

		FOR BHF USE					

LL1

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>0053850</u> Facility Name: <u>The Grove of Elmhurst</u> Address: <u>127 West Diversy Ave</u> <u>Elmhurst</u> <u>60126</u> Number City Zip Code County: <u>Dupage</u> Telephone Number: <u>(630)530-5225</u> Fax # <u>(630)530-7775</u> HFS ID Number: _____ Date of Initial License for Current Owners: <u>10/1/2010</u> Type of Ownership: <table><tr><td>☐</td><td>VOLUNTARY,NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☒</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table> 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: _____	☐	VOLUNTARY,NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☒	"Sub-S" Corp.					☐	Limited Liability Co.					☐	Trust					☐	Other _____			II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER 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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. <table><tr><td rowspan="3">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____ (Date) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Signed) _____ <u>05/27/2021</u></td></tr><tr><td>* Subject to the attached Accountants' Consulting Report (Date) _____</td></tr><tr><td>(Print Name <u>Steven N. Lavenda, CPA</u> and Title) <u>Partner</u></td></tr><tr><td>(Firm Name <u>Marcum, LLP</u> & Address) <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td></tr></table> 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	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____ (Date) _____	(Title) _____	Paid Preparer	(Signed) _____ <u>05/27/2021</u>	* Subject to the attached Accountants' Consulting Report (Date) _____	(Print Name <u>Steven N. Lavenda, CPA</u> and Title) <u>Partner</u>	(Firm Name <u>Marcum, LLP</u> & Address) <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>
☐	VOLUNTARY,NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL																																																						
☐	Charitable Corp.	☐	Individual	☐	State																																																						
☐	Trust	☐	Partnership	☐	County																																																						
IRS Exemption Code _____		☐	Corporation	☐	Other _____																																																						
		☒	"Sub-S" Corp.																																																								
		☐	Limited Liability Co.																																																								
		☐	Trust																																																								
		☐	Other _____																																																								
Officer or Administrator of Provider	(Signed) _____																																																										
	(Type or Print Name) _____ (Date) _____																																																										
	(Title) _____																																																										
Paid Preparer	(Signed) _____ <u>05/27/2021</u>																																																										
	* Subject to the attached Accountants' Consulting Report (Date) _____																																																										
	(Print Name <u>Steven N. Lavenda, CPA</u> and Title) <u>Partner</u>																																																										
	(Firm Name <u>Marcum, LLP</u> & Address) <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>																																																										
	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>																																																										

#	0053850	Report Period Beginning:	01/01/20	Ending:	12/31/20
---	---------	--------------------------	----------	---------	----------

D. How many bed reserve days during this year were paid by the Department?

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

N/A

None

Yes

YES ☐ NO ☒

YES ☐ NO ☒

Date started 10/1/2010

YES ☒ Date 10/1/2010 NO ☐

YES ☒ NO ☐ If YES, enter number
of beds certified 176 and days of care provided 3,307

IV. ACCOUNTING BASIS

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

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

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) **75.93%**

75.93%

Facility Name & ID Number The Grove of Elmhurst # 0053850 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	462,329	80,398		542,727		542,727	3,397	546,124			1
2	Food Purchase		310,542		310,542		310,542	6,158	316,700			2
3	Housekeeping	231,489	39,803	2,309	273,601		273,601	2,203	275,804			3
4	Laundry	53,037	30,372	138,885	222,294		222,294	150	222,444			4
5	Heat and Other Utilities			313,326	313,326		313,326	(7,561)	305,765			5
6	Maintenance	142,807	8,120	191,356	342,283		342,283	5,515	347,798			6
7	Other (specify):*											7
8	TOTAL General Services	889,662	469,235	645,876	2,004,773		2,004,773	9,862	2,014,635			8
	B. Health Care and Programs											
9	Medical Director			25,500	25,500		25,500		25,500			9
10	Nursing and Medical Records	4,669,962	478,864	56,203	5,205,029		5,205,029	97,262	5,302,291			10
10a	Therapy	82,584			82,584		82,584		82,584			10a
11	Activities	222,850	5,018	2,394	230,262		230,262	9	230,271			11
12	Social Services	360,511		3,662	364,173		364,173	5,902	370,075			12
13	CNA Training											13
14	Program Transportation			7,851	7,851		7,851		7,851			14
15	Other (specify):*							6,121	6,121			15
16	TOTAL Health Care and Programs	5,335,907	483,882	95,610	5,915,399		5,915,399	109,294	6,024,693			16
	C. General Administration											
17	Administrative	114,069			114,069		114,069	65,697	179,766			17
18	Directors Fees											18
19	Professional Services			206,964	206,964	(394)	206,570	(11,931)	194,639			19
20	Dues, Fees, Subscriptions & Promotions			77,838	77,838		77,838	(36,424)	41,414			20
21	Clerical & General Office Expenses	143,351	775	398,919	543,045		543,045	22,810	565,855			21
22	Employee Benefits & Payroll Taxes			1,015,747	1,015,747		1,015,747		1,015,747			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,130	1,130		1,130	147	1,277			24
25	Other Admin. Staff Transportation			563	563		563	4,911	5,474			25
26	Insurance-Prop.Liab.Malpractice			367,633	367,633		367,633	418	368,051			26
27	Other (specify):*							26,332	26,332			27
28	TOTAL General Administration	257,420	775	2,068,794	2,326,989	(394)	2,326,595	71,959	2,398,554			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,482,989	953,892	2,810,280	10,247,161	(394)	10,246,767	191,115	10,437,882			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							646,088	646,088			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,719	30,719		30,719	795,303	826,022			32
33	Real Estate Taxes			(2,660)	(2,660)	394	(2,266)	83,463	81,196			33
34	Rent-Facility & Grounds			1,238,640	1,238,640		1,238,640	(1,238,538)	102			34
35	Rent-Equipment & Vehicles			7,930	7,930		7,930	4,771	12,701			35
36	Other (specify):*											36
37	TOTAL Ownership			1,274,629	1,274,629	394	1,275,023	291,087	1,566,109			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	434,845	590,464	679,698	1,705,007		1,705,007	(24,578)	1,680,429			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			395,523	395,523		395,523		395,523			42
43	Other (specify):*			675,587	675,587		675,587	(675,587)				43
44	TOTAL Special Cost Centers	434,845	590,464	1,750,808	2,776,117		2,776,117	(700,165)	2,075,952			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	6,917,834	1,544,356	5,835,717	14,297,907		14,297,907	(217,963)	14,079,944			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	(8,710)	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	639,001	30		9
10	Interest and Other Investment Income	(2,284)	32		10
11	Discounts, Allowances, Rebates & Refunds	(11,510)	10		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(306)	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	(6,118)	21		18
19	Entertainment	(5,557)	21		19
20	Contributions	(12,197)	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	(227,224)	21		24
25	Fund Raising, Advertising and Promotional	(8,116)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(950,104)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (596,125)		\$	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)	378,161		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 378,161		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (217,964)		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	\$ (674,094)	43	1
2	Patient Personal Items	(1,302)	10	2
3	Sequestration Expense	(19,962)	21	3
4	Pharmacy Discounts	(191)	10	4
5	Capitalized R&M	(5,805)	06	5
6	Chamber of Commerce	(960)	20	6
7	PAC Dues	(18,315)	20	7
8	Non-Allowable Expense	(1,493)	43	8
9	Non-Allowable Legal Fees	(26,491)	19	9
10	Out of Period Dues	(519)	20	10
11	Building Co. - Closing Costs	(4,033)	21	11
12	Building Co - Permits & Licenses	(75)	20	12
13	Building Co - Tax Tracking Fee	(316)	21	13
14	Building Co - Title Fees	(16,796)	20	14
15	Building Co - Accounting Fees	(19,448)	19	15
16	Building Co - Legal Fees	(39,453)	19	16
17	Building Co - Professional Fees - Loan	(120,850)	19	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	(950,104)		49

Summary A

12/31/20

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Grove of Elmhurst # 0053850 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	639,001				7,087							646,088	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,284)	793,604			3,983							795,303	32
33	Real Estate Taxes		79,844			3,619							83,463	33
34	Rent-Facility & Grounds		(1,238,640)	33,350		(33,248)							(1,238,538)	34
35	Rent-Equipment & Vehicles				4,771								4,771	35
36	Other (specify):*													36
37	TOTAL Ownership	636,717	(365,192)	33,350	4,771	(18,560)							291,087	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers										(24,578)		(24,578)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(675,587)											(675,587)	43
44	TOTAL Special Cost Centers	(675,587)									(24,578)		(700,165)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(596,125)	(164,221)	582,368	10,892	(15,257)	(838)	(2,713)	(7,492)		(24,578)		(217,963)	45

VII. RELATED PARTIES

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

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

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 1,238,640	Elmbrook Real Properties		\$	(1,238,640)	1
2	V	32	Interest	90	Elmbrook Real Properties		793,694	793,604	2
3	V	33	Real Estate Tax Expense		Elmbrook Real Properties		79,844	79,844	3
4	V	21	Closing Costs		Elmbrook Real Properties		4,033	4,033	4
5	V	20	Permits & Licenses		Elmbrook Real Properties		75	75	5
6	V	21	Tax Tracking Fee		Elmbrook Real Properties		316	316	6
7	V	20	Title Fees		Elmbrook Real Properties		16,796	16,796	7
8	V	19	Professional Fees - Accounting		Elmbrook Real Properties		19,448	19,448	8
9	V	19	Professional Fees - Legal		Elmbrook Real Properties		39,453	39,453	9
10	V	19	Professional Fees - Loan		Elmbrook Real Properties		120,850	120,850	10
11	V				Elmbrook Real Properties				11
12	V								12
13	V								13
14	Total			\$ 1,238,730			\$ 1,074,509	\$ * (164,221)	14

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	GPN Family Trust	50.00%	Astoria Place Skilled Nursing Facility LLC	Chicago			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			Evanston Skilled Nursing Facility LLC	Evanston				1
2			Grove at the Lake Skilled Nursing Facility LLC	Zion				2
3			Grove of Berwyn	Berwyn				3
4			Grove of Fox Valley	Aurora				4
5			Grove of St. Charles	St. Charles				5
6			Lagrange Skilled Nursing Facility LLC	Lagrange Park				6
7			Lakefront Skilled Nursing Facility LLC	Chicago				7
8			Lincoln Park Skilled Nursing Facility LLC	Chicago				8
9			Lincolnshire Living & Rehab Center LLC	Lincolnshire				9
10			Northbrook Skilled Nursing Facility LLC	Northbrook				10
11			Peterson Park Associates Limited Partnership	Chicago				11
12			Skokie Skilled Nursing Facility LLC	Skokie				12
13			Valley Skilled Nursing Facility	Billings, MT				13
14			Warren Barr Living And Rehab	Chicago				14
15			Warren Barr North Shore	Highland Park				15
16			Warren Barr South Loop	Chicago				16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ **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		\$ 3,379	\$ 3,379	15
16	V	01	Dietary Supplies		Legacy Healthcare Financial Services		18	18	16
17	V	02	Food		Legacy Healthcare Financial Services		6,464	6,464	17
18	V	03	Housekeeping		Legacy Healthcare Financial Services		2,203	2,203	18
19	V	04	Linen Replacement		Legacy Healthcare Financial Services		150	150	19
20	V	06	Maintenance Salary		Legacy Healthcare Financial Services		10,426	10,426	20
21	V	06	Repairs & Maintenance		Legacy Healthcare Financial Services		619	619	21
22	V	10	Nursing Salary		Legacy Healthcare Financial Services		86,294	86,294	22
23	V	10	Nurse/Medical Director Consultant		Legacy Healthcare Financial Services		8,145	8,145	23
24	V	10	Medical Supplies		Legacy Healthcare Financial Services		18,539	18,539	24
25	V	12	Social Service Salary		Legacy Healthcare Financial Services		5,879	5,879	25
26	V	11	Activities Program		Legacy Healthcare Financial Services		9	9	26
27	V	12	Social Service Consultant		Legacy Healthcare Financial Services		23	23	27
28	V	17	COO / Administrative Salary		Legacy Healthcare Financial Services		65,697	65,697	28
29	V	19	Professional Fees		Legacy Healthcare Financial Services		21,568	21,568	29
30	V	20	Dues / Licenses / Permits		Legacy Healthcare Financial Services		3,682	3,682	30
31	V	21	Clerical & General Wages		Legacy Healthcare Financial Services		265,074	265,074	31
32	V	21	Clerical & Office Expense		Legacy Healthcare Financial Services		19,330	19,330	32
33	V	24	Education & Seminars		Legacy Healthcare Financial Services		147	147	33
34	V	25	Travel		Legacy Healthcare Financial Services		4,911	4,911	34
35	V	26	Insurance - General		Legacy Healthcare Financial Services		130	130	35
36	V	27	Non-Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		26,332	26,332	36
37	V	34	Rent		Legacy Healthcare Financial Services		33,248	33,248	37
38	V	34	Offsite Storage / Parking		Legacy Healthcare Financial Services		102	102	38
39	Total			\$			\$ 582,368	\$ * 582,368	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		444	\$	444
16	V	35	Auto Rental		Legacy Healthcare Financial Services		4,327		4,327
17	V	15	Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		6,121		6,121
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			\$			10,892	\$ *	10,892

* 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		\$ 1,149	\$ 1,149	15
16	V	6	Repairs & Maintenance		CF St. Louis LLC		1,113	1,113	16
17	V	19	Property Valuation Fee		CF St. Louis LLC		394	394	17
18	V	19	Accounting Fees		CF St. Louis LLC		90	90	18
19	V	20	Dues & Subscriptions		CF St. Louis LLC		1	1	19
20	V	21	Office Expense		CF St. Louis LLC		267	267	20
21	V	26	Insurance		CF St. Louis LLC		289	289	21
22	V	30	Depreciation		CF St. Louis LLC		7,087	7,087	22
23	V	32	Interest Expense		CF St. Louis LLC		3,983	3,983	23
24	V	33	Real Estate Taxes		CF St. Louis LLC		3,619	3,619	24
25	V								25
26	V	34	Rent	33,248	CF St. Louis LLC			(33,248)	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			\$ 33,248			\$ 17,991	\$ * (15,257)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance	\$ 34,200	ML Group Design & Development		\$ 33,362	\$ (838)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 34,200			\$ 33,362	\$ * (838)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	\$ 32,702	ProPay HR LLC		\$ 25,210	\$ (7,492)	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			\$ 32,702			\$ 25,210	\$ * (7,492)	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.

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	04	Laundry Services	\$ 188,306	EcoBrite Linen		\$ 188,306	\$	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			\$ 188,306			\$ 188,306	\$ *	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	\$ 60,387	Lifescan Labs of Illinois		\$ 35,809	\$ (24,578)	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			\$ 60,387			\$ 35,809	\$ * (24,578)	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 Elmhurst# 0053850

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	65,880	\$ 3,379	1
2	01	Dietary Supplies	Available Bed Days	53	697		65,880	18	2
3	02	Food	Available Bed Days	53	249,220		65,880	6,464	3
4	03	Housekeeping	Available Bed Days	53	84,952		65,880	2,203	4
5	04	Linen Replacement	Available Bed Days	53	5,771		65,880	150	5
6	06	Maintenance Salary	Available Bed Days	53	401,986	401,986	65,880	10,426	6
7	06	Repairs & Maintenance	Available Bed Days	53	23,857		65,880	619	7
8	10	Nursing Salary	Available Bed Days	53	3,327,223	3,327,223	65,880	86,294	8
9	10	Nurse/Medical Director Consultant	Available Bed Days	53	314,035		65,880	8,145	9
10	10	Medical Supplies	Available Bed Days	53	714,824		65,880	18,539	10
11	12	Social Service Salary	Available Bed Days	53	226,662	226,662	65,880	5,879	11
12	11	Activities Program	Available Bed Days	53	335		65,880	9	12
13	12	Social Service Consultant	Available Bed Days	53	893		65,880	23	13
14	17	COO / Administrative Salary	Available Bed Days	53	2,533,078	2,533,078	65,880	65,697	14
15	19	Professional Fees	Available Bed Days	53	831,592		65,880	21,568	15
16	20	Dues / Licenses / Permits	Available Bed Days	53	141,983		65,880	3,682	16
17	21	Clerical & General Wages	Available Bed Days	53	10,220,453	10,220,453	65,880	265,074	17
18	21	Clerical & Office Expense	Available Bed Days	53	745,293		65,880	19,330	18
19	24	Education & Seminars	Available Bed Days	53	5,655		65,880	147	19
20	25	Travel	Available Bed Days	53	189,364		65,880	4,911	20
21	26	Insurance - General	Available Bed Days	53	4,997		65,880	130	21
22	27	Non-Nursing Payroll Taxes / Bene	Available Bed Days	53	1,015,274		65,880	26,332	22
23	34	Rent	Available Bed Days	53	1,281,940		65,880	33,248	23
24	34	Offsite Storage / Parking	Available Bed Days	53	3,949		65,880	102	24
25	TOTALS				\$ 22,454,338	\$ 16,839,706		\$ 582,368	25

Ending: 12/31/20

(847) 683-2900

IL478-2471

Ending: 12/31/20

(847) 676-5348

IL478-2471

Ending: 12/31/20

()

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

()

IL478-2471

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			\$	18,241,660			\$ 786,839	1
2	CIBC		X	Note Payable				819,550			6,855	2
3												3
4												4
5												5
	Working Capital											
6	CIBC		X	Note Payable				424,000			30,719	6
7	Allocated from CF St. Louis		X								3,983	7
8												8
9	TOTAL Facility Related						\$	19,485,211			\$ 828,395	9
	B. Non-Facility Related*											
10	Interest Income		X								(2,284)	10
11	Interest Income - Bldg Co.		X								(90)	11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$ (2,374)	14
15	TOTALS (line 9+line14)						\$	19,485,211			\$ 826,021	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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2019 report.				\$	71,017 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.)				\$	74,549 2
3. Under or (over) accrual (line 2 minus line 1).				\$	3,532 3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	77,270 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.)				\$	394 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.				\$	81,196 7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	63,000	8	
		2016	63,959	9	
		2017	66,473	10	
		2018	67,635	11	
		2019	70,931	12	
2020 Accrual = \$70,931 x 1.09 = \$77,270					
Allocated from CF St. Louis: \$3,619					

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

FACILITY NAME The Grove of Elmhurst COUNTY Dupage
FACILITY IDPH LICENSE NUMBER 0053850
CONTACT PERSON REGARDING THIS REPORT Steven Lavenda
TELEPHONE (847) 282-6330 FAX #: ()

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

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

IMPORTANT NOTICE

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

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

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

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

FACILITY NAME The Grove of Elmhurst COUNTY Dupage
FACILITY IDPH LICENSE NUMBER 0053850
CONTACT PERSON REGARDING THIS REPORT Steven Lavenda
TELEPHONE () FAX #: ()

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.

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

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.

Page 10B

A. Square Feet: 44,800

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).

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	67,000	2010	\$ 606,331	1
2	Allocated from CF St. Louis, LLC			5,118	2
3	TOTALS	67,000		\$ 611,449	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	180		2010	1977	\$ 7,403,102	\$	35	\$ 211,517	\$ 211,517	\$ 846,068	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2011	831,792		20	41,590	41,590	415,896	9
10	Various			2012	243,002		20	12,150	12,150	109,351	10
11	Various			2013	155,927		20	7,796	7,796	60,602	11
12	Various			2014	79,902		20	3,995	3,995	27,966	12
13	Various			2015	60,295		20	3,015	3,015	17,416	13
14	Various			2016	62,037		20	3,102	3,102	12,407	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number The Grove of Elmhurst

0053850

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
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		240,899	6,534		11,454	4,921	51,244	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		\$ 9,076,957	\$ 6,534		\$ 294,619	\$ 288,086	\$ 1,540,950	70

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

Facility Name & ID Number The Grove of Elmhurst

0053850

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		\$ 9,076,957	\$ 6,534		\$ 294,619	\$ 288,086	\$ 1,540,950	1
2	Patched And Painted Dining Room	2017	20,700		20	1,035	1,035	3,450	2
3	Installed Signage - Side Elevation	2017	12,802		20	640	640	2,134	3
4	Installed 1 New Carrier Oil Pump For Compressor - Chiller	2017	6,442		20	322	322	2,362	4
5	Installed New Elevator Valve - Elevator	2017	3,800		20	190	190	1,774	5
6	Installed Signage - Side Elevation	2017	12,349		20	617	617	2,367	6
7	Powerwashed Copings, Installed New Copings - Roof	2017	16,500		20	825	825	2,062	7
8	Floor Tiling In Resident Rooms	2017	11,500		20	575	575	2,300	8
9	Painting Room, Dry Wall -Resident Rooms	2017	3,250		20	163	163	650	9
10	Installed Branch Pannel And Pipe-Closet/Vent Wing	2017	17,775		20	889	889	3,555	10
11	Added New Tiles In Resident Room	2017	5,750		20	288	288	1,150	11
12	Rewired Vent Wiring - Main Vent	2017	5,900		20	295	295	1,180	12
13	Removed Head, Replaced Condenser Shell Tube - Chiller	2017	4,899		20	245	245	980	13
14	Room Repairs To Tile, Lighting, Walls (23,000)	2017	21,289		20	1,064	1,064	3,193	14
15	Window Treatments - 2Nd & 3Rd Floors (8,220)	2018	7,608		20	380	380	1,446	15
16	Electrical Work & Outlets (3,500)	2018	3,240		20	162	162	499	16
17	Air Damper Replacements For Boiler & Generator Rooms (3,764)	2018	3,484		20	174	174	751	17
18	Chiller Repair (2,786)	2018	2,579		20	129	129	387	18
19	Ejector Pump Replacements (18,515)	2018	17,137		20	857	857	2,571	19
20	Light Fixture & Window Treatments - 2Nd & 3Rd Floors (5,356.2	2018	4,958		20	248	248	744	20
21	Repaired Sewer (\$3300)	2019	3,198		20	160	160	288	21
22	Tuckpointing - 3Rd Flr Wall, Patch Roof Drain	2019	2,825		20	141	141	283	22
23	Rooftop Exhuast Repair, Patch 2 Leaky Roof Drains (\$3,165)	2020	3,087		20	154	154	154	23
24	2Nd Floor Vent Wing Electrical Work (\$7,450)	2020	7,267		20	363	363	363	24
25	Rebuild Injection Pump, Replace Gaskets (\$4,627)	2020	4,514		20	226	226	226	25
26	Boiler Repair - New Pressure Relief, Gas Valve (\$2,715)	2020	2,649		20	132	132	132	26
27	Generator Repair - Fuel Filters,Injectors,Injection Pump (\$3,205)	2020	3,126		20	156	156	156	27
28	Generator Repair - Replace Ats Controller (\$2,600)	2020	2,536		20	127	127	127	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,288,122	\$ 6,534		\$ 305,178	\$ 298,644	\$ 1,576,235	34

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

Facility Name & ID Number The Grove of Elmhurst

0053850

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		\$ 9,288,122	\$ 6,534		\$ 305,178	\$ 298,644	\$ 1,576,235	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,288,122	\$ 6,534		\$ 305,178	\$ 298,644	\$ 1,576,235	34

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

Facility Name & ID Number The Grove of Elmhurst

0053850

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		\$ 9,288,122	\$ 6,534		\$ 305,178	\$ 298,644	\$ 1,576,235	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,288,122	\$ 6,534		\$ 305,178	\$ 298,644	\$ 1,576,235	34

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

Facility Name & ID Number The Grove of Elmhurst

0053850

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		\$ 9,288,122	\$ 6,534		\$ 305,178	\$ 298,644	\$ 1,576,235	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,288,122	\$ 6,534		\$ 305,178	\$ 298,644	\$ 1,576,235	34

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

Facility Name & ID Number The Grove of Elmhurst

0053850

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number The Grove of Elmhurst

0053850

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party								1
2	Buildings:								2
3	Allocated from CF St. Louis, LLC	2016	27,561	1,280	35	787	(492)	3,937	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	171,116	4,221	20	8,556	4,334	42,779	9
10	Allocated from CF St. Louis, LLC	2017	3,972	98	20	199	101	794	10
11	Allocated from CF St. Louis, LLC	2019	35,998	888	20	1,800	912	3,600	11
12	Allocated from CF St. Louis, LLC	2019	1,893	47	20	95	48	95	12
13									13
14	Allocated from Legacy HC	2018	204		20	10	10	31	14
15	Allocated from Legacy HC	2020	154		20	8	8	8	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)		\$ 240,899	\$ 6,534		\$ 11,454	\$ 4,921	\$ 51,244	34

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

Facility Name & ID Number The Grove of Elmhurst

0053850

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		\$ 240,899	\$ 6,534		\$ 11,454	\$ 4,921	\$ 51,244	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 240,899	\$ 6,534		\$ 11,454	\$ 4,921	\$ 51,244	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	\$ 3,521,255	\$ 552	\$ 339,558	\$ 339,006	10	\$ 1,563,993	71
72	Current Year Purchases	15,386	2	1,353	1,351	10	1,353	72
73	Fully Depreciated Assets	2,021,359				10	2,021,359	73
74								74
75	TOTALS	\$ 5,558,001	\$ 553	\$ 340,911	\$ 340,357		\$ 3,586,705	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)			\$	15,457,572
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	7,087
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	646,089
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	639,001
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	5,162,940

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		\$
93		
94		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated from Legacy Financial				102			5
6								6
7	TOTAL				\$ 102			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: \$ 8,374
- 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 Financial		\$	\$ 4,327	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 4,327	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	\$		\$ 203,738	\$		\$ 203,738	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			88,551			88,551	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			248,350			248,350	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				354,654		354,654	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached			434,845		139,059	235,810		809,714	13
14	TOTAL			\$ 434,845		\$ 679,698	\$ 590,464		\$ 1,705,007	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	\$ 241,328	\$ 241,328	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,592,664	3,592,664	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,639	7,639	6
7	Other Prepaid Expenses	413,445	413,445	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	529,006	544,756	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,784,082	\$ 4,799,832	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,309,500	13
14	Buildings, at Historical Cost	3,165	5,183,500	14
15	Leasehold Improvements, at Historical Cost	197,599	867,730	15
16	Equipment, at Historical Cost	273,211	288,211	16
17	Accumulated Depreciation (book methods)	(178,233)	(1,871,102)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	3,507,263	5,649,926	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,803,005	\$ 11,427,765	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,587,087	\$ 16,227,597	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 442,120	\$ 442,121	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	424,000	424,000	29
30	Accrued Salaries Payable	540,249	540,249	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	316,280	316,280	31
32	Accrued Real Estate Taxes(Sch.IX-B)		77,270	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	2,405,336	2,539,146	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,127,985	\$ 4,339,066	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		819,550	39
40	Mortgage Payable		18,241,660	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	5,506,755	4,497,519	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 5,506,755	\$ 23,558,729	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,634,740	\$ 27,897,795	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,047,653)	\$ (11,670,198)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,587,087	\$ 16,227,597	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,938,551)	1
2	Restatements (describe):		2
3	Equity Restatement	422,580	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,515,971)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	468,318	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)	\$ 468,318	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)	\$ (1,047,653)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **The Grove of Elmhurst**# **0053850**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	\$ 17,603,509	1
2	Discounts and Allowances for all Levels	(6,284,787)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,318,722	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,715,460	6
7	Oxygen	470	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,715,930	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	341,510	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	89,648	19
20	Radiology and X-Ray		20
21	Other Medical Services	23,544	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 454,702	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,284	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,284	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached</u>	1,274,587	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,274,587	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,766,225	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,004,773	31
32	Health Care	5,915,399	32
33	General Administration	2,326,989	33
	B. Capital Expense		
34	Ownership	1,274,629	34
	C. Ancillary Expense		
35	Special Cost Centers	2,380,594	35
36	Provider Participation Fee	395,523	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,297,907	40
41	Income before Income Taxes (line 30 minus line 40)**	468,318	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 468,318	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 8,583,752	44
45	Private Pay - Net Inpatient Revenue	450,764	45
46	Medicare - Net Inpatient Revenue	1,165,221	46
47	Other-(specify) <u>Insurance</u>	448,730	47
48	Other-(specify) <u>Veterans</u>	670,255	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,318,722	49

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

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

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

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

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,189	2,389	\$ 143,881	\$ 60.23	1
2	Assistant Director of Nursing	2,048	2,281	106,109	46.52	2
3	Registered Nurses	31,759	39,320	1,474,229	37.49	3
4	Licensed Practical Nurses	33,159	39,989	1,349,159	33.74	4
5	CNAs & Orderlies	66,084	80,681	1,557,652	19.31	5
6	CNA Trainees					6
7	Licensed Therapist	11,803	13,128	434,845	33.12	7
8	Rehab/Therapy Aides	3,826	4,632	82,584	17.83	8
9	Activity Director	2,928	3,160	68,115	21.56	9
10	Activity Assistants	8,683	9,881	154,735	15.66	10
11	Social Service Workers	7,536	8,177	203,649	24.91	11
12	Dietician					12
13	Food Service Supervisor	1,944	2,080	74,409	35.77	13
14	Head Cook	10,599	11,497	194,947	16.96	14
15	Cook Helpers/Assistants	11,991	13,744	192,973	14.04	15
16	Dishwashers					16
17	Maintenance Workers	5,906	6,289	142,807	22.71	17
18	Housekeepers	14,092	15,787	231,489	14.66	18
19	Laundry	2,584	3,019	53,037	17.57	19
20	Administrator	1,952	2,056	114,069	55.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,000	6,575	143,351	21.80	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	9,102	11,180	195,794	17.51	33
34	TOTAL (lines 1 - 33)	234,185	275,865	\$ 6,917,834 *	\$ 25.08	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		\$		35
36	Medical Director	Monthly	25,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	51,245	10-03	38
39	Pharmacist Consultant	Monthly	4,958	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	2,394	11-03	44
45	Social Service Consultant	Monthly	3,662	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 87,759		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 Elmhurst

0053850

Report Period Beginning:

01/01/20

Ending:

12/31/20

Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership %

Amount

Renee Patel

Administrator

0

\$ 114,069

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

(List each licensed administrator separately.)

\$ 114,069

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

32,702

Onyx Procurement Solutions

Procurement Services

11,670

Achieve Accreditation

Accreditation

11,281

Compliagent

Compliance

3,843

PatientPing, Inc.

Care Collaboration Software

18,000

Personnel Planners

Unemployment Tax Consultant

977

2401 Incorporated of Illinois

Architect

5,370

Cortex Health Care

Data Processing

9,835

Telemedicine Solutions

Risk Prevention Software

5,308

See Attached

Legal

80,745

See Supplemental Schedule

3,234

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

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

\$ 206,964

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 97,918

Unemployment Compensation Insurance

21,887

FICA Taxes

529,214

Employee Health Insurance

201,667

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Union Pension

93,151

Employee Benefits

19,586

401K Expense

26,644

Voluntary Benefit Contributions

19,152

Employee Physical Exams

6,528

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

\$ 1,015,747

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

\$ 1,990

Advertising: Employee Recruitment

404

Health Care Worker Background Check

3,075

(Indicate # of checks performed 308)

Patient Background Checks

8

75

Dues & Subscriptions

30,745

Licenses & Fees

1,443

See Supplemental Schedule

3,683

Less: Public Relations Expense

()

Non-allowable advertising

()

Yellow page advertising

()

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

\$ 41,414

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

1,130

See Supplemental Schedule

147

Entertainment Expense

()

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

TOTAL

\$ 1,277

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HCCI - \$28,044, IHCA - \$15,624

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

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 65,683 Line 10

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 395,523
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14

d. Have vehicle usage logs been maintained? N/A

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A

g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.