

		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: <u>0055442</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>The Grove of Berwyn</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/20</u> to <u>12/31/20</u> 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.	
Address: <u>3601 S Harlem Avenue</u> <u>Berwyn</u> <u>60402</u>		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>			
Telephone Number: <u>(708) 749-4160</u> Fax # <u>(708) 749-7696</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>2/1/2019</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ Corporation	
		☐ "Sub-S" Corp.	
		☒ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>Steven N. Lavenda</u>		Telephone Number: <u>(847) 282-6300</u>	
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) _____	
		(Title) _____	
		(Signed) _____ 05/13/2021	
		* Subject to the attached Accountants' Consulting Report (Date)	
		Paid Preparer	
		(Print Name and Title) <u>Steven N. Lavenda, CPA</u> <u>Partner</u>	
		(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>	
		(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>	
		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: 01/01/20 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>145</u>	Skilled (SNF)	<u>145</u>	<u>53,070</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>145</u>	TOTALS	<u>145</u>	<u>53,070</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>3,094</u>	<u>3,094</u>	8
9	SNF/PED					9
10	ICF	<u>34,015</u>	<u>1,830</u>	<u>315</u>	<u>36,160</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>34,015</u>	<u>1,830</u>	<u>3,409</u>	<u>39,254</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 73.97%

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 2/1/2019

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 145 and days of care provided 3,094

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 of Berwyn # 0055442 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	352,885	51,158	32,517	436,560		436,560	2,737	439,297			1
2	Food Purchase		291,075		291,075		291,075	5,071	296,146			2
3	Housekeeping	235,638	23,532	814	259,984		259,984	1,775	261,759			3
4	Laundry	101,529	12,778		114,307		114,307	121	114,428			4
5	Heat and Other Utilities			112,751	112,751		112,751	926	113,677			5
6	Maintenance	96,179	13,365	170,695	280,239		280,239	(12,148)	268,091			6
7	Other (specify):*											7
8	TOTAL General Services	786,231	391,908	316,777	1,494,916		1,494,916	(1,519)	1,493,397			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	3,350,604	158,518	117,606	3,626,728		3,626,728	88,170	3,714,898			10
10a	Therapy	124,426			124,426		124,426		124,426			10a
11	Activities	157,441	2,847	21	160,309		160,309	7	160,316			11
12	Social Services	174,267		22,825	197,092		197,092	4,754	201,846			12
13	CNA Training											13
14	Program Transportation			14,722	14,722		14,722		14,722			14
15	Other (specify):*							4,931	4,931			15
16	TOTAL Health Care and Programs	3,806,738	161,365	179,174	4,147,277		4,147,277	97,862	4,245,139			16
	C. General Administration											
17	Administrative	186,115			186,115		186,115	52,923	239,038			17
18	Directors Fees											18
19	Professional Services			123,375	123,375	(18,612)	104,763	2,543	107,306			19
20	Dues, Fees, Subscriptions & Promotions			38,318	38,318		38,318	(21,407)	16,911			20
21	Clerical & General Office Expenses	201,478	868	416,150	618,496		618,496	(46,672)	571,824			21
22	Employee Benefits & Payroll Taxes			740,130	740,130		740,130		740,130			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,742	1,742		1,742	118	1,860			24
25	Other Admin. Staff Transportation			346	346		346	3,956	4,302			25
26	Insurance-Prop.Liab.Malpractice			243,677	243,677		243,677	337	244,014			26
27	Other (specify):*							21,212	21,212			27
28	TOTAL General Administration	387,593	868	1,563,738	1,952,199	(18,612)	1,933,587	13,010	1,946,597			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,980,562	554,141	2,059,689	7,594,392	(18,612)	7,575,780	109,353	7,685,133			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			80,657	80,657		80,657	272,006	352,663			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,201	17,201		17,201	267,835	285,036			32
33	Real Estate Taxes			582,604	582,604	18,612	601,216	2,915	604,131			33
34	Rent-Facility & Grounds			675,000	675,000		675,000	(674,917)	83			34
35	Rent-Equipment & Vehicles			12,877	12,877		12,877	3,843	16,720			35
36	Other (specify):*											36
37	TOTAL Ownership			1,368,339	1,368,339	18,612	1,386,951	(128,318)	1,258,633			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		207,511	647,411	854,922		854,922	(8,873)	846,049			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			306,788	306,788		306,788		306,788			42
43	Other (specify):*			481,963	481,963		481,963	(481,963)				43
44	TOTAL Special Cost Centers		207,511	1,436,162	1,643,673		1,643,673	(490,836)	1,152,837			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,980,562	761,652	4,864,190	10,606,404		10,606,404	(509,801)	10,096,603			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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(189,549)	30		9
10	Interest and Other Investment Income	(5,990)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(136)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(7,193)	21		18
19	Entertainment	(1,485)	21		19
20	Contributions	(15,000)	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	(249,574)	21		24
25	Fund Raising, Advertising and Promotional	(4,740)	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	(582,694)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,056,361)		\$	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)	546,560		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 546,560		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (509,801)		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	Rebates	\$ (443)	21	1
2	Patient Personal Items	(127)	10	2
3	Sequestration	(17,295)	21	3
4	Marketing License	(176)	20	4
5	Capitalized R&M	(21,942)	06	5
6	PAC Dues	(1,813)	20	6
7	Out of Period Dues	(519)	20	7
8	Marketing Dues	(2,126)	20	8
9	Non Allowable Legal	(8,719)	19	9
10	Bldg Co - Accounting	(226)	19	10
11	Bldg Co - Cost Segregation Study	(5,950)	19	11
12	Bldg Co - Amortization	(41,395)	36	12
13	Non Allowable Expense	(481,963)	43	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
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	(582,694)		49

Summary A

12/31/20

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Grove of Berwyn # 0055442 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	(189,549)	455,846			5,709							272,006	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(5,990)	270,617			3,208							267,835	32
33	Real Estate Taxes					2,915							2,915	33
34	Rent-Facility & Grounds		(675,000)	26,866		(26,783)							(674,917)	34
35	Rent-Equipment & Vehicles				3,843								3,843	35
36	Other (specify):*	(41,395)	41,395											36
37	TOTAL Ownership	(236,934)	92,858	26,866	3,843	(14,951)							(128,318)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(8,873)				(8,873)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(481,963)											(481,963)	43
44	TOTAL Special Cost Centers	(481,963)							(8,873)				(490,836)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,056,361)	99,034	469,130	8,774	(12,291)	(6,501)	(2,713)	(8,873)				(509,801)	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	\$ 675,000	Berwyn Property Holdings LLC		\$	(675,000)	1
2	V	32	Interest	21	Berwyn Property Holdings LLC		270,638	270,617	2
3	V	19	Accounting		Berwyn Property Holdings LLC		226	226	3
4	V	19	Cost Segregation Study		Berwyn Property Holdings LLC		5,950	5,950	4
5	V	30	Depreciation		Berwyn Property Holdings LLC		455,846	455,846	5
6	V	36	Amortization		Berwyn Property Holdings LLC		41,395	41,395	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 675,021			\$ 774,055	\$ * 99,034	14

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	GPN FAMILY TRUST	42.50 %	Astoria Place Skilled Nursing Facility LLC	Chicago	Berwyn Property Holdings LLC		Building Company	1
2	DOROS GENERATION TRUST	42.50 %	Avantara Arlington	Arlington, SD	Legacy HC & Financial Services	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 & 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 at the Lake Skilled Nursing Facility LLC	Zion				3
4			Grove of Fox Valley	Aurora				4
5			Grove of St. Charles	St. Charles				5
6			Lagrange Skilled Nursing Facility LLC	Lagrange Park				6
7			Lakefront Skilled Nursing Facility LLC	Chicago				7
8			Lincoln Park Skilled Nursing Facility LLC	Chicago				8
9			Lincolnshire Living & Rehab Center LLC	Lincolnshire				9
10			Northbrook Skilled Nursing Facility LLC	Northbrook				10
11			Peterson Park Associates Limited Partnership	Chicago				11
12			Skokie Skilled Nursing Facility LLC	Skokie				12
13			Valley Skilled Nursing Facility	Billings, MT				13
14			Warren Barr Living And Rehab	Chicago				14
15			Warren Barr North Shore	Highland Park				15
16			Warren Barr South Loop	Chicago				16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ **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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietician Salary	\$	Legacy Healthcare Financial Services		\$ 2,722	\$ 2,722	15
16	V	01	Dietary Supplies		Legacy Healthcare Financial Services		15	15	16
17	V	02	Food		Legacy Healthcare Financial Services		5,207	5,207	17
18	V	03	Housekeeping		Legacy Healthcare Financial Services		1,775	1,775	18
19	V	04	Linen Replacement		Legacy Healthcare Financial Services		121	121	19
20	V	06	Maintenance Salary		Legacy Healthcare Financial Services		8,399	8,399	20
21	V	06	Repairs & Maintenance		Legacy Healthcare Financial Services		498	498	21
22	V	10	Nursing Salary		Legacy Healthcare Financial Services		69,514	69,514	22
23	V	10	Nurse/Medical Director Consultant		Legacy Healthcare Financial Services		6,561	6,561	23
24	V	10	Medical Supplies		Legacy Healthcare Financial Services		14,935	14,935	24
25	V	12	Social Service Salary		Legacy Healthcare Financial Services		4,736	4,736	25
26	V	11	Activities Program		Legacy Healthcare Financial Services		7	7	26
27	V	12	Social Service Consultant		Legacy Healthcare Financial Services		19	19	27
28	V	17	COO / Administrative Salary		Legacy Healthcare Financial Services		52,923	52,923	28
29	V	19	Professional Fees		Legacy Healthcare Financial Services		17,374	17,374	29
30	V	20	Dues / Licenses / Permits		Legacy Healthcare Financial Services		2,966	2,966	30
31	V	21	Clerical & General Wages		Legacy Healthcare Financial Services		213,532	213,532	31
32	V	21	Clerical & Office Expense		Legacy Healthcare Financial Services		15,571	15,571	32
33	V	24	Education & Seminars		Legacy Healthcare Financial Services		118	118	33
34	V	25	Travel		Legacy Healthcare Financial Services		3,956	3,956	34
35	V	26	Insurance - General		Legacy Healthcare Financial Services		104	104	35
36	V	27	Non-Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		21,212	21,212	36
37	V	34	Rent		Legacy Healthcare Financial Services		26,783	26,783	37
38	V	34	Offsite Storage / Parking		Legacy Healthcare Financial Services		83	83	38
39	Total			\$			\$ 469,130	\$ * 469,130	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		357	\$	357
16	V	35	Auto Rental		Legacy Healthcare Financial Services		3,486		3,486
17	V	15	Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		4,931		4,931
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			\$			8,774	\$ *	8,774

* 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		\$ 926	\$ 926	15
16	V	6	Repairs & Maintenance		CF St. Louis LLC		897	897	16
17	V	19	Property Valuation Fee		CF St. Louis LLC		317	317	17
18	V	19	Accounting Fees		CF St. Louis LLC		72	72	18
19	V	20	Dues & Subscriptions		CF St. Louis LLC		0	0	19
20	V	21	Office Expense		CF St. Louis LLC		215	215	20
21	V	26	Insurance		CF St. Louis LLC		232	232	21
22	V	30	Depreciation		CF St. Louis LLC		5,709	5,709	22
23	V	32	Interest Expense		CF St. Louis LLC		3,208	3,208	23
24	V	33	Real Estate Taxes		CF St. Louis LLC		2,915	2,915	24
25	V								25
26	V	34	Rent	26,783	CF St. Louis LLC			(26,783)	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			\$ 26,783			\$ 14,492	\$ * (12,291)	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	\$ 28,376	ProPay HR LLC		\$ 21,875	\$ (6,501)	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			\$ 28,376			\$ 21,875	\$ * (6,501)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Medical Supplies	\$ 9,000	ReMED Services		\$ 6,287	\$ (2,713)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 9,000			\$ 6,287	\$ * (2,713)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Laboratory	\$ 21,801	Lifescan Labs of Illinois		\$ 12,928	\$ (8,873)	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			\$ 21,801			\$ 12,928	\$ * (8,873)	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)

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

Facility Name & ID Number The Grove of Berwyn# 0055442

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	53,070	\$ 2,722	1
2	01	Dietary Supplies	Available Bed Days	53	697		53,070	15	2
3	02	Food	Available Bed Days	53	249,220		53,070	5,207	3
4	03	Housekeeping	Available Bed Days	53	84,952		53,070	1,775	4
5	04	Linen Replacement	Available Bed Days	53	5,771		53,070	121	5
6	06	Maintenance Salary	Available Bed Days	53	401,986	401,986	53,070	8,399	6
7	06	Repairs & Maintenance	Available Bed Days	53	23,857		53,070	498	7
8	10	Nursing Salary	Available Bed Days	53	3,327,223	3,327,223	53,070	69,514	8
9	10	Nurse/Medical Director Consultant	Available Bed Days	53	314,035		53,070	6,561	9
10	10	Medical Supplies	Available Bed Days	53	714,824		53,070	14,935	10
11	12	Social Service Salary	Available Bed Days	53	226,662	226,662	53,070	4,736	11
12	11	Activities Program	Available Bed Days	53	335		53,070	7	12
13	12	Social Service Consultant	Available Bed Days	53	893		53,070	19	13
14	17	COO / Administrative Salary	Available Bed Days	53	2,533,078	2,533,078	53,070	52,923	14
15	19	Professional Fees	Available Bed Days	53	831,592		53,070	17,374	15
16	20	Dues / Licenses / Permits	Available Bed Days	53	141,983		53,070	2,966	16
17	21	Clerical & General Wages	Available Bed Days	53	10,220,453	10,220,453	53,070	213,532	17
18	21	Clerical & Office Expense	Available Bed Days	53	745,293		53,070	15,571	18
19	24	Education & Seminars	Available Bed Days	53	5,655		53,070	118	19
20	25	Travel	Available Bed Days	53	189,364		53,070	3,956	20
21	26	Insurance - General	Available Bed Days	53	4,997		53,070	104	21
22	27	Non-Nursing Payroll Taxes / Bene	Available Bed Days	53	1,015,274		53,070	21,212	22
23	34	Rent	Available Bed Days	53	1,281,940		53,070	26,783	23
24	34	Offsite Storage / Parking	Available Bed Days	53	3,949		53,070	83	24
25	TOTALS				\$ 22,454,338	\$ 16,839,706		\$ 469,130	25

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

()

IL478-2471

Ending: 12/31/20

	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

Ending: 12/31/20

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		X	Mortgage Payable			\$	5,500,000			\$	267,436	1
2													2
3													3
4													4
5													5
	Working Capital												
6	CIBC		X	Note Payable				289,999				17,201	6
7	CIBC		X	Line of Credit				413,652				3,202	7
8													8
9	TOTAL Facility Related						\$	6,203,651			\$	287,839	9
	B. Non-Facility Related*												
10	Interest Income		X									(5,990)	10
11	Interest Income - Bldg Co		X									(21)	11
12	Allocated from CF St. Louis	X										3,208	12
13													13
14	TOTAL Non-Facility Related						\$				\$	(2,803)	14
15	TOTALS (line 9+line14)						\$	6,203,651			\$	285,036	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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	601,397	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.)				\$	585,953	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(15,444)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	600,963	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.)				\$	18,612	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.				\$	604,131	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2015	473,463	8	FOR BHF USE ONLY	
		2016	483,001	9		
		2017	499,424	10		
		2018	546,330	11		
		2019	583,038	12		
2020 Accrual = \$583,038 x 1.03 = \$600,963						
*Beginning Accrual Adjusted				13	FROM R. E. TAX STATEMENT FOR 2019 \$	13
Allocated from CF St. Louis \$2,915				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.

FACILITY NAME	<u>The Grove of Berwyn</u>	COUNTY	<u>Cook</u>
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CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D)
			<u>Tax</u>
			<u>Applicable to</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Nursing Home</u>

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

IMPORTANT NOTICE

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

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

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

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Grove of Berwyn COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0055442

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:

44,431

B. General Construction Type:

Exterior

Brick

Frame

Concrete Steel

Number of Stories

3

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility			\$ 511,755	1
2	Allocated from CF St. Louis, LLC			4,123	2
3	TOTALS			\$ 515,878	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	145		2019	1964	\$ 6,691,521	\$ 455,846	35	\$ 191,186	\$ (264,660)	\$ 343,718	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
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21											21
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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:

01/01/20

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			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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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)		194,058	5,263		9,227	3,964	41,280	68
69	Financial Statement Depreciation			80,657			(80,657)		69
70	TOTAL (lines 4 thru 69)		\$ 6,885,579	\$ 541,766		\$ 200,413	\$ (341,353)	\$ 384,998	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:

01/01/20

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		\$ 6,885,579	\$ 541,766		\$ 200,413	\$ (341,353)	\$ 384,998	1
2	Paint Project - Wood Panels/Entry Way/Window Panels (\$14900)	2019	14,440		20	722	722	939	2
3	Installed 70 Windows - Primed/Paint Patio /Tuckpoint/Patch (\$29)	2019	2,835		20	142	142	179	3
4	Installed New Receptacles On 1St-3Rd Floor (\$4235)	2019	4,104		20	205	205	302	4
5	Elevator Door Operator, Detector (\$10711)	2019	10,380		20	519	519	608	5
6	Installed Cables On 2Nd Floor Pipes/Closets (\$14340)	2019	13,897		20	695	695	2,129	6
7	Repaired Nurse Call System Wiring / Mount Kit (\$22093)	2019	21,410		20	1,071	1,071	3,280	7
8	Replaced Ejector Pumps In Basement (\$18945)	2019	18,360		20	918	918	2,813	8
9	Exhaust Fan (\$3165)	2019	3,067		20	153	153	443	9
10	Air Conditioners (\$5630)	2019	5,456		20	273	273	601	10
11	Air Conditioners (\$7132)	2019	6,912		20	346	346	821	11
12	Air Conditioners (\$7523)	2019	7,291		20	365	365	804	12
13	Air Conditioners (\$5750)	2019	5,572		20	279	279	614	13
14	Walk In Freezer Door (\$3180)	2019	3,082		20	154	154	313	14
15	Crane Hot Water Heating Boiler (\$4980)	2019	4,826		20	241	241	739	15
16	Hot Water Piping (\$8460)	2019	8,199		20	410	410	1,256	16
17	Repaired Nurse Call System 1St-3Rd Floor (\$66278)	2019	64,230		20	3,212	3,212	7,078	17
18	Landscape By Courtyard (\$15000)	2019	14,537		20	727	727	1,165	18
19	Air Conditioners (\$4128.8)	2019	4,001		20	200	200	400	19
20	Sign Installation (\$15649.4)	2019	15,166		20	758	758	1,517	20
21	Repair Leaks On 3-Way Valve (\$3,750)	2019	3,634		20	182	182	363	21
22	Furnish And Install New Hydraulic Packing (\$2,500)	2019	2,423		20	121	121	242	22
23	Replace Rotten P-Trap In Dish Area (\$2,650)	2019	2,568		20	128	128	257	23
24	Repair Leaking Hot Water Pipe In Boiler Room (\$8,722.11)	2019	8,452		20	423	423	749	24
25	Reroute Circuits To Panel On Second Floor, And Install 2 Quad R	2019	7,951		20	398	398	795	25
26	Install New Panel For Relocation Of Critical Panel Circuits (\$10,6	2019	10,304		20	515	515	1,030	26
27	Replace Elevator Flooring, Replace Deck Wood Planks (2,725)	2020	2,658		20	133	133	133	27
28	Freight Elevator Vinyl Tiles & Door Installation (2,975)	2020	2,902		20	145	145	145	28
29	Dialysis Rm Doors, Acoustic Ceilings, Flooring, Painting, Plumbin	2020	131,393		20	6,570	6,570	6,570	29
30	Replace Block Heater (2,906)	2020	2,835		20	142	142	142	30
31	Keypad Wander For Door (6,059)	2020	5,910		20	296	296	296	31
32	2 Wanderguards In Basement & Alarm On 1St Fl (13,960)	2020	13,618		20	681	681	681	32
33	Shaker Assembled In Kitchen Cabinet Drawer Base (3,301)	2020	3,221		20	161	161	161	33
34	TOTAL (lines 1 thru 33)		\$ 7,311,210	\$ 541,766		\$ 221,695	\$ (320,071)	\$ 422,560	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:

01/01/20

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 12B, Carried Forward		\$ 7,311,210	\$ 541,766		\$ 221,695	\$ (320,071)	\$ 422,560	1
2	Hdmi Cables (3,039)	2020	2,964		20	296	296	296	2
3	Elevator Repair (15,000)	2020	14,633		20	732	732	732	3
4	Replace 2 Sump Pit Motor Starters (2,932)	2020	2,860		20	143	143	143	4
5	North Freight Elevator Repair (7,459)	2020	7,276		20	364	364	364	5
6	South Passenger Elevator Repair (3,894)	2020	3,799		20	190	190	190	6
7	South Passenger Elevator Repair (4,445)	2020	4,336		20	217	217	217	7
8	Repair Heat On 3Rd Floor (3,212)	2020	3,133		20	157	157	157	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,350,211	\$ 541,766		\$ 223,793	\$ (317,973)	\$ 424,658	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,350,211	\$ 541,766		\$ 223,793	\$ (317,973)	\$ 424,658	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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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,350,211	\$ 541,766		\$ 223,793	\$ (317,973)	\$ 424,658	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:

01/01/20

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		\$ 7,350,211	\$ 541,766		\$ 223,793	\$ (317,973)	\$ 424,658	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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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,350,211	\$ 541,766		\$ 223,793	\$ (317,973)	\$ 424,658	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									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
19									19
20									20
21									21
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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.

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 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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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:

01/01/20

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	22,202	1,031	35	634	(396)	3,172	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	137,844	3,401	20	6,892	3,492	34,461	9
10	Allocated from CF St. Louis, LLC	2017	3,199	79	20	160	81	640	10
11	Allocated from CF St. Louis, LLC	2019	28,998	715	20	1,450	735	2,900	11
12	Allocated from CF St. Louis, LLC	2019	1,525	38	20	76	39	76	12
13									13
14	Allocated from Legacy HC	2018	165		20	8	8	25	14
15	Allocated from Legacy HC	2020	124		20	6	6	6	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)		\$ 194,058	\$ 5,263		\$ 9,227	\$ 3,964	\$ 41,280	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:

01/01/20

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 12H, Carried Forward		\$ 194,058	\$ 5,263		\$ 9,227	\$ 3,964	\$ 41,280	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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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 194,058	\$ 5,263		\$ 9,227	\$ 3,964	\$ 41,280	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	\$ 1,276,033	\$ 444	\$ 127,603	\$ 127,159	10	\$ 233,099	71
72	Current Year Purchases	12,666	1	1,267	1,265	10	1,267	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,288,699	\$ 446	\$ 128,870	\$ 128,424		\$ 234,365	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

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)			\$	9,154,788
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	542,212
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	352,663
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(189,549)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	659,023

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	Construction in Progress	\$ 8,662
93		
94		
95		\$ 8,662

* 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	Allocated from Legacy HC				83			5
6								6
7	TOTAL				\$83			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: \$13,234
- 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		\$	\$3,486	17
18					18
19					19
20					20
21	TOTAL		\$	\$3,486	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)	\$			

- (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.

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	

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	\$			\$ 238,047	\$		\$ 238,047	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				70,217			70,217	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39 - 03	hrs				260,574			260,574	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					109,393		109,393	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						78,573	98,118		176,691	13
14	TOTAL			\$			\$ 647,411	\$ 207,511		\$ 854,922	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.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,578	\$ 1,019,982	1
2	Cash-Patient Deposits	5,478	5,478	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,852,308	1,852,308	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,767	5,767	6
7	Other Prepaid Expenses	156,084	156,084	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	331,772	336,772	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,352,987	\$ 3,376,391	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	177,524	177,524	15
16	Equipment, at Historical Cost	388,373	1,878,373	16
17	Accumulated Depreciation (book methods)	(129,604)	(1,003,308)	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	65,554	3,587,298	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 501,847	\$ 11,479,887	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,854,834	\$ 14,856,278	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 455,978	\$ 614,077	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	289,999	703,651	29
30	Accrued Salaries Payable	251,644	251,644	30
31	Accrued Taxes Payable (excluding real estate taxes)	200,444	200,444	31
32	Accrued Real Estate Taxes(Sch.IX-B)		600,963	32
33	Accrued Interest Payable		17,401	33
34	Deferred Compensation		149,038	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,378,998	1,378,998	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,577,063	\$ 3,916,216	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	1,796,030	1,468,691	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,796,030	\$ 6,968,691	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,373,093	\$ 10,884,907	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,518,259)	\$ 3,971,371	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,854,834	\$ 14,856,278	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,319,582)	1
2	Restatements (describe):		2
3	Bad Debts	(243,495)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,563,077)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	44,818	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)	\$ 44,818	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)	\$ (1,518,259)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **The Grove of Berwyn**# **0055442**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	\$ 14,108,243	1
2	Discounts and Allowances for all Levels	(6,253,512)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,854,731	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,635,781	6
7	Oxygen	367	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,636,148	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	124,220	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,167	19
20	Radiology and X-Ray	55	20
21	Other Medical Services	11,530	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 155,972	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,990	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,990	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	998,381	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 998,381	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,651,222	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,494,916	31
32	Health Care	4,147,277	32
33	General Administration	1,952,199	33
	B. Capital Expense		
34	Ownership	1,368,339	34
	C. Ancillary Expense		
35	Special Cost Centers	1,336,885	35
36	Provider Participation Fee	306,788	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,606,404	40
41	Income before Income Taxes (line 30 minus line 40)**	44,818	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 44,818	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 5,667,714	44
45	Private Pay - Net Inpatient Revenue	544,012	45
46	Medicare - Net Inpatient Revenue	973,035	46
47	Other-(specify) Insurance	4,085	47
48	Other-(specify)	665,885	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,854,731	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	1,936	2,145	\$ 131,926	\$ 61.49	1
2	Assistant Director of Nursing	920	1,111	54,603	49.15	2
3	Registered Nurses	9,481	10,807	396,799	36.72	3
4	Licensed Practical Nurses	36,429	46,492	1,587,984	34.16	4
5	CNAs & Orderlies	50,887	64,435	1,141,635	17.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,167	5,150	124,426	24.16	8
9	Activity Director	1,672	2,006	39,109	19.50	9
10	Activity Assistants	7,069	7,802	118,332	15.17	10
11	Social Service Workers	5,014	5,513	151,766	27.53	11
12	Dietician					12
13	Food Service Supervisor	2,016	2,088	55,563	26.61	13
14	Head Cook	4,863	5,337	83,257	15.60	14
15	Cook Helpers/Assistants	12,558	14,353	214,065	14.91	15
16	Dishwashers					16
17	Maintenance Workers	3,691	4,107	96,179	23.42	17
18	Housekeepers	14,522	15,848	235,638	14.87	18
19	Laundry	6,427	7,179	101,529	14.14	19
20	Administrator	2,016	2,080	109,001	52.40	20
21	Assistant Administrator	1,898	2,009	77,114	38.38	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,807	12,174	201,478	16.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,896	2,072	37,657	18.17	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	1,387	1,510	22,501	14.90	33
34	TOTAL (lines 1 - 33)	179,655	214,218	\$ 4,980,562 *	\$ 23.25	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	\$ 32,517	01-03	35
36	Medical Director	Monthly	24,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	49,970	10-03	38
39	Pharmacist Consultant	Monthly	5,906	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	1	21	11-03	44
45	Social Service Consultant	Monthly	22,825	12-03	45
46	Other(specify) Dialysis Consultant	Monthly	61,730	10-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1	\$ 196,969		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.

STATE OF ILLINOIS

Facility Name & ID Number

The Grove of Berwyn

#

0055442

Report Period Beginning:

01/01/20

Ending:

12/31/20

Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership %

Amount

Sarah Parker

Administrator

0

\$ 109,001

Valetta Brown

Asst. Admin.

0

49,253

Adam Zollinger

Asst. Admin.

0

27,861

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 186,115

B. Administrative - Other

Description

Amount

\$

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$

C. Professional Services

Vendor/Payee

Type

Amount

Marcum LLP

Accounting

\$ 24,000

ProPay HR

Payroll Processing

28,376

Onyx Procurement Solutions

Procurement Services

9,470

Compliagent

Compliance

3,843

Cortex Health

Data Processing

9,725

Language Line Services

Translation Services

841

MTS Consulting

Tax Consultant

1,158

Personnel Planners

Unemployment Consultant

2,175

Telemedicine

Risk Prevention Services

7,408

See Attached

Legal

36,379

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 123,374

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 50,944

Unemployment Compensation Insurance

74,966

FICA Taxes

381,013

Employee Health Insurance

175,120

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Union Pension

33,069

Employee Benefits

14,473

401K Expense

743

Voluntary Benefit Contributions

8,128

Employee Physical Exams

1,674

TOTAL (agree to Schedule V, line 22, col.8)

\$ 740,130

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

Description

Line #

Amount

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$ 2,863

Advertising: Employee Recruitment

468

Health Care Worker Background Check

(Indicate # of checks performed 170)

1,707

Patient Background Checks

375

3,753

Dues & Subscriptions

3,136

Licenses & Fees

2,018

See Supplemental Schedule

2,967

Less: Public Relations Expense

()

Non-allowable advertising

()

Yellow page advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 16,911

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

1,742

See Supplemental Schedule

118

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 1,860

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

XX. GENERAL INFORMATION:

- | | |
|--|---|
| <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>No</u></p> <p>(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 \$3,625</u></p> <p>(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></p> <p>(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></p> <p>(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></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>26,592</u> Line <u>10</u></p> <p>(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.</p> <p>(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></p> <p>(9) Are you presently operating under a sublease agreement? YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u> </u> 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></p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>306,788</u>
This amount is to be recorded on line 42 of Schedule V.</p> <p>(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.</p> | <p>(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></p> <p>(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.</p> <p>(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. \$ <u> </u></p> <p>(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>N/A</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></p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>No</u>
Firm Name: <u>N/A</u></p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u></p> <p>(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.</p> |
|--|---|