2											2								
3											3								
4											4								
5											5								
Working Capital																			
6	The Private Bank		X	Line of Credit				525,000		1,698	6								
7	Alloc from Legacy HC	X								10	7								
8	See Supplemental Schedule									899	8								
9	TOTAL Facility Related						\$	\$ 24,767,169		\$ 161,397	9								
B. Non-Facility Related*																			
10	Interest Income		X							(2,818)	10								
11	Building Co - Interest		X							(20)	11								
12											12								
13											13								
14	TOTAL Non-Facility Related						\$	\$		\$ (2,838)	14								
15	TOTALS (line 9+line14)						\$	\$ 24,767,169		\$ 158,559	15								

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	TOTAL Long-Term										7									
Working Capital																				
8	Alloc from Legacy Real Prop	X								899	8									
9											9									
10											10									
11											11									
12											12									
13											13									
14	TOTAL Working Capital										899	14								
B. Non-Facility Related*																				
15											15									
16											16									
17											17									
18											18									
19											19									
20	TOTAL Non-Facility Related										20									

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

** 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

0053876 Report Period Beginning:

01/01/15 Ending:

12/31/15

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 (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>51,712</u>		<u>\$ 869,565</u>	<u>1</u>
2	<u>Allocated from Legacy Real Properties</u>			<u>2,954</u>	<u>2</u>
3	TOTALS	<u>51,712</u>		<u>\$ 872,519</u>	<u>3</u>

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	124	2010	1961	\$ 6,411,594	\$ 91,890	39	\$ 84,593	\$ (7,297)	\$ 448,343	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		2010	87,650		20	5,346	5,346	66,156	9
10	Various		2011	841,939		20	43,388	43,388	216,437	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										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

0053876

Report Period Beginning:

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Ending:

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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	
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		22,435			1,122	1,122	5,610	67
68		50,537	1,445		2,106	661	11,722	68
69			313,165			(313,165)		69
70		\$ 7,414,155	\$ 406,500		\$ 136,555	\$ (269,945)	\$ 748,268	70

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

Facility Name & ID Number Grove Of Evanston

0053876

Report Period Beginning:

01/01/15

Ending:

12/31/15

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		\$ 7,414,155	\$ 406,500		\$ 136,555	\$ (269,945)	\$ 748,268	1
2	Drain Line, Branch Line, Connection To Fire Protection Backflow	2012	3,045		20	127	127	571	2
3	Exhaust System For Shower & Utility Rooms	2012	4,800		20	200	200	900	3
4	Installed Fire Dampers	2012	4,862		20	203	203	851	4
5	Dock Doors - Fire Code Compliant	2012	4,896		20	204	204	775	5
6	Water Heater	2012	5,980		20	249	249	1,047	6
7	Security Cameras	2012	2,970		20	495	495	1,881	7
8	Econocare - 39 Yr	2012	140,878		20	5,870	5,870	25,241	8
9	Installation Of Railing Bars For Existing Outside Fence	2012	8,750		20	365	365	1,604	9
10	Sewage Pump Installation	2013	3,770		20	314	314	1,068	10
11	Repair 1St Floor Nurse Call System, 5 Bathroom Pull Stations	2013	2,750		20	229	229	733	11
12	Wood Flush Door, Wood Casing To Door	2013	6,382		20	532	532	1,542	12
13	EpcO Status Panel At Receptionist'S Desk, Emt, Travel Cable, Etc.	2013	7,840		20	653	653	1,829	13
14	Electric Conduits, Heating Pipe, Ceiling Light Fixtures, Tiling	2013	6,310		20	526	526	1,420	14
15	Fire Rated Push Bar Exit Device, Lever Trim, Etc.	2013	2,940		20	245	245	686	15
16	Copper Pipe For Hot Water Heater	2013	2,740		20	457	457	1,370	16
17	New Wallpaper	2014	3,534		20	589	589	648	17
18	Elevator Repair Work	2014	4,200		20	175	175	368	18
19	3Rd Floor Hallway Wallcoverings/Paint Frames	2015	5,500		20	275	275	275	19
20	Installed Poplar Beams On Ceiling	2015	4,550		20	228	228	228	20
21	Repaired/Paint Brick Wall, Drywall/Installed Window	2015	3,450		20	173	173	173	21
22	Shower Room - Demo/Masonry/Carpentry/Electric	2015	53,500		20	2,675	2,675	2,675	22
23	Repaired Roof	2015	8,900		20	445	445	445	23
24	Repaired Sewer/Installed Concrete Blocks	2015	4,860		20	243	243	243	24
25	Installed 2 Passenger Elevator Pit Ladders	2015	2,500		20	125	125	125	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,714,063	\$ 406,500		\$ 152,150	\$ (254,350)	\$ 794,965	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		\$ 7,714,063	\$ 406,500		\$ 152,150	\$ (254,350)	\$ 794,965	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)	\$ 7,714,063	\$ 406,500		\$ 152,150	\$ (254,350)	\$ 794,965	34

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

Facility Name & ID Number Grove Of Evanston

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Report Period Beginning:

01/01/15

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12/31/15

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		\$ 7,714,063	\$ 406,500		\$ 152,150	\$ (254,350)	\$ 794,965	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)	\$ 7,714,063	\$ 406,500		\$ 152,150	\$ (254,350)	\$ 794,965	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		\$ 7,714,063	\$ 406,500		\$ 152,150	\$ (254,350)	\$ 794,965	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		\$ 7,714,063	\$ 406,500		\$ 152,150	\$ (254,350)	\$ 794,965	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	Building Company		\$	\$		\$	\$	\$	1
2	Buildings:								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	705	9
10	Landscape Restoration	2010	12,110		20	606	606	3,030	10
11	Landscape Irrigation System - Installation	2010	7,500		20	375	375	1,875	11
12	Depreciation								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	\$ 5,610	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		\$ 22,435	\$		\$ 1,122	\$ 1,122	\$ 5,610	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)	\$ 22,435	\$		\$ 1,122	\$ 1,122	\$ 5,610	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Related Party		\$	\$		\$	\$		1
2	Buildings:								2
3	Allocated from Legacy Real Properties	2009	22,885	779	20	763	(16)	4,958	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Legacy HC Financial Services	2012	1,029	67	20	51	(16)	206	9
10	Allocated from Legacy HC Financial Services	2013	3,293	215	20	165	(50)	494	10
11	Allocated from Legacy HC Financial Services	2014	322	21	20	16	(5)	32	11
12	Allocated from Legacy HC Financial Services	2015	443	29	20	22	(7)	22	12
13									13
14	Allocated from Legacy Real Properties	2009	12,996	192	20	650	458	3,736	14
15	Allocated from Legacy Real Properties	2010	3,952	59	20	158	99	870	15
16	Allocated from Legacy Real Properties	2011	5,617	83	20	281	198	1,404	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)		\$ 50,537	\$ 1,445		\$ 2,106	\$ 661	\$ 11,722	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		\$ 50,537	\$ 1,445		\$ 2,106	\$ 661	\$ 11,722
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 50,537	\$ 1,445		\$ 2,106	\$ 661	\$ 11,722

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

Facility Name & ID Number Grove Of Evanston

0053876

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	\$ 2,325,459	\$ 1,435	\$ 245,159	\$ 243,724	10	\$ 1,751,652	71
72	Current Year Purchases	96,899	47	9,690	9,643	10	9,690	72
73	Fully Depreciated Assets	42,567				10	42,567	73
74								74
75	TOTALS	\$ 2,464,925	\$ 1,482	\$ 254,849	\$ 253,367		\$ 1,803,909	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)	\$ 11,051,507	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 407,982	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 406,999	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (983)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,598,873	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	Bathroom Remodel	\$ 2,800	92
93			93
94			94
95		\$ 2,800	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? YES NO

If NO, see instructions.

		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								5
6								6
7	TOTAL				\$			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: \$ 6,514 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	<u>Allocated from Progressive HC</u>		\$	\$ <u>485</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>485</u>	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. /2016 \$ _____

13. /2017 \$ _____

14. /2018 \$ _____

* 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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.)

	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	\$		\$ 543,830	\$		\$ 543,830	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			138,610			138,610	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			743,379			743,379	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				587,474		587,474	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>					94,194	82,939		177,133	13
14	TOTAL			\$		\$ 1,520,013	\$ 670,413		\$ 2,190,426	14

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

Facility Name & ID Number Grove Of Evanston# 0053876Report Period Beginning: 01/01/15Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15

(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	\$	\$ 10,225,271	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,975,565	1,975,565	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,169	34,169	6
7	Other Prepaid Expenses	24,206	164,751	7
8	Accounts Receivable (owners or related parties)	553,158	553,158	8
9	Other(specify):	91	4,326,289	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,587,189	\$ 17,279,203	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		3,280,962	14
15	Leasehold Improvements, at Historical Cost		480,114	15
16	Equipment, at Historical Cost	1,818	23,323	16
17	Accumulated Depreciation (book methods)	(61)	(580,092)	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):		6,756,556	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,757	\$ 10,785,014	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,588,946	\$ 28,064,217	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,734,569	\$ 1,734,587	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	525,000	525,000	29
30	Accrued Salaries Payable	181,892	181,892	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,869	3,869	31
32	Accrued Real Estate Taxes(Sch.IX-B)		290,605	32
33	Accrued Interest Payable		389,342	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Attached Schedule	30,446	104,077	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,475,776	\$ 3,229,372	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		24,242,169	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 24,242,169	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,475,776	\$ 27,471,541	46
47	TOTAL EQUITY(page 18, line 24)	\$ 113,170	\$ 592,676	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,588,946	\$ 28,064,217	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3	Adjustment for change in ownership	231,813	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 231,813	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(118,643)	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)	\$ (118,643)	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)	\$ 113,170	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Grove Of Evanston

0053876

Report Period Beginning: 01/01/15

Ending:

12/31/15

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		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 11,055,793	1
2	Discounts and Allowances for all Levels	(6,337,264)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,718,529	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	7,190,525	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 7,190,525	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	559,961	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	84,000	19
20	Radiology and X-Ray	19,170	20
21	Other Medical Services	26,782	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 689,913	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,818	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,818	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	16,733	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 16,733	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,618,518	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,222,704	31
32	Health Care	3,296,508	32
33	General Administration	2,314,283	33
B. Capital Expense			
34	Ownership	2,833,175	34
C. Ancillary Expense			
35	Special Cost Centers	2,880,908	35
36	Provider Participation Fee	189,583	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,737,161	40
41	Income before Income Taxes (line 30 minus line 40)**	(118,643)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (118,643)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,630,418	44
45	Private Pay - Net Inpatient Revenue	444,175	45
46	Medicare - Net Inpatient Revenue	479,973	46
47	Other-(specify) <u>Insurance</u>	163,963	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,718,529	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**

0053876

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	2,300	2,326	\$ 102,622	\$ 44.12	1
2	Assistant Director of Nursing	2,086	2,118	84,978	40.12	2
3	Registered Nurses	24,382	24,903	730,209	29.32	3
4	Licensed Practical Nurses	22,585	23,059	604,334	26.21	4
5	CNAs & Orderlies	68,830	70,758	840,028	11.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,019	4,080	115,521	28.31	8
9	Activity Director	1,975	2,007	41,789	20.82	9
10	Activity Assistants	7,274	7,462	80,729	10.82	10
11	Social Service Workers	6,163	6,259	145,608	23.26	11
12	Dietician	2,048	2,080	48,217	23.18	12
13	Food Service Supervisor	1,899	1,939	39,070	20.15	13
14	Head Cook	9,159	9,422	120,504	12.79	14
15	Cook Helpers/Assistants	9,379	9,644	106,308	11.02	15
16	Dishwashers					16
17	Maintenance Workers	2,035	2,067	55,828	27.01	17
18	Housekeepers	13,380	13,775	143,099	10.39	18
19	Laundry					19
20	Administrator	2,122	2,136	83,652	39.16	20
21	Assistant Administrator	696	696	14,932	21.45	21
22	Other Administrative					22
23	Office Manager	1,735	1,759	29,743	16.91	23
24	Clerical	17,241	17,611	216,877	12.31	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	1,897	1,960	34,148	17.42	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,715	2,951	41,231	13.97	33
34	TOTAL (lines 1 - 33)	203,920	209,012	\$ 3,679,427 *	\$ 17.60	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director	Monthly 145,653	09-03	36
37	Medical Records Consultant	Monthly 3,544	10-03	37
38	Nurse Consultant	Monthly 68,388	10-03	38
39	Pharmacist Consultant	Monthly 1,612	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			44
45	Social Service Consultant	73 4,449	12-03	45
46	Other(specify)			46
47	Clergy	Monthly 1,200	12-03	47
48				48
49	TOTAL (lines 35 - 48)	73 \$ 224,846		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Isaac Freund	Administrator	0.00%	\$ 59,786	Workers' Compensation Insurance	\$ 117,256	IDPH License Fee	\$	
Etan Blechman	Administrator	0.00%	23,867	Unemployment Compensation Insurance	32,821	Advertising: Employee Recruitment	1,246	
Matt Reardon	Assitant Admin	0.00%	14,933	FICA Taxes	281,476	Health Care Worker Background Check	23,509	
				Employee Health Insurance	173,839	(Indicate # of checks performed _____)		
				Employee Meals		<u>Patient Background Checks</u>		
				Illinois Municipal Retirement Fund (IMRF)*		<u>Dues and Subscriptions</u>	24,382	
				<u>Union Pension</u>	24,679	<u>License and Permits</u>	17,368	
				<u>401K Expense</u>	7,436	<u>Allocated from Legacy HC Financial Serv</u>	741	
				<u>Employee Physical Exam</u>	3,815	<u>Allocated from Progressive HC</u>	61	
				<u>Other Employee Benefits</u>	33,603			
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 98,585	TOTAL (agree to Schedule V, line 22, col.8)	\$ 674,924	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 67,308	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Yair Zuckerman - Management Fees</u>			\$ 1,272				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,272	TOTAL		\$	Seminar Expense	8,488
C. Professional Services							<u>Allocated from Legacy HC Financial Serv</u>	
Vendor/Payee	Type		Amount				<u>Allocated from Progressive HC</u>	
<u>FR&R/Marcum LLP</u>	<u>Accounting</u>		\$ 21,917					
<u>Legacy Healthcare</u>	<u>Bookkeeping</u>		220,000				Entertainment Expense	()
<u>Document Solutions</u>	<u>Compliance Audit</u>		7,594				(agree to Sch. V, line 24, col. 8)	
<u>Creative Technology</u>	<u>Data Processing</u>		14,073				TOTAL	\$ 9,294
<u>Health Data Systems</u>	<u>Data Processing</u>		8,775					
<u>Lexis Nexis</u>	<u>Data Processing</u>		1,925					
<u>Prime Care Technologies</u>	<u>Data Processing</u>		1,815					
<u>Wescom Solutions</u>	<u>Data Processing</u>		17,747					
<u>National Datacare Corporation</u>	<u>Data Processing</u>		1,977					
<u>Joy Cases</u>	<u>Medicare Reimb Consult</u>		5,000					
<u>Achieve Accreditation</u>	<u>Joint Commission Consult</u>		11,981					
<u>See Supplemental Schedule</u>			47,769					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 360,573					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Grove Of Evanston# 0053876

Report Period Beginning:

01/01/15

Ending:

12/31/15**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. Illinois Council on LTC \$10,974
- (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. \$ 22,465 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. \$ 189,583
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. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? 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.