

		FOR BHF USE					

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

IMPORTANT NOTICE

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

I. IDPH License ID Number: 0053926

Facility Name: The Grove at the Lake

Address: 2534 Elim Avenue Zion 60099

County: Lake

Telephone Number: (847) 746-8435 Fax #: (847) 746-1744

HFS ID Number:

Date of Initial License for Current Owners: 10/10/1982

Type of Ownership:

VOLUNTARY,NON-PROFIT
Charitable Corp.
Trust
IRS Exemption Code

X PROPRIETARY
Individual
Partnership
Corporation
"Sub-S" Corp.
X Limited Liability Co.
Trust
Other

GOVERNMENTAL
State
County
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 01/01/20 to 12/31/20 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) 04/30/2021
(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 at the Lake

0053926 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>244</u>	Skilled (SNF)	<u>244</u>	<u>89,304</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>244</u>	TOTALS	<u>244</u>	<u>89,304</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>47,229</u>	<u>2,292</u>	<u>5,192</u>	<u>54,713</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>47,229</u>	<u>2,292</u>	<u>5,192</u>	<u>54,713</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 61.27%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 10/10/1982

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 10/10/1982 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 244 and days of care provided 3,820

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number The Grove at the Lake # 0053926 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	443,259	48,711	65,055	557,025		557,025	4,341	561,366			1
2	Food Purchase		310,865		310,865		310,865	8,129	318,994			2
3	Housekeeping	374,504	76,256	2,029	452,789		452,789	2,815	455,604			3
4	Laundry	136,380	38,921		175,301		175,301	191	175,492			4
5	Heat and Other Utilities			211,706	211,706		211,706	(12,464)	199,242			5
6	Maintenance	152,426	30,265	168,736	351,427		351,427	11,752	363,179			6
7	Other (specify):*											7
8	TOTAL General Services	1,106,569	505,018	447,526	2,059,113		2,059,113	14,765	2,073,878			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	4,374,783	372,211	262,034	5,009,028		5,009,028	138,811	5,147,839			10
10a	Therapy	208,188			208,188		208,188		208,188			10a
11	Activities	219,864	4,069	3,387	227,320		227,320	11	227,331			11
12	Social Services	737,298		1,582	738,880		738,880	7,541	746,421			12
13	CNA Training											13
14	Program Transportation			8,300	8,300		8,300		8,300			14
15	Other (specify):*							7,822	7,822			15
16	TOTAL Health Care and Programs	5,540,133	376,280	293,303	6,209,716		6,209,716	154,185	6,363,901			16
	C. General Administration											
17	Administrative	145,456			145,456		145,456	83,946	229,402			17
18	Directors Fees											18
19	Professional Services			371,693	371,693	(7,098)	364,595	(12,013)	352,582			19
20	Dues, Fees, Subscriptions & Promotions			104,185	104,185		104,185	(55,358)	48,827			20
21	Clerical & General Office Expenses	231,992	3,137	529,967	765,096		765,096	(29,856)	735,240			21
22	Employee Benefits & Payroll Taxes			1,245,318	1,245,318		1,245,318	(11,000)	1,234,318			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,958	1,958		1,958	187	2,145			24
25	Other Admin. Staff Transportation			880	880		880	6,276	7,156			25
26	Insurance-Prop.Liab.Malpractice			466,527	466,527		466,527	16,921	483,448			26
27	Other (specify):*							33,646	33,646			27
28	TOTAL General Administration	377,448	3,137	2,720,528	3,101,113	(7,098)	3,094,015	32,750	3,126,765			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,024,150	884,435	3,461,357	11,369,942	(7,098)	11,362,844	201,699	11,564,543			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							583,932	583,932			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,215	30,215		30,215	808,619	838,834			32
33	Real Estate Taxes			44,931	44,931	7,098	52,029	233,999	286,028			33
34	Rent-Facility & Grounds			1,750,913	1,750,913		1,750,913	(1,746,938)	3,975			34
35	Rent-Equipment & Vehicles			10,227	10,227		10,227	6,096	16,323			35
36	Other (specify):*							106,280	106,280			36
37	TOTAL Ownership			1,836,286	1,836,286	7,098	1,843,384	(8,012)	1,835,372			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	378,482	478,610	728,752	1,585,844		1,585,844	(15,222)	1,570,622			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			446,324	446,324		446,324		446,324			42
43	Other (specify):*			701,710	701,710		701,710	(701,710)				43
44	TOTAL Special Cost Centers	378,482	478,610	1,876,786	2,733,878		2,733,878	(716,932)	2,016,946			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,402,632	1,363,045	7,174,429	15,940,106		15,940,106	(523,245)	15,416,861			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(13,932)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	167,947	30		9
10	Interest and Other Investment Income	(6,403)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(130)	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	(45,686)	21		18
19	Entertainment	(4,424)	21		19
20	Contributions	(12,732)	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	(295,836)	21		24
25	Fund Raising, Advertising and Promotional	(27,487)	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	(851,942)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,090,625)		\$	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)	567,380		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 567,380		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (523,245)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non Allowable Expense	\$ (701,710)	43	1
2	Rebates	(6,757)	21	2
3	Patient Personal Items	(4,002)	10	3
4	Bank Charges	(7,091)	21	4
5	Sequestration	(32,077)	21	5
6	Pharmacy Discounts	(191)	10	6
7	Misc Income	(1,731)	21	7
8	Executive Insurance	(11,000)	22	8
9	Bldg Co - Filing Fees	(75)	20	9
10	Bldg Co - Accounting	(17,258)	19	10
11	Bldg Co - Legal Fees	(9,557)	19	11
12	Bldg Co - Amortization	(4,906)	36	12
13	Non Allowable Legal	(32,547)	19	13
14	Marketing Licenses	(1,438)	20	14
15	PAC Dues	(18,407)	20	15
16	Capitalized R&M	(3,195)	06	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
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30				30
31				31
32				32
33				33
34				34
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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	(851,942)		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 58

The Grove at the Lake

08/5/26

12/31/26

Report Period Beginning: 01/01/26

Ending: 12/31/26

NON-ALLOWABLE EXPENSES

Amount

Sch. Y Line

Reference

58

\$

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Total

49

[illegible]

Summary A

12/31/20

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Grove at the Lake # 0053926 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	167,947	406,929			9,056							583,932	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(6,403)	809,933			5,089							808,619	32
33	Real Estate Taxes		229,375			4,624							233,999	33
34	Rent-Facility & Grounds		(1,747,069)	42,614		(42,483)							(1,746,938)	34
35	Rent-Equipment & Vehicles				6,096								6,096	35
36	Other (specify):*	(4,906)	111,186										106,280	36
37	TOTAL Ownership	156,638	(189,646)	42,614	6,096	(23,714)							(8,012)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers									(15,222)			(15,222)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(701,710)											(701,710)	43
44	TOTAL Special Cost Centers	(701,710)								(15,222)			(716,932)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,090,625)	(146,369)	744,136	13,918	(19,496)	(7,642)	(588)	(1,357)	(15,222)			(523,245)	45

VII. RELATED PARTIES

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

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

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 1,747,069	Grove at the Lake Realty		\$	(1,747,069)	1
2	V	32	Interest	557	Grove at the Lake Realty		810,490	809,933	2
3	V	33	Real Estate Taxes		Grove at the Lake Realty		229,375	229,375	3
4	V	26	Property Insurance		Grove at the Lake Realty		16,387	16,387	4
5	V	36	MIP Expense		Grove at the Lake Realty		106,280	106,280	5
6	V	20	Filing Fees		Grove at the Lake Realty		75	75	6
7	V	19	Accounting		Grove at the Lake Realty		17,258	17,258	7
8	V	19	Legal Fees		Grove at the Lake Realty		9,557	9,557	8
9	V	30	Depreciation		Grove at the Lake Realty		406,929	406,929	9
10	V	36	Amortization		Grove at the Lake Realty		4,906	4,906	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,747,626			\$ 1,601,257	\$ * (146,369)	14

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

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Elmbrook Skilled Nursing Facility LLC	Elmhurst				1
2			Evanston Skilled Nursing Facility LLC	Evanston				2
3			Grove of Berwyn	Berwyn				3
4			Grove of Fox Valley	Aurora				4
5			Grove of St. Charles	St. Charles				5
6			Lagrange Skilled Nursing Facility LLC	Lagrange Park				6
7			Lakefront Skilled Nursing Facility LLC	Chicago				7
8			Lincoln Park Skilled Nursing Facility LLC	Chicago				8
9			Lincolnshire Living & Rehab Center LLC	Lincolnshire				9
10			Northbrook Skilled Nursing Facility LLC	Northbrook				10
11			Peterson Park Associates Limited Partnership	Chicago				11
12			Skokie Skilled Nursing Facility LLC	Skokie				12
13			Valley Skilled Nursing Facility	Billings, MT				13
14			Warren Barr Living And Rehab	Chicago				14
15			Warren Barr North Shore	Highland Park				15
16			Warren Barr South Loop	Chicago				16
17								17
18								18
19								19
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22								22
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25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietician Salary	\$	Legacy Healthcare Financial Services		\$ 4,318	\$ 4,318	15
16	V	01	Dietary Supplies		Legacy Healthcare Financial Services		23	23	16
17	V	02	Food		Legacy Healthcare Financial Services		8,259	8,259	17
18	V	03	Housekeeping		Legacy Healthcare Financial Services		2,815	2,815	18
19	V	04	Linen Replacement		Legacy Healthcare Financial Services		191	191	19
20	V	06	Maintenance Salary		Legacy Healthcare Financial Services		13,322	13,322	20
21	V	06	Repairs & Maintenance		Legacy Healthcare Financial Services		791	791	21
22	V	10	Nursing Salary		Legacy Healthcare Financial Services		110,264	110,264	22
23	V	10	Nurse/Medical Director Consultant		Legacy Healthcare Financial Services		10,407	10,407	23
24	V	10	Medical Supplies		Legacy Healthcare Financial Services		23,689	23,689	24
25	V	12	Social Service Salary		Legacy Healthcare Financial Services		7,512	7,512	25
26	V	11	Activities Program		Legacy Healthcare Financial Services		11	11	26
27	V	12	Social Service Consultant		Legacy Healthcare Financial Services		30	30	27
28	V	17	COO / Administrative Salary		Legacy Healthcare Financial Services		83,946	83,946	28
29	V	19	Professional Fees		Legacy Healthcare Financial Services		27,559	27,559	29
30	V	20	Dues / Licenses / Permits		Legacy Healthcare Financial Services		4,705	4,705	30
31	V	21	Clerical & General Wages		Legacy Healthcare Financial Services		338,706	338,706	31
32	V	21	Clerical & Office Expense		Legacy Healthcare Financial Services		24,699	24,699	32
33	V	24	Education & Seminars		Legacy Healthcare Financial Services		187	187	33
34	V	25	Travel		Legacy Healthcare Financial Services		6,276	6,276	34
35	V	26	Insurance - General		Legacy Healthcare Financial Services		166	166	35
36	V	27	Non-Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		33,646	33,646	36
37	V	34	Rent		Legacy Healthcare Financial Services		42,483	42,483	37
38	V	34	Offsite Storage / Parking		Legacy Healthcare Financial Services		131	131	38
39	Total			\$			\$ 744,136	\$ * 744,136	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Equipment Rental		Legacy Healthcare Financial Services		567	\$	567
16	V	35	Auto Rental		Legacy Healthcare Financial Services		5,529		5,529
17	V	15	Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		7,822		7,822
18	V								
19	V								
20	V								
21	V								
22	V								
23	V								
24	V								
25	V								
26	V								
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$			13,918	\$ *	13,918

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	\$	CF St. Louis LLC		\$ 1,468	\$ 1,468	15
16	V	6	Repairs & Maintenance		CF St. Louis LLC		1,423	1,423	16
17	V	19	Property Valuation Fee		CF St. Louis LLC		503	503	17
18	V	19	Accounting Fees		CF St. Louis LLC		114	114	18
19	V	20	Dues & Subscriptions		CF St. Louis LLC		1	1	19
20	V	21	Office Expense		CF St. Louis LLC		341	341	20
21	V	26	Insurance		CF St. Louis LLC		369	369	21
22	V	30	Depreciation		CF St. Louis LLC		9,056	9,056	22
23	V	32	Interest Expense		CF St. Louis LLC		5,089	5,089	23
24	V	33	Real Estate Taxes		CF St. Louis LLC		4,624	4,624	24
25	V								25
26	V	34	Rent	42,483	CF St. Louis LLC			(42,483)	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			\$ 42,483			\$ 22,987	\$ * (19,496)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	\$ 33,356	ProPay HR LLC		\$ 25,714	\$ (7,642)	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			\$ 33,356			\$ 25,714	\$ * (7,642)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance	\$ 24,000	ML Group Design & Development		\$ 23,412	\$ (588)	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			\$ 24,000			\$ 23,412	\$ * (588)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Medical Supplies	\$ 4,500	ReMED Services		\$ 3,143	\$ (1,357)	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			\$ 4,500			\$ 3,143	\$ * (1,357)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Laboratory	\$ 37,400	Lifescan Labs of Illinois		\$ 22,178	\$ (15,222)	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			\$ 37,400			\$ 22,178	\$ * (15,222)	39

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

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

Ending: 12/31/20

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

IL478-2471

Facility Name & ID Number The Grove at the Lake# 0053926

Report Period Beginning:

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Legacy Healthcare Financial Services

Street Address

3450 Oakton Street

City / State / Zip Code

Skokie, IL 60076

Phone Number

(847) 679-9797

Fax Number

(847) 683-2900

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	01	Dietician Salary	Available Bed Days	53	\$ 130,303	\$ 130,303	84,180	\$ 4,318	1
2	01	Dietary Supplies	Available Bed Days	53	697		84,180	23	2
3	02	Food	Available Bed Days	53	249,220		84,180	8,259	3
4	03	Housekeeping	Available Bed Days	53	84,952		84,180	2,815	4
5	04	Linen Replacement	Available Bed Days	53	5,771		84,180	191	5
6	06	Maintenance Salary	Available Bed Days	53	401,986	401,986	84,180	13,322	6
7	06	Repairs & Maintenance	Available Bed Days	53	23,857		84,180	791	7
8	10	Nursing Salary	Available Bed Days	53	3,327,223	3,327,223	84,180	110,264	8
9	10	Nurse/Medical Director Consultant	Available Bed Days	53	314,035		84,180	10,407	9
10	10	Medical Supplies	Available Bed Days	53	714,824		84,180	23,689	10
11	12	Social Service Salary	Available Bed Days	53	226,662	226,662	84,180	7,512	11
12	11	Activities Program	Available Bed Days	53	335		84,180	11	12
13	12	Social Service Consultant	Available Bed Days	53	893		84,180	30	13
14	17	COO / Administrative Salary	Available Bed Days	53	2,533,078	2,533,078	84,180	83,946	14
15	19	Professional Fees	Available Bed Days	53	831,592		84,180	27,559	15
16	20	Dues / Licenses / Permits	Available Bed Days	53	141,983		84,180	4,705	16
17	21	Clerical & General Wages	Available Bed Days	53	10,220,453	10,220,453	84,180	338,706	17
18	21	Clerical & Office Expense	Available Bed Days	53	745,293		84,180	24,699	18
19	24	Education & Seminars	Available Bed Days	53	5,655		84,180	187	19
20	25	Travel	Available Bed Days	53	189,364		84,180	6,276	20
21	26	Insurance - General	Available Bed Days	53	4,997		84,180	166	21
22	27	Non-Nursing Payroll Taxes / Bene	Available Bed Days	53	1,015,274		84,180	33,646	22
23	34	Rent	Available Bed Days	53	1,281,940		84,180	42,483	23
24	34	Offsite Storage / Parking	Available Bed Days	53	3,949		84,180	131	24
25	TOTALS				\$ 22,454,338	\$ 16,839,706		\$ 744,136	25

Ending: 12/31/20

Ending: 12/31/20

(847) 676-5348

Ending: 12/31/20

()

Ending: 12/31/20

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

IL478-2471

Ending: 12/31/20

()

Ending: 12/31/20

()

IL478-2471

Ending: 12/31/20

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 Bank		X	Mortgage			\$	18,190,483			\$	810,490	1
2													2
3													3
4													4
5													5
	Working Capital												
6	CIBC Bank		X	Line of Credit				361,196				30,215	6
7													7
8													8
9	TOTAL Facility Related						\$	18,551,679			\$	840,705	9
	B. Non-Facility Related*												
10	Interest Income		X									(6,403)	10
11	Interest Income - Bldg Co		X									(557)	11
12	Allocated from CF St. Louis	X										5,089	12
13													13
14	TOTAL Non-Facility Related						\$				\$	(1,871)	14
15	TOTALS (line 9+line14)						\$	18,551,679			\$	838,834	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 106,280 Line # 36

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

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

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Grove at the Lake COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0053926

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

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

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	50,091	1990	\$ 28,460	1
2	Allocated from CF St. Louis, LLC			6,540	2
3	TOTALS	50,091		\$ 35,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	244		1990	1975	\$ 5,384,307	\$ 406,929	39	\$ 138,059	\$ (268,870)	\$ 1,554,736	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1980	5,655		20			5,655	9
10	Various			1981	13,906		20			13,906	10
11	Various			1982	1,171		20			1,171	11
12	Various			1983	17,000		20			17,000	12
13	Various			1984	36,737		20			36,737	13
14	Various			1985	135,882		20			135,882	14
15	Various			1986	63,852		20			63,852	15
16	Various			1987	60,439		20			60,439	16
17	Various			1988	24,257		20			24,257	17
18	Various			1989	102,083		20			102,083	18
19	Various			1990	84,998		20			84,998	19
20	Various			1991	10,496		20			10,496	20
21	Various			1992	18,109		20			18,109	21
22	Various			1993	39,981		20			39,981	22
23	Various			1994	123,996		20	70	70	122,883	23
24	Various			1995	157,007		20			157,007	24
25	Various			1996	210,423		20			210,423	25
26	Various			1997	97,938		20			97,938	26
27	Various			1998	76,538		20			76,538	27
28	Various			1999	232,757		20	700	700	232,757	28
29	Various			2000	88,771		20	4,439	4,439	88,771	29
30	Various			2001	147,900		20	7,395	7,395	140,705	30
31	Various			2002	156,984		20	7,675	7,675	141,634	31
32	Various			2003	473,434		20	23,911	23,911	401,702	32
33	Various			2004	276,659		20	13,833	13,833	221,327	33
34	Various			2005	89,356		20	4,467	4,467	67,020	34
35	Various			2006	90,306		20	4,515	4,515	63,214	35
36	Various			2007	115,795		20	5,790		75,266	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 at the Lake

0053926

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various	2008	\$ 117,156	\$	20	\$ 5,858	\$ 5,858	\$ 70,294	37
38	Various	2009	186,177		20	8,985	8,985	98,836	38
39	Various	2010	425,373		20	21,269	21,269	212,687	39
40	Various	2011	172,439		20	8,622	8,622	77,597	40
41	Various	2012	39,393		20	1,970	1,970	15,757	41
42	Various	2013	313,912		20	15,696	15,696	109,869	42
43	Various	2014	152,332		20	7,617	7,617	45,700	43
44	Various	2015	2,553		20	128	128	638	44
45	Various	2016	365,248		20	18,262	18,262	73,050	45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		2,192,019			109,601	109,601	979,265	67
68	Related Party Allocations (Pages 12H & 12I)		307,816	8,349		14,636	6,287	65,478	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		\$ 12,611,156	\$ 415,277		\$ 423,496	\$ 2,429	\$ 6,015,658	70

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

Facility Name & ID Number The Grove at the Lake

0053926

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 12,611,156	\$ 415,277		\$ 423,496	\$ 8,219	\$ 6,015,658	1
2	Interior Pain & Wallpaper - Penthouse Hallway	2017	3,489		20	174	174	698	2
3	Flooring, Vinyl Base And Planks	2017	3,518		20	176	176	617	3
4	Installation Of Wireless Vent Alarm System	2017	29,760		20	1,488	1,488	13,392	4
5	Replacing Condensing Unit	2017	2,904		20	145	145	364	5
6	Penthouse Ac Unit Repair	2017	15,203		20	760	760	5,320	6
7	Repaired Condensing Unit For Penthouse Unit	2017	22,313		20	1,116	1,116	7,809	7
8	Flooring, Cove Base	2017	4,771		20	239	239	2,864	8
9	Replaced Valves On Cooling System	2017	3,155		20	158	158	395	9
10	Heat Pump In Dialysis Room	2017	10,897		20	545	545	1,634	10
11	Repaired Fire Alarm System	2017	4,914		20	246	246	621	11
12	5Th Floor Air Handler	2017	4,788		20	239	239	3,113	12
13	Reparied Sprinkler System On 9Th Floor	2017	3,370		20	169	169	2,023	13
14	Wall Box Water Only, Water Valves	2017	5,822		20	291	291	3,492	14
15	Mini Split Ac System In Elevator Room	2017	7,288		20	364	364	2,914	15
16	Flooring In Dialysis Unit	2017	4,724		20	236	236	944	16
17	Piston Pump	2017	2,664		20	133	133	1,732	17
18	Hot Water Heater In Kitchen	2017	13,999		20	700	700	8,398	18
19	Cubicle Curtains	2017	2,642		20	132	132	1,452	19
20	Sink Pipe Insulation, Door Knob Replacement, Door Frames,Fauc	2018	3,610		20	180	180	700	20
21	Lever Passage Locksets For Doors	2018	6,266		20	313	313	2,247	21
22	Hot Water Mixing Valve Replacement	2018	3,193		20	160	160	640	22
23	Domestic Hot Water Tank	2018	8,640		20	432	432	1,296	23
24	Repaired Deck, Gravel Stop, Walkway Fence (\$30950)	2019	29,994		20	1,500	1,500	3,563	24
25	Repaired Fire Alarm System (\$8518.44)	2019	8,255		20	413	413	1,123	25
26	Installed New Pump Coupler (\$3626)	2019	3,514		20	176	176	521	26
27	Ceiling Shade (\$3185)	2019	3,087		20	154	154	207	27
28	Electrical Wiring For Rooms 232-234	2019	8,527		20	426	426	646	28
29	Repaired Vent Winger Breaker, And Added Circuits To Rm 202 &	2019	4,169		20	208	208	417	29
30	Repaired Delayed Egress Mag Locks To 3Rd, 4Th Floors And Pen	2019	3,426		20	171	171	343	30
31	Repair Car Port Area (11,250)	2020	10,974		20	549	549	549	31
32	Install New Steel Fire Doors (4,750)	2020	4,634		20	232	232	232	32
33	Roofing Repair By North Exit Door (3,484)	2020	3,399		20	170	170	170	33
34	TOTAL (lines 1 thru 33)		\$ 12,859,065	\$ 415,277		\$ 435,891	\$ 20,614	\$ 6,086,094	34

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

Facility Name & ID Number The Grove at the Lake

0053926

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 12,859,065	\$ 415,277		\$ 435,891	\$ 20,614	\$ 6,086,094	1
2	Repair New Compressor (3,300)	2020	3,219		20	161	161	161	2
3	Repair A/C Compressor (6,135)	2020	5,985		20	299	299	299	3
4	Replace Compressor (13,300)	2020	12,974		20	649	649	649	4
5	New Brick Installation On 1S Floor (6,500)	2020	6,341		20	317	317	317	5
6	Replace North Triple Duty Valve (8,700)	2020	8,487		20	424	424	424	6
7	Repaired 16 Roof Exhaust Fans (3,195)	2020	3,117		20	156	156	156	7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		\$ 12,899,187	\$ 415,277		\$ 437,898	\$ 22,620	\$ 6,088,100	34

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

Facility Name & ID Number The Grove at the Lake

0053926

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 12,899,187	\$ 415,277		\$ 437,898	\$ 22,620	\$ 6,088,100	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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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)		\$ 12,899,187	\$ 415,277		\$ 437,898	\$ 22,620	\$ 6,088,100	34

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

Facility Name & ID Number The Grove at the Lake

0053926

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 12,899,187	\$ 415,277		\$ 437,898	\$ 22,620	\$ 6,088,100	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)		\$ 12,899,187	\$ 415,277		\$ 437,898	\$ 22,620	\$ 6,088,100	34

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

Facility Name & ID Number The Grove at the Lake

0053926

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	4Th Floor Nurse Call System	2012	5,054		20	253	253	2,274	9
10	Framing/Drywall For Nurses Stations	2012	6,000		20	300	300	2,700	10
11	1St Flr Flooring, Masonry, Doors, Windows, Painting, Electrical	2012	797,114		20	39,856	39,856	358,701	11
12	1St Floor Sas Architect Fees	2012	39,728		20	1,986	1,986	17,878	12
13	Install new framing, drywall, and taping in corridors.	2012	15,375		20	769	769	6,919	13
14	Installation of cable jacks, patching and sanding of sprinkler pipe.	2012	47,760		20	2,388	2,388	21,492	14
15	Install receptacles for TV in residence bedrooms	2012	6,204		20	310	310	2,792	15
16	Complete installation of Landscape, irrigation system per proposa	2012	14,500		20	725	725	6,525	16
17	Add additional soffits for nurses stations, patching	2012	9,000		20	450	450	4,050	17
18	Room 313,319,334,405-411-Repair dry wall, new tiles	2012	8,535		20	427	427	3,841	18
19	Remove baseboard and prep for paint, work throughtout guestroom	2012	45,779		20	2,289	2,289	20,601	19
20	116 VT-Door	2012	31,933		20	1,597	1,597	14,370	20
21	Remove all existing baseboard and prep for paint in guest baths, p	2012	19,955		20	998	998	8,980	21
22	Complete the framing and installation of drywall for all soffits, re	2012	30,484		20	1,524	1,524	12,194	22
23	Replace 117 new and four old doors, install seven diving walls, ins	2012	12,658		20	633	633	5,697	23
24	TV plates installed behind the TV's	2012	3,745		20	187	187	1,686	24
25	Provide and install drywall patches and tape due to springler pipe	2012	11,830		20	592	592	5,324	25
26	Completed all work throughout guestrooms, additional drywall an	2012	26,747		20	1,337	1,337	12,036	26
27	Checked existing bx wiring, installed 63 new receptacles	2012	13,058		20	653	653	5,877	27
28	Installed j-box for microwave, steam table outlet, wall light	2012	5,158		20	258	258	2,322	28
29	Install 2 new shrub zones for plantings, electric solenoid valves, sh	2012	3,000		20	150	150	1,350	29
30	Low voltage installations	2012	28,475		20	1,424	1,424	12,814	30
31	81.25 X 59.00 General Suppliers	2012	2,696		20	135	135	1,213	31
32	Rmored Nurse Station lights; Installed 4 ceiling lights, 1 exit sign,	2012	24,185		20	1,209	1,209	10,884	32
33	Triton DVR	2012	14,818		20	741	741	6,669	33
34	TOTAL (lines 1 thru 33)		\$ 1,223,791	\$		\$ 61,190	\$ 61,190	\$ 549,185	34

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

Facility Name & ID Number The Grove at the Lake

0053926

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 1,223,791	\$		\$ 61,190	\$ 61,190	\$ 549,185	1
2	Triton DVR CCTV Sytem with installation and cutover	2012	4,238		20	212	212	1,908	2
3	3rd Floor Corridor & Patient Room-Installed lights, exit signs, spr	2012	12,215		20	611	611	5,497	3
4	3rd & 4th Floor-Framing, drywall & taping; Installed all 2x2 ultin	2012	20,000		20	1,000	1,000	9,000	4
5	Building Permit, City of Zion for Interior Remodel- Office Space	2012	8,300		20	415	415	3,735	5
6	Exterior Signage and Lighting	2012	37,709		20	1,885	1,885	16,969	6
7	1st Floor, 2nd Floor, 3rd Floor, and 4th Floor - Fire Sprinklers	2012	211,240		20	10,562	10,562	95,058	7
8	2nd Floor Res Rms, 3rd Floor Rms, Nurse Stations, Bathrooms -								8
9	Removed existing wall tiles, installed new light fixtures, ceramic wall tile								9
10	Removed existing cove base, floor prep, and installed cornices	2012	264,819		20	13,241	13,241	119,169	10
11	Nurse Stations, 2nd-4th Floors Corridors, dining & resid rms, bathrooms								11
12	Light fixtures, floor prep, handrails, wallcoverings, cornices								12
13	cove bases, ceramic tiles, millwork base, and signage	2012	297,229		20	14,861	14,861	133,753	13
14	Therapy Rms, 2nd Flr Rms- new mirror, drop ceilings, sinks, ceili	2012	36,465		20	1,823	1,823	14,587	14
15	3rd Floor dining rms-Removed existing light fixtures and installed	2013	6,117		20	306	306	2,447	15
16	3rd Flr Dining area & Rm 231-patching,painting, and installed wa	2013	4,230		20	212	212	1,692	16
17	3rd Flr Dining Rm-Installed new 2x2 drop ceilings, sinks, and cha	2013	7,625		20	381	381	3,051	17
18	20 loc overhead paging systems	2013	4,747		20	237	237	1,899	18
19	Furnished and installed hot water boiler	2013	14,470		20	724	724	5,788	19
20	Generator repair-Removed and replaced oil filters, cylinder head	2013	28,820		20	1,441	1,441	11,528	20
21	4th Flr Dining Rm-Removed conduit in floor, ceiling fixtures; Inst	2013	4,639		20	232	232	1,856	21
22	Lobby, Laundry Rm and elevators-Installed 4 new receptacles;cir	2013	5,365		20	268	268	2,146	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,192,019	\$		\$ 109,601	\$ 109,601	\$ 979,265	34

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

Facility Name & ID Number The Grove at the Lake

0053926

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party								1
2	Buildings:								2
3	Allocated from CF St. Louis, LLC	2016	35,217	1,635	35	1,006	(629)	5,031	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	218,648	5,394	20	10,932	5,538	54,662	9
10	Allocated from CF St. Louis, LLC	2017	5,075	125	20	254	129	1,015	10
11	Allocated from CF St. Louis, LLC	2019	45,998	1,135	20	2,300	1,165	4,600	11
12	Allocated from CF St. Louis, LLC	2019	2,419	60	20	121	61	121	12
13									13
14	Allocated from Legacy HC	2018	261		20	13	13	39	14
15	Allocated from Legacy HC	2020	197		20	10	10	10	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)		\$ 307,816	\$ 8,349		\$ 14,636	\$ 6,287	\$ 65,478	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 307,816	\$ 8,349		\$ 14,636	\$ 6,287	\$ 65,478	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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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)		\$ 307,816	\$ 8,349		\$ 14,636	\$ 6,287	\$ 65,478	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,429,417	\$ 705	\$ 142,942	\$ 142,237	10	\$ 1,162,244	71
72	Current Year Purchases	30,922	2	3,092	3,090	10	3,092	72
73	Fully Depreciated Assets	1,103,694				10	1,103,694	73
74								74
75	TOTALS	\$ 2,564,034	\$ 707	\$ 146,034	\$ 145,327		\$ 2,269,030	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76		VAN	2008	\$ 15,461	\$	\$	\$	5	\$ 15,461
77									
78									
79									
80	TOTALS			\$ 15,461	\$	\$	\$		\$ 15,461

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$	15,513,683
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	415,985
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	583,932
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	167,947
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	8,372,591

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86	LAND - 1994	\$ 199,000	\$	\$
87	REMODEL STORAGE ROOM - 1999	4,000		
88	REMODEL STORAGE RM - 1999	10,000		
89	REMODEL STORAGE ROOM - 1999	4,300		
90	DAYCARE CTR ARCHITEC - 2000	787		
91	TOTALS	\$ 218,087	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	CIP	\$ 6,975
93		
94		
95		\$ 6,975

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Storage				3,844			5
6	Allocated from Legacy Healthcare				131			6
7	TOTAL				\$ 3,975			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-
-

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

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 10,794
- Description:
- See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Legacy Healthcare		\$	\$ 5,529	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 5,529	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2021	\$
13.	/2022	\$
14.	/2023	\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 232,972	\$		\$ 232,972	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			99,107			99,107	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			274,366			274,366	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				280,141		280,141	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached			378,482		122,307	198,469		699,258	13
14	TOTAL			\$ 378,482		\$ 728,752	\$ 478,610		\$ 1,585,844	14

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 324,845	\$ 1,071,355	1
2	Cash-Patient Deposits	1,470	1,470	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,627,842	1,627,842	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	476,650	526,460	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	445,059	455,202	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,875,866	\$ 3,682,329	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,000,000	13
14	Buildings, at Historical Cost		8,124,904	14
15	Leasehold Improvements, at Historical Cost	307,556	3,105,667	15
16	Equipment, at Historical Cost	596,346	1,042,611	16
17	Accumulated Depreciation (book methods)	(340,980)	(4,281,622)	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	1,819,074	2,513,165	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,381,996	\$ 11,504,725	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,257,862	\$ 15,187,054	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,114,956	\$ 1,114,988	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	361,196	692,361	29
30	Accrued Salaries Payable	524,629	524,629	30
31	Accrued Taxes Payable (excluding real estate taxes)	323,974	323,974	31
32	Accrued Real Estate Taxes(Sch.IX-B)	17,973	325,776	32
33	Accrued Interest Payable		67,002	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	2,335,708	2,480,708	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,678,436	\$ 5,529,438	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		17,859,318	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	1,287,209	(297,744)	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,287,209	\$ 17,561,574	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,965,645	\$ 23,091,012	46
47	TOTAL EQUITY(page 18, line 24)	\$ (707,783)	\$ (7,903,958)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,257,862	\$ 15,187,054	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 620,753	1
2	Restatements (describe):		2
3	Bad Debt	(204,612)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 416,141	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(382,938)	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	(740,986)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,123,924)	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)	\$ (707,783)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The Grove at the Lake

0053926

Report Period Beginning:

01/01/20

Ending:

12/31/20

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 19,542,669	1
2	Discounts and Allowances for all Levels	(8,077,721)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,464,948	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,219,684	6
7	Oxygen	2,512	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,222,196	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	286,823	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	33,281	19
20	Radiology and X-Ray	1,225	20
21	Other Medical Services	35,086	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 356,415	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,403	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,403	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	1,507,206	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,507,206	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,557,168	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,059,113	31
32	Health Care	6,209,716	32
33	General Administration	3,101,113	33
	B. Capital Expense		
34	Ownership	1,836,286	34
	C. Ancillary Expense		
35	Special Cost Centers	2,287,554	35
36	Provider Participation Fee	446,324	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,940,106	40
41	Income before Income Taxes (line 30 minus line 40)**	(382,938)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (382,938)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 9,793,348	44
45	Private Pay - Net Inpatient Revenue	149,280	45
46	Medicare - Net Inpatient Revenue	1,276,863	46
47	Other-(specify) Insurance	245,457	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,464,948	49

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

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

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

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

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,944	2,120	\$ 156,341	\$ 73.75	1
2	Assistant Director of Nursing	1,888	1,920	92,937	48.40	2
3	Registered Nurses	12,616	14,526	573,236	39.46	3
4	Licensed Practical Nurses	39,219	53,037	1,992,704	37.57	4
5	CNAs & Orderlies	55,820	75,999	1,527,795	20.10	5
6	CNA Trainees					6
7	Licensed Therapist	9,568	10,614	378,482	35.66	7
8	Rehab/Therapy Aides	7,462	8,485	208,188	24.54	8
9	Activity Director	2,560	2,880	60,880	21.14	9
10	Activity Assistants	10,534	11,294	158,984	14.08	10
11	Social Service Workers	9,860	11,063	299,947	27.11	11
12	Dietician					12
13	Food Service Supervisor	2,016	2,016	54,616	27.09	13
14	Head Cook	5,767	5,767	100,421	17.41	14
15	Cook Helpers/Assistants	17,705	17,705	288,222	16.28	15
16	Dishwashers					16
17	Maintenance Workers	5,480	6,300	152,426	24.19	17
18	Housekeepers	20,823	23,646	374,504	15.84	18
19	Laundry	6,930	8,326	136,380	16.38	19
20	Administrator	1,904	2,080	145,456	69.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,854	12,081	231,992	19.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	24,310	27,815	469,121	16.87	33
34	TOTAL (lines 1 - 33)	247,259	297,674	\$ 7,402,632 *	\$ 24.87	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 65,055	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	61,402	10-03	38
39	Pharmacist Consultant	Monthly	7,807	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	3,387	11-03	44
45	Social Service Consultant	Monthly	1,582	12-03	45
46	Other(specify)				46
47	Dialysis	Monthly	192,825	10-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 350,058		49

C. CONTRACT NURSES

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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Julie Stangel	Administrator	0	\$ 145,456	Workers' Compensation Insurance	\$	129,374	IDPH License Fee	\$ 3,980	
				Unemployment Compensation Insurance		51,035	Advertising: Employee Recruitment	400	
				FICA Taxes		566,301	Health Care Worker Background Check		
				Employee Health Insurance		340,171	(Indicate # of checks performed 130)	1,302	
				Employee Meals			Patient Background Checks 215	2,150	
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions	34,855	
				Union Pension		67,542	Licenses & Fees	1,434	
				Employee Benefits		27,476			
				401K Expense		22,471			
				Voluntary Benefit Contribution		23,904			
				Employee Physical Exams		6,044			
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 145,456						
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense	1,958	
TOTAL (agree to Schedule V, line 17, col. 3)			\$				See Supplemental Schedule	187	
(Attach a copy of any management service agreement)							Entertainment Expense	(	
C. Professional Services				TOTAL			(agree to Sch. V, line 24, col. 8)		
Vendor/Payee	Type		Amount			\$	TOTAL		\$
Marcum LLP	Accounting	\$	24,000						
ProPay HR	Payroll Processing		33,356						
Onyx Procurement Solutions	Procurement Service		12,870						
Achieve Accreditation	Accreditation		8,559						
Compliagent	Compliance Services		3,761						
Cortex Health	Data Processing		10,065						
IIT/Sourcetch	Data Processing		300						
Personnel Planners	Unemployment Consultant		2,580						
Prospect Resources	Energy Procurement		500						
Telemedicine Solutions	Risk Prevention Services		6,813						
See Attached	Legal		268,889						
TOTAL (agree to Schedule V, line 19, column 3)									
(For legal fee disclosure, see page 39 of instructions)			\$ 371,693						

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name & ID Number <u>The Grove at the Lake</u>	STATE OF ILLINOIS # <u>0053926</u>	Report Period Beginning: <u>01/01/20</u>	Ending: <u>12/31/20</u>
XX. GENERAL INFORMATION:			
(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>Yes</u> (2) Are there any dues to nursing home associations included on the cost report? <u>Yes</u> If YES, give association name and amount. <u>HCCI \$36,814</u> (3) Did the nursing home make political contributions or payments to a political action organization? <u>Yes</u> If YES, have these costs been properly adjusted out of the cost report? <u>Yes</u> (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? <u>N/A</u> (5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u> What was the average life used for new equipment added during this period? <u>10 Years</u> (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>46,508</u> Line <u>10</u> (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation. (8) Are you presently operating under a sale and leaseback arrangement? <u>No</u> If YES, give effective date of lease. <u>N/A</u> (9) Are you presently operating under a sublease agreement? YES <u>X</u> NO (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. <u>N/A</u> (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>446,324</u> 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? <u>No</u> 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? <u>Yes</u> (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? <u>No</u> 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. \$ <u>N/A</u> Has any meal income been offset against related costs? <u>N/A</u> Indicate the amount. \$ _____ (16) Travel and Transportation a. Are there costs included for out-of-state travel? <u>No</u> If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>N/A</u> c. What percent of all travel expense relates to transportation of nurses and patients? <u>100% Ln 14</u> d. Have vehicle usage logs been maintained? <u>No</u> e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>N/A</u> f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u> g. Does the facility transport residents to and from day training? <u>No</u> Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u> (17) Has an audit been performed by an independent certified public accounting firm? <u>No</u> Firm Name: <u>N/A</u> (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u> (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. <u>Yes</u> Attach invoices and a summary of services for all architect and appraisal fees.		