FOR BHF USE

LL1

2021
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2021)

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: 0055442

Facility Name: The Grove of Berwyn

Address: 3601 S Harlem Avenue (Number) Berwyn (City) 60402 (Zip Code)

County: Cook

Telephone Number: (708) 749-4160 **Fax #** (708) 749-7696

HFS ID Number:

Date of Initial License for Current Owners: 2/1/2019

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/21 to 12/31/21 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

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

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

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	145	Skilled (SNF)	145	52,925	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	145	TOTALS	145	52,925	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,252	2,252	8
9	SNF/PED					9
10	ICF	35,600	1,376		36,976	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,600	1,376	2,252	39,228	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.12%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 2/1/2019

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/2019 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 145 and days of care provided 1,952

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/21 Fiscal Year: 12/31/21

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

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	70,432	14,210	668,804	753,446		753,446	2,184	755,630			1
2	Food Purchase		49,736		49,736		49,736	(17)	49,719			2
3	Housekeeping	220,402	18,647	266	239,315		239,315	1,601	240,916			3
4	Laundry	107,246	13,675		120,921		120,921		120,921			4
5	Heat and Other Utilities			126,348	126,348		126,348	941	127,289			5
6	Maintenance	124,306	14,061	163,602	301,969		301,969	4,220	306,189			6
7	Other (specify):*							597	597			7
8	**TOTAL General Services**	522,386	110,329	959,020	1,591,735		1,591,735	9,526	1,601,261			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000	6,800	30,800			9
10	Nursing and Medical Records	2,933,549	115,694	284,856	3,334,099		3,334,099	93,380	3,427,479			10
10a	Therapy	138,252			138,252		138,252		138,252			10a
11	Activities	185,194	3,183	1,254	189,631		189,631		189,631			11
12	Social Services	156,173		10,227	166,400		166,400	3,159	169,559			12
13	CNA Training											13
14	Program Transportation			9,037	9,037		9,037		9,037			14
15	Other (specify):*							(263,491)	(263,491)			15
16	**TOTAL Health Care and Programs**	3,413,168	118,877	329,374	3,861,419		3,861,419	(160,152)	3,701,267			16
	C. General Administration											
17	Administrative	188,271			188,271		188,271	61,779	250,050			17
18	Directors Fees											18
19	Professional Services			304,107	304,107	(15,664)	288,443	6,587	295,030			19
20	Dues, Fees, Subscriptions & Promotions			61,495	61,495		61,495	(29,327)	32,168			20
21	Clerical & General Office Expenses	184,986	923	374,500	560,409		560,409	(30,319)	530,090			21
22	Employee Benefits & Payroll Taxes			654,924	654,924		654,924		654,924			22
23	Inservice Training & Education											23
24	Travel and Seminar			600	600		600	477	1,077			24
25	Other Admin. Staff Transportation			485	485		485	1,517	2,002			25
26	Insurance-Prop.Liab.Malpractice			215,660	215,660		215,660	9,300	224,960			26
27	Other (specify):*							14,336	14,336			27
28	**TOTAL General Administration**	373,257	923	1,611,771	1,985,951	(15,664)	1,970,287	34,350	2,004,637			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,308,811	230,129	2,900,165	7,439,105	(15,664)	7,423,441	(116,276)	7,307,165			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 The Grove of Berwyn #0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			102,332	102,332		102,332	255,697	358,029			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,569	8,569		8,569	212,324	220,893			32
33	Real Estate Taxes			494,581	494,581	15,664	510,245	2,484	512,728			33
34	Rent-Facility & Grounds			788,069	788,069		788,069	(787,962)	107			34
35	Rent-Equipment & Vehicles			13,161	13,161		13,161	3,095	16,256			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,406,712	1,406,712	15,664	1,422,376	(314,362)	1,108,014			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		154,890	526,119	681,009		681,009	(1,943)	679,066			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			303,352	303,352		303,352		303,352			42
43	Other (specify):*			459,768	459,768		459,768	(459,768)	(0)			43
44	**TOTAL Special Cost Centers**		154,890	1,289,239	1,444,129		1,444,129	(461,712)	982,417			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,308,811	385,019	5,596,116	10,289,946		10,289,946	(892,350)	9,397,596			45

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

Facility Name & ID Number The Grove of Berwyn # #0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(205,114)	30		9
10	Interest and Other Investment Income	(5,033)	32		10
11	Discounts, Allowances, Rebates & Refunds	(7,008)	10		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(17)	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	(29,695)	21		18
19	Entertainment	(94)	21		19
20	Contributions	(16,563)	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	(208,252)	21		24
25	Fund Raising, Advertising and Promotional	(4,769)	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	(845,694)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,322,239)		$	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)	429,889		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 429,889		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (892,350)		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

The Grove of Berwyn

ID# 0055442

Report Period Beginning: 01/01/21

Ending: 12/31/21

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Additional R&M	2,449	06	1
2	Bank Charges	(4,674)	21	2
3	Patient Personal Items	(516)	10	3
4	Sequestration Expense	(359)	21	4
5	Non-Allowable Expense	(458,856)	43	5
6	Therapy Discount	(1,943)	39	6
7	Capitalized R&M	(8,913)	06	7
8	PAC Dues	(12,180)	20	8
9	Marketing License	(912)	43	9
10	Collections	(176)	21	10
11	Non-Allowable Legal	(12,932)	19	11
12	Grant Income	(268,434)	15	12
13	Building Co. - Broker Fees	(35,000)	19	13
14	Building Co. - Accounting Fees	(1,853)	19	14
15	Building Co. - Amortization	(41,395)	36	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**	(845,694)		49

Detail lines 29 and 35 of Page 5 starting in C12. DO NOT DRAG AND DROP CELLS.

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 5B**

The Grove of Berwyn

ID# 0055442
Report Period Beginning: 01/01/21
Ending: 12/31/21

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		b		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

Reference 1 Reference 2 Reference 3 Reference 4 Reference 5 Reference 6 Reference 7 Reference 9 Reference 10 Reference 10a Reference 11 Reference 12 Reference 13 Reference 14 Reference 15 Reference 17 Reference 18 Reference 19 Reference 20 Reference 21 Reference 22 Reference 23 Reference 24 Reference 25 Reference 26 Reference 27 Reference 30 Reference 31 Reference 32 Reference 33 Reference 34 Reference 35 Reference 36 Reference 38 Reference 39 Reference 40 Reference 41 Reference 42 Reference 43

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			2,184									2,184	1
2	Food Purchase	(17)											(17)	2
3	Housekeeping			1,601									1,601	3
4	Laundry													4
5	Heat and Other Utilities			10		931							941	5
6	Maintenance	(6,465)		9,443		1,241							4,220	6
7	Other (specify):*			597									597	7
8	**TOTAL General Services**	(6,482)		13,835		2,172							9,526	8
	B. Health Care and Programs													
9	Medical Director			6,800									6,800	9
10	Nursing and Medical Records	(7,524)		102,167			(1,263)						93,380	10
10a	Therapy													10a
11	Activities													11
12	Social Services			3,159									3,159	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*	(268,434)		4,943									(263,491)	15
16	**TOTAL Health Care and Programs**	(275,958)		117,069			(1,263)						(160,152)	16
	C. General Administration													
17	Administrative			61,779									61,779	17
18	Directors Fees													18
19	Professional Services	(49,785)	36,853	24,025		146		(4,652)					6,587	19
20	Fees, Subscriptions & Promotions	(33,512)		4,184		0							(29,327)	20
21	Clerical & General Office Expenses	(243,249)		212,324		606							(30,319)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			477									477	24
25	Other Admin. Staff Transportation			1,517									1,517	25
26	Insurance-Prop.Liab.Malpractice			9,129		171							9,300	26
27	Other (specify):*			14,336									14,336	27
28	**TOTAL General Administration**	(326,546)	36,853	327,772		924		(4,652)					34,350	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(608,985)	36,853	458,676		3,095	(1,263)	(4,652)					(116,276)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(205,114)	455,846			4,965							255,697	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(5,033)	215,776			1,581							212,324	32
33	Real Estate Taxes		1			2,483							2,484	33
34	Rent-Facility & Grounds		(788,069)	20,897		(20,790)							(787,962)	34
35	Rent-Equipment & Vehicles				3,095								3,095	35
36	Other (specify):*	(41,395)	41,395											36
37	TOTAL Ownership	(251,542)	(75,051)	20,897	3,095	(11,761)							(314,362)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(1,943)											(1,943)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(459,768)											(459,768)	43
44	TOTAL Special Cost Centers	(461,712)											(461,712)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,322,239)	(38,198)	479,573	3,095	(8,666)	(1,263)	(4,652)					(892,350)	45

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 788,069	Berwyn Property Holdings LLC		$	$ (788,069)	1
2	V	33	Real Estate Tax	494,581	Berwyn Property Holdings LLC		494,582	1	2
3	V	32	Interest	73	Berwyn Property Holdings LLC		215,849	215,776	3
4	V	19	Broker Fees		Berwyn Property Holdings LLC		35,000	35,000	4
5	V	19	Accounting Fees		Berwyn Property Holdings LLC		1,853	1,853	5
6	V	30	Depreciation		Berwyn Property Holdings LLC		455,846	455,846	6
7	V	36	Amortization		Berwyn Property Holdings LLC		41,395	41,395	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,282,723			$ 1,244,525	$ * (38,198)	14

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

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

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	42.50%	Astoria Place Skilled Nursing Facility LLC	Chicago	Berwyn Property Holdings LL		Building Company	1
2	DOROS GENERATION TRUST	42.50%	Avantara Arlington	Arlington, SD	Legacy HC & Financial Servic	Lincolnwood	Home Office/Bookkeeping	2
3	OAKWAY OPERATIONS, LLC	15.00%	Avantara Armour	Armour, SD	CF St. Louis LLC	Skokie	Building Company	3
4			Avantara Arrowhead	Rapid City, SD	ML Group Design & Developm	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 Chicago Ridge	Chicago Ridge	Ecobrite Linen	Skokie	Laundry Supplies	7
8			Avantara Clark	Clark, SD	Lifescan Labs of Illinois	Skokie	Laboratory Services	8
9			Avantara Elgin	Elgin	Aurora Supportive Living	Aurora	Supportive Living	9
10			Avantara Evergreen Park	Evergreen Park	Terrace Gardens	Morton Grove	Assisted Living	10
11			Avantara Groton	Groton, SD	Lincolnshire Assisted Living C	Lincolnshire	Assisted Living	11
12			Avantara Huron	Huron, SD	Wellshire Park Place	Milbank, SD	Assisted Living	12
13			Avantara Ipswich	Ipswich, SD	Wellshire Huron	Huron, SD	Assisted Living	13
14			Avantara Lake Norden	Lake Norden, SD				14
15			Avantara Lake Zurich	Lake Zurich				15
16			Avantara Long Grove	Long Grove				16
17			Avantara Milbank	Milbank, SD				17
18			Avantara Mountainview	Rapid City, SD				18
19			Avantara North	Rapid City, SD				19
20			Avantara Norton	Sioux Falls, SD				20
21			Avantara Park Ridge	Park Ridge				21
22			Avantara Pierre	Pierre, SD				22
23			Avantara Redfield	Redfield, SD				23
24			Avantara Salem	Salem, SD				24
25			Avantara St. Cloud	Rapid City, SD				25
26			Avantara Watertown	Watertown, SD				26
27			Bella Terra Bloomingdale	Bloomingdale				27
28			Bella Terra Elmhurst	Elmhurst				28
29			Bella Terra LaGrange	Lagrange				29
30			Bella Terra Lombard	Lombard				30

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

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			Bella Terra Schaumburg	Schaumburg				1
2			Bella Terra Streamwood	Streamwood				2
3			Bella Terra Wheeling	Wheeling				3
4			Bella Terra Morton Grove	Morton Grove				4
5			Carlton Skilled Nursing Facility LLC	Chicago				5
6			Chalet Skilled Nursing Facility LLC	Chicago				6
7			Clark Skilled Nursing Facility	Chicago				7
8			Elmbrook Skilled Nursing Facility LLC	Elmhurst				8
9			Evanston Skilled Nursing Facility LLC	Evanston				9
10			Grove at the Lake Skilled Nursing Facility LLC	Zion				10
11			Grove of Fox Valley	Aurora				11
12			Grove of St. Charles	St. Charles				12
13			Lagrange Skilled Nursing Facility LLC	Lagrange Park				13
14			Lakefront Skilled Nursing Facility LLC	Chicago				14
15			Lincoln Park Skilled Nursing Facility LLC	Chicago				15
16			Lincolnshire Living & Rehab Center LLC	Lincolnshire				16
17			Northbrook Skilled Nursing Facility LLC	Northbrook				17
18			Peterson Park Associates Limited Partnership	Chicago				18
19			Skokie Skilled Nursing Facility LLC	Skokie				19
20			Valley Skilled Nursing Facility	Billings, MT				20
21			Warren Barr Lieberman	Skokie				21
22			Warren Barr Orland Park	Orland Park				22
23			Warren Barr Living And Rehab	Chicago				23
24			Warren Barr North Shore	Highland Park				24
25			Warren Barr South Loop	Chicago				25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietician Salary	$	Legacy Healthcare Financial Services		$ 2,162	$ 2,162	15
16	V	01	Dietary Supplies		Legacy Healthcare Financial Services		22	22	16
17	V	03	Housekeeping		Legacy Healthcare Financial Services		1,601	1,601	17
18	V	05	Utilities		Legacy Healthcare Financial Services		10	10	18
19	V	06	Maintenance Salary		Legacy Healthcare Financial Services		8,895	8,895	19
20	V	06	Repairs & Maintenance		Legacy Healthcare Financial Services		548	548	20
21	V	07	General Service Payroll Taxes / Benefits		Legacy Healthcare Financial Services		597	597	21
22	V	09	Medical Director Consultant		Legacy Healthcare Financial Services		6,800	6,800	22
23	V	10	Nursing Salary		Legacy Healthcare Financial Services		86,225	86,225	23
24	V	10	Nurse Consultant		Legacy Healthcare Financial Services		2,109	2,109	24
25	V	10	Medical Supplies	14,280	Legacy Healthcare Financial Services		28,113	13,833	25
26	V	12	Social Service Salary		Legacy Healthcare Financial Services		3,159	3,159	26
27	V	15	Healthcare Payroll Taxes / Benefits		Legacy Healthcare Financial Services		4,943	4,943	27
28	V	17	COO / Administrator Salary		Legacy Healthcare Financial Services		61,779	61,779	28
29	V	19	Professional Fees		Legacy Healthcare Financial Services		24,025	24,025	29
30	V	20	Dues / Licenses / Permits		Legacy Healthcare Financial Services		4,184	4,184	30
31	V	21	Clerical & General Wages		Legacy Healthcare Financial Services		195,976	195,976	31
32	V	21	Clerical & Office Expense		Legacy Healthcare Financial Services		16,348	16,348	32
33	V	24	Education & Seminars		Legacy Healthcare Financial Services		477	477	33
34	V	25	Travel		Legacy Healthcare Financial Services		1,517	1,517	34
35	V	26	Insurance - General		Legacy Healthcare Financial Services		9,129	9,129	35
36	V	27	General and Administrative Payroll Taxes / Benefits		Legacy Healthcare Financial Services		14,336	14,336	36
37	V	34	Rent		Legacy Healthcare Financial Services		20,790	20,790	37
38	V	34	Offsite Storage / Parking		Legacy Healthcare Financial Services		107	107	38
39	Total			$ 14,280			$ 493,852	$ * 479,573	39

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

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Equipment Rental		Legacy Healthcare Financial Services		337	$ 337	15
16	V	35	Auto Rental		Legacy Healthcare Financial Services		2,758	2,758	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			$			$ 3,095	$ * 3,095	39

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

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	CF St. Louis LLC		$ 931	$ 931	15
16	V	6	Repairs And Maintenance		CF St. Louis LLC		1,241	1,241	16
17	V	19	Property Valuation Fee		CF St. Louis LLC		14	14	17
18	V	19	Professional Fees		CF St. Louis LLC		132	132	18
19	V	20	Dues And Subscriptions		CF St. Louis LLC		0	0	19
20	V	21	Office Expense		CF St. Louis LLC		606	606	20
21	V	26	Insurance		CF St. Louis LLC		171	171	21
22	V	30	Depreciation		CF St. Louis LLC		4,965	4,965	22
23	V	32	Interest Expense		CF St. Louis LLC		1,581	1,581	23
24	V	33	Real Estate Taxes		CF St. Louis LLC		2,483	2,483	24
25	V								25
26	V	34	Rent	20,790	CF St. Louis LLC			(20,790)	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			$ 20,790			$ 12,124	$ * (8,666)	39

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

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Medical Supplies	$ 9,000	ReMED Services		$ 7,737	$ (1,263)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,000			$ 7,737	$ * (1,263)	39

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

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	$ 23,771	ProPay HR LLC		$ 19,119	$ (4,652)	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			$ 23,771			$ 19,119	$ * (4,652)	39

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

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietician Salary	Available Bed Days	2,889,840	61	$ 118,039	$ 118,039	52,925	$ 2,162	1
2	01	Dietary Supplies	Available Bed Days	2,889,840	61	1,195		52,925	22	2
3	03	Housekeeping	Available Bed Days	2,889,840	61	87,421		52,925	1,601	3
4	05	Utilities	Available Bed Days	2,889,840	61	557		52,925	10	4
5	06	Maintenance Salary	Available Bed Days	2,889,840	61	485,663	485,663	52,925	8,895	5
6	06	Repairs & Maintenance	Available Bed Days	2,889,840	61	29,943		52,925	548	6
7	07	General Service Payroll Taxes / Be	Available Bed Days	2,889,840	61	32,603		52,925	597	7
8	09	Medical Director Consultant	Available Bed Days	2,889,840	61	371,300		52,925	6,800	8
9	10	Nursing Salary	Available Bed Days	2,889,840	61	4,708,099	4,708,099	52,925	86,225	9
10	10	Nurse Consultant	Available Bed Days	2,889,840	61	115,160		52,925	2,109	10
11	10	Medical Supplies	Available Bed Days	2,889,840	61	1,535,045		52,925	28,113	11
12	12	Social Service Salary	Available Bed Days	2,889,840	61	172,481	172,481	52,925	3,159	12
13	15	Healthcare Payroll Taxes / Benefit	Available Bed Days	2,889,840	61	269,882		52,925	4,943	13
14	17	COO / Administrator Salary	Available Bed Days	2,889,840	61	3,373,265	3,373,265	52,925	61,779	14
15	19	Professional Fees	Available Bed Days	2,889,840	61	1,311,825		52,925	24,025	15
16	20	Dues / Licenses / Permits	Available Bed Days	2,889,840	61	228,478		52,925	4,184	16
17	21	Clerical & General Wages	Available Bed Days	2,889,840	61	10,700,801	10,700,801	52,925	195,976	17
18	21	Clerical & Office Expense	Available Bed Days	2,889,840	61	892,657		52,925	16,348	18
19	24	Education & Seminars	Available Bed Days	2,889,840	61	26,063		52,925	477	19
20	25	Travel	Available Bed Days	2,889,840	61	82,841		52,925	1,517	20
21	26	Insurance - General	Available Bed Days	2,889,840	61	498,476		52,925	9,129	21
22	27	General and Administrative Payro	Available Bed Days	2,889,840	61	782,756		52,925	14,336	22
23	34	Rent	Available Bed Days	2,889,840	61	1,135,189		52,925	20,790	23
24	34	Offsite Storage / Parking	Available Bed Days	2,889,840	61	5,843		52,925	107	24
25	TOTALS					$ 26,965,583	$ 19,558,349		$ 493,852	25

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	35	Equipment Rental	Available Bed Days	2,889,840	61	18,390		52,925	337	1
2	35	Auto Rental	Available Bed Days	2,889,840	61	150,617		52,925	2,758	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					$ 169,007	$		$ 3,095	25

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Available Bed Days	2,889,840	61	$ 50,814	$	52,925	$ 931	1
2	6	Repairs And Maintenance	Available Bed Days	2,889,840	61	67,777		52,925	1,241	2
3	19	Property Valuation Fee	Available Bed Days	2,889,840	61	759		52,925	14	3
4	19	Professional Fees	Available Bed Days	2,889,840	61	7,198		52,925	132	4
5	20	Dues And Subscriptions	Available Bed Days	2,889,840	61	23		52,925	0	5
6	21	Office Expense	Available Bed Days	2,889,840	61	33,091		52,925	606	6
7	26	Insurance	Available Bed Days	2,889,840	61	9,348		52,925	171	7
8	30	Depreciation	Available Bed Days	2,889,840	61	271,114		52,925	4,965	8
9	32	Interest Expense	Available Bed Days	2,889,840	61	86,317		52,925	1,581	9
10	33	Real Estate Taxes	Available Bed Days	2,889,840	61	135,576		52,925	2,483	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					$ 662,017	$		$ 12,124	25

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Medical Supplies	Direct			$	$		$ 7,737	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 7,737	25

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct			$	$		$ 19,119	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
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14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 19,119	25

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
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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 The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
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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 The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

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 Payable			$	$ 5,500,000			$ 200,749	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CIBC		X	Note Payable				470,000			8,343	6
7	IPFS Corporation		X	Prepaid Insurance - Interest Only							227	7
8	CIBC		X	Line of Credit				413,652			15,100	8
9	TOTAL Facility Related						$	$ 6,383,652			$ 224,419	9
	B. Non-Facility Related*											
10	Interest Income		X								(5,033)	10
11	Interest Income - Bldg Co.		X								(73)	11
12	Allocated from CF St. Louis	X									1,581	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (3,525)	14
15	TOTALS (line 9+line14)						$	$ 6,383,652			$ 220,894	15

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

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

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

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2020 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 600,529	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 528,063	2
3. Under or (over) accrual (line 2 minus line 1).		$ (72,466)	3
4. Real Estate Tax accrual used for 2021 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 569,530	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$ 15,664	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 512,728	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2016	483,001	8
	2017	499,424	9
	2018	546,330	10
	2019	583,038	11
	2020	525,580	12

2021 Accrual = $525,580 x 1.084 = $569,530 (rounded)

Allocated from CF St. Louis $2,483

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2020	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2020 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Grove of Berwyn COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0055442

CONTACT PERSON REGARDING THIS REPORT Steven N. Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2020 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 2020.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-31-308-001-0000	Long Term Care Property	$ 112,920.68	$ 112,920.68
2.	16-31-308-002-0000	Long Term Care Property	$ 105,873.07	$ 105,873.07
3.	16-31-308-003-0000	Long Term Care Property	$ 33,900.72	$ 33,900.72
4.	16-31-308-004-0000	Long Term Care Property	$ 110,106.39	$ 110,106.39
5.	16-31-308-005-0000	Long Term Care Property	$ 105,873.07	$ 105,873.07
6.	16-31-308-006-0000	Long Term Care Property	$ 30,030.33	$ 30,030.33
7.	16-31-308-007-0000	Long Term Care Property	$ 9,019.07	$ 9,019.07
8.	16-31-308-008-0000	Long Term Care Property	$ 8,781.25	$ 8,781.25
9.	16-31-308-009-0000	Long Term Care Property	$ 9,075.81	$ 9,075.81
10.	10-23-406-034-0000	Home Office Allocation	$ 446,531.16	$ 2,482.97
		TOTALS	$ 972,111.55	$ 528,063.36

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach copies of the original 2020 tax bills which were listed in Section A to this statement. Be sure to use the 2020 tax bill which is normally paid during 2021.

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: 2020 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 2020 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2020.

Please complete the Real Estate Tax Statement below and include it in the 2021 cost report along with a copy of your 2020 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) 524-4489.

2020 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Grove of Berwyn COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0055442

CONTACT PERSON REGARDING THIS REPORT Steven N. Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2020 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 2020.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach copies of the original 2020 tax bills which were listed in Section A to this statement. Be sure to use the 2020 tax bill which is normally paid during 2021.

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

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,431 B. General Construction Type: Exterior Brick Frame Concrete Steel Number of Stories 3

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

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

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

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

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

None

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 511,755	1
2	Allocated from CF St. Louis, LLC			3,614	2
3	TOTALS			$ 515,369	3

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	145		2019	1964	$ 6,691,521	$ 455,846	35	$ 191,186	$ (264,660)	$ 534,904	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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											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 The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

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)								67
68	Related Party Allocations (Pages 12H & 12I)		174,855	4,589		8,326	3,737	44,511	68
69	Financial Statement Depreciation			102,332			(102,332)		69
70	TOTAL (lines 4 thru 69)		$ 6,866,376	$ 562,767		$ 199,512	$ (363,255)	$ 579,415	70

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

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,866,376	$ 562,767		$ 199,512	$ (363,255)	$ 579,415	1
2	Paint Project - Wood Panels/Entry Way/Window Panels ($14900)	2019	14,440		20	722	722	1,661	2
3	Installed 70 Windows - Primed/Paint Patio /Tuckpoint/Patch ($292	2019	2,835		20	142	142	321	3
4	Installed New Receptacles On 1St-3Rd Floor ($4235)	2019	4,104		20	205	205	507	4
5	Elevator Door Operator, Detector ($10711)	2019	10,380		20	519	519	1,127	5
6	Installed Cables On 2Nd Floor Pipes/Closets ($14340)	2019	13,897		20	695	695	2,824	6
7	Repaired Nurse Call System Wiring / Mount Kit ($22093)	2019	21,410		20	1,071	1,071	4,351	7
8	Replaced Ejector Pumps In Basement ($18945)	2019	18,360		20	918	918	3,731	8
9	Exhaust Fan ($3165)	2019	3,067		20	153	153	596	9
10	Air Conditioners ($5630)	2019	5,456		20	273	273	874	10
11	Air Conditioners ($7132)	2019	6,912		20	346	346	1,167	11
12	Air Conditioners ($7523)	2019	7,291		20	365	365	1,169	12
13	Air Conditioners ($5750)	2019	5,572		20	279	279	893	13
14	Walk In Freezer Door ($3180)	2019	3,082		20	154	154	467	14
15	Crane Hot Water Heating Boiler ($4980)	2019	4,826		20	241	241	980	15
16	Hot Water Piping ($8460)	2019	8,199		20	410	410	1,666	16
17	Repaired Nurse Call System 1St-3Rd Floor ($66278)	2019	64,230		20	3,212	3,212	10,290	17
18	Landscape By Courtyard ($15000)	2019	14,537		20	727	727	1,892	18
19	Air Conditioners ($4128.8)	2019	4,001		20	200	200	600	19
20	Sign Installation ($15649.4)	2019	15,166		20	758	758	2,275	20
21	Repair Leaks On 3-Way Valve ($3,750)	2019	3,634		20	182	182	545	21
22	Furnish And Install New Hydraulic Packing ($2,500)	2019	2,423		20	121	121	363	22
23	Replace Rotten P-Trap In Dish Area ($2,650)	2019	2,568		20	128	128	385	23
24	Repair Leaking Hot Water Pipe In Boiler Room ($8,722.11)	2019	8,452		20	423	423	1,172	24
25	Reroute Circuits To Panel On Second Floor, And Install 2 Quad R	2019	7,951		20	398	398	1,193	25
26	Install New Panel For Relocation Of Critical Panel Circuits ($10,6	2019	10,304		20	515	515	1,545	26
27	Replace Elevator Flooring, Replace Deck Wood Planks (2,725)	2020	2,658		20	133	133	266	27
28	Freight Elevator Vinyl Tiles & Door Installation (2,975)	2020	2,902		20	145	145	290	28
29	Dialysis Rm Doors, Acoustic Ceilings, Flooring, Painting, Plumbin	2020	131,393		20	6,570	6,570	13,140	29
30	Replace Block Heater (2,906)	2020	2,835		20	142	142	284	30
31	Keypad Wander For Door (6,059)	2020	5,910		20	296	296	592	31
32	2 Wanderguards In Basement & Alarm On 1St Fl (13,960)	2020	13,618		20	681	681	1,362	32
33	Shaker Assembled In Kitchen Cabinet Drawer Base (3,301)	2020	3,221		20	161	161	322	33
34	TOTAL (lines 1 thru 33)		$ 7,292,010	$ 562,767		$ 220,797	$ (341,970)	$ 638,265	34

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

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 7,292,010	$ 562,767		$ 220,797	$ (341,970)	$ 638,265	1
2	Hdmi Cables (3,039)	2020	2,964		20	148	148	444	2
3	Elevator Repair (15,000)	2020	14,633		20	732	732	1,464	3
4	Replace 2 Sump Pit Motor Starters (2,932)	2020	2,860		20	143	143	286	4
5	North Freight Elevator Repair (7,459)	2020	7,276		20	364	364	728	5
6	South Passenger Elevator Repair (3,894)	2020	3,799		20	190	190	380	6
7	South Passenger Elevator Repair (4,445)	2020	4,336		20	217	217	434	7
8	Repair Heat On 3Rd Floor (3,212)	2020	3,133		20	157	157	314	8
9	Install Fire Doors - 1St,2Nd,3Rd Flr,Repair Leaky Toilet Piping ($	2021	3,193		20	160	160	160	9
10	Install New Boiler ($25,800)	2021	25,261		20	1,263	1,263	1,263	10
11	Repaired Hot Water Mixing Valves On A/C Unit ($3,200)	2021	3,133		20	157	157	157	11
12	Repaired Water Heaters And Boilers In Boiler Room ($12,236)	2021	11,980		20	599	599	599	12
13	Dialysis And Pump Room - Wallcabinets, Countertops, Valves/Pip	2021	2,448		20	122	122	122	13
14	Repaired Sensors, Safety Beams, Controls On Lobby Doors ($3,54	2021	3,475		20	174	174	174	14
15	Repaired Circuit Light Fixtures In Dialysis Room ($6,338)	2021	6,206		20	310	310	310	15
16	Repaired Heat Basement Boiler Room & Fire Alarm Systems ($7,9	2021	7,766		20	388	388	388	16
17	Install Pipe Insulation-Boiler Rm,Hallway,Laundry & Break Rm (	2021	4,930		20	247	247	247	17
18	North Elevator Repair - Output Door, Rack On Passenger Car ($4	2021	4,525		20	226	226	226	18
19	Install New Exit Signs - Dialysis Door, Basement South Exit ($2,96	2021	2,898		20	145	145	145	19
20	Installed Pumping Unit On South Passenger Elevator ($15,00)	2021	14,687		20	734	734	734	20
21	Replaced Motor For 1St & 2Nd Floor Pump ($3,970)	2021	3,887		20	194	194	194	21
22	North Elevator Repair - Adjust Valve And Leveling Vain ($3,517)	2021	3,443		20	172	172	172	22
23	South Elevator Repair - Front Detector Edge, Rear Relating Cable	2021	2,500		20	125	125	125	23
24	Replace Main Domestic Hot Water Boiler Pump ($2,843)	2021	2,784		20	139	139	139	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)		$ 7,434,126	$ 562,767		$ 227,904	$ (334,863)	$ 647,471	34

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

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 7,434,126	$ 562,767		$ 227,904	$ (334,863)	$ 647,471	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)		$ 7,434,126	$ 562,767		$ 227,904	$ (334,863)	$ 647,471	34

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

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 7,434,126	$ 562,767		$ 227,904	$ (334,863)	$ 647,471	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,434,126	$ 562,767		$ 227,904	$ (334,863)	$ 647,471	34

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

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

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									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

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		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party								1
2	Buildings:								2
3	Allocated from CF St. Louis, LLC	2016	19,462	879	35	556	(323)	3,336	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	120,832	2,890	20	6,042	3,152	36,250	9
10	Allocated from CF St. Louis, LLC	2017	2,805	67	20	140	73	701	10
11	Allocated from CF St. Louis, LLC	2019	25,420	608	20	1,271	663	3,813	11
12	Allocated from CF St. Louis, LLC	2020	1,337	32	20	67	35	134	12
13	Allocated from CF St. Louis, LLC	2021	4,747	114	20	237	124	237	13
14									14
15	Allocated from Legacy HC	2018	144		20	7	7	29	15
16	Allocated from Legacy HC	2020	109		20	5	5	11	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)		$ 174,855	$ 4,589		$ 8,326	$ 3,737	$ 44,511	34

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

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

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		$ 174,855	$ 4,589		$ 8,326	$ 3,737	$ 44,511	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 174,855	$ 4,589		$ 8,326	$ 3,737	$ 44,511	34

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

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,287,519	$ 379	$ 128,753	$ 128,374	10	$ 361,767	71
72	Current Year Purchases	13,750		1,375	1,375	10	1,375	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,301,269	$ 379	$ 130,128	$ 129,749		$ 363,142	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)	$ 9,250,765	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 563,146	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 358,032	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (205,114)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,010,613	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	Elevator Modernization	$ 29,162	92
93			93
94			94
95		$ 29,162	95

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

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

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Legacy HC				107			5
6								6
7	TOTAL				$ 107 **			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: *

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.	/2022	$
13.	/2023	$
14.	/2024	$

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: $ 13,498 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 HC		$	$ 2,758	17
18					18
19					19
20					20
21	TOTAL		$	$ 2,758	21

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

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

Facility Name & ID Number The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 182,630	$		$ 182,630	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			66,323			66,323	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			248,836			248,836	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				84,848		84,848	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					28,330	70,042		98,372	13
14	TOTAL			$		$ 526,119	$ 154,890		$ 681,009	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 The Grove of Berwyn # 0055442 Report Period Beginning: 01/01/21 Ending: 12/31/21

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/21 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,578	$ 1,401,208	1
2	Cash-Patient Deposits	19,443	19,443	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,173,897	1,173,897	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,267	7,267	6
7	Other Prepaid Expenses	98,970	98,970	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	43,316	48,316	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,344,471	$ 2,749,101	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		684,000	13
14	Buildings, at Historical Cost		6,156,000	14
15	Leasehold Improvements, at Historical Cost	254,957	254,957	15
16	Equipment, at Historical Cost	423,543	1,913,543	16
17	Accumulated Depreciation (book methods)	(231,936)	(1,561,487)	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	29,804	3,510,153	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 476,368	$ 10,957,166	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,820,839	$ 13,706,267	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 664,624	$ 899,417	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	470,000	883,652	29
30	Accrued Salaries Payable	249,907	249,907	30
31	Accrued Taxes Payable (excluding real estate taxes)	105,099	105,099	31
32	Accrued Real Estate Taxes(Sch.IX-B)		569,530	32
33	Accrued Interest Payable	1,175	18,933	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	191,763	191,763	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,682,568	$ 2,918,301	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,500,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	1,565,489	1,729,542	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,565,489	$ 7,229,542	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,248,057	$ 10,147,843	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,427,218)	$ 3,558,424	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,820,839	$ 13,706,267	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,518,259)	1
2	Restatements (describe):		2
3	Depreciation	(70,002)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,588,261)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	161,043	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)**	$ 161,043	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)**	$ (1,427,218)	24 *

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 14,836,023	1
2	Discounts and Allowances for all Levels	(7,216,728)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,619,295	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,450,070	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,450,070	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	268,434	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	87,874	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,343	19
20	Radiology and X-Ray	3,860	20
21	Other Medical Services	5,456	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 384,967	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,033	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,033	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	991,624	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 991,624	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,450,989	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,591,735	31
32	Health Care	3,861,419	32
33	General Administration	1,985,951	33
	B. Capital Expense		
34	Ownership	1,406,712	34
	C. Ancillary Expense		
35	Special Cost Centers	1,140,777	35
36	Provider Participation Fee	303,352	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,289,946	40
41	**Income before Income Taxes (line 30 minus line 40)****	161,043	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 161,043	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,530,674	44
45	Private Pay - Net Inpatient Revenue	366,000	45
46	Medicare - Net Inpatient Revenue	638,086	46
47	Other-(specify) Insurance	84,535	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,619,295	49

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

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

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

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

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,615	1,870	$ 117,162	$ 62.65	1
2	Assistant Director of Nursing	817	910	42,569	46.78	2
3	Registered Nurses	8,584	9,507	378,803	39.84	3
4	Licensed Practical Nurses	34,473	37,687	1,299,277	34.48	4
5	CNAs & Orderlies	47,651	52,322	963,567	18.42	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,149	5,773	138,252	23.95	8
9	Activity Director	1,576	1,728	38,122	22.06	9
10	Activity Assistants	8,142	8,954	147,072	16.43	10
11	Social Service Workers	5,512	5,952	156,173	26.24	11
12	Dietician					12
13	Food Service Supervisor	374	409	11,047	27.01	13
14	Head Cook	1,348	1,419	22,510	15.86	14
15	Cook Helpers/Assistants	2,507	2,634	36,875	14.00	15
16	Dishwashers					16
17	Maintenance Workers	5,043	5,395	124,306	23.04	17
18	Housekeepers	12,822	13,751	220,402	16.03	18
19	Laundry	6,115	6,592	107,246	16.27	19
20	Administrator	2,008	2,160	115,888	53.65	20
21	Assistant Administrator	2,024	2,088	72,383	34.67	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,161	10,887	184,986	16.99	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	3,079	3,434	82,628	24.06	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	2,214	2,432	49,543	20.37	33
34	TOTAL (lines 1 - 33)	161,214	175,904	$ 4,308,811 *	$ 24.50	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 668,804	01-03	35
36	Medical Director	Monthly	24,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	42,320	10-03	38
39	Pharmacist Consultant	Monthly	13,490	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,254	11-03	44
45	Social Service Consultant	Monthly	9,727	12-03	45
46	Other(specify) Dialysis Consultant	Monthly	65,010	10-03	46
47	Psychiatric Consultant	Monthly	500	12-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 825,105		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	603	$ 62,769	10-03	50
51	Licensed Practical Nurses	914	79,409	10-03	51
52	Certified Nurse Assistants/Aides	571	21,858	10-03	52
53	TOTAL (lines 50 - 52)	2,087	$ 164,036		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sarah Parker	Administrator	0	$ 115,888
Emilio Benitez	Assistant Admin	0	13,573
Adam Zollinger	Assistant Admin	0	58,810
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 188,271

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
See Attached	Legal	221,562
Propay HR LLC	Payroll Processing	23,771
Onyx Procurement Solutions	Procurement Services	9,120
CertiSurv, LLC	Healthcare Consulting	380
Patient Ping, Inc.	Healthcare Software	6,000
Telemedicine Solutions	Risk Prevention Software	4,879
Personnel Planners	Unemployment Consultant	2,534
Compliagent	Compliance	3,380
Proactive Workflows	Revenue Cycle Management	1,143
Cortex Health Inc.	Data Processing	4,060
See Supplemental Schedule		3,277
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 304,107

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 63,975
Unemployment Compensation Insurance	61,391
FICA Taxes	310,538
Employee Health Insurance	142,787
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	24,688
Other Employee Benefits	21,167
401K Expense	2,461
Voluntary Benefit Contributions	18,969
Employee Physical Exams	8,948
TOTAL (agree to Schedule V, line 22, col.8)	$ 654,924

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	5,475
Health Care Worker Background Check	
(Indicate # of checks performed 206)	2,060
Patient Background Checks 266	2,662
Dues & Subscriptions	13,460
Licenses & Fees	2,336
See Supplemental Schedule	4,185
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,167

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	600
See Supplemental Schedule	477
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,077

**See instructions.

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI $24,360**

(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. $ **26,570** Line **10**

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

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **303,352**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

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