

		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>0053884</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>The Grove of Lagrange Park</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
Address: <u>701 N Lagrange Road</u> <u>Lagrange Park</u> <u>60526</u>			
Number City Zip Code			
County: <u>Cook</u>			
Telephone Number: <u>(708) 354-7300</u> Fax # <u>(708) 354-8928</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>4/1/2009</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) _____	
		Paid Preparer	
		(Signed) _____ 05/03/2021 (Date) _____	
		* Subject to the attached Accountants' Consulting Report	
		(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	

#	0053884	Report Period Beginning:	01/01/20	Ending:	12/31/20
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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 4/1/2009

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 4/1/2009 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☐ If YES, enter number
of beds certified 131 and days of care provided

Medicare Intermediary CGS Administrators**MODIFIED**

ACCRUAL	X
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CASH*	
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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.

	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	4,284	920	7,890	13,094	8
9	SNF/PED					9
10	ICF	22,498	3,266	1,384	27,148	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,782	4,186	9,274	40,242	14

83.93%

Facility Name & ID Number The Grove of Lagrange Park # 0053884 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	387,562	36,735		424,297		424,297	2,473	426,770			1
2	Food Purchase		220,619		220,619		220,619	3,678	224,297			2
3	Housekeeping	251,631	21,020		272,651		272,651	1,604	274,255			3
4	Laundry	67,220	16,580	114,133	197,933		197,933	109	198,042			4
5	Heat and Other Utilities			122,518	122,518		122,518	(5,233)	117,285			5
6	Maintenance	54,936	8,233	162,724	225,893		225,893	208	226,101			6
7	Other (specify):*											7
8	TOTAL General Services	761,349	303,187	399,375	1,463,911		1,463,911	2,839	1,466,750			8
	B. Health Care and Programs											
9	Medical Director			49,063	49,063		49,063		49,063			9
10	Nursing and Medical Records	3,285,836	220,247	48,279	3,554,362		3,554,362	78,281	3,632,643			10
10a	Therapy	155,901			155,901		155,901		155,901			10a
11	Activities	154,820	2,056	1,321	158,197		158,197	6	158,203			11
12	Social Services	201,722	43,479	5,107	250,308		250,308	4,295	254,603			12
13	CNA Training											13
14	Program Transportation			12,288	12,288		12,288		12,288			14
15	Other (specify):*							4,455	4,455			15
16	TOTAL Health Care and Programs	3,798,279	265,782	116,058	4,180,119		4,180,119	87,037	4,267,156			16
	C. General Administration											
17	Administrative	164,905			164,905		164,905	47,813	212,718			17
18	Directors Fees											18
19	Professional Services			208,349	208,349	(3,537)	204,812	1,991	206,803			19
20	Dues, Fees, Subscriptions & Promotions			67,566	67,566		67,566	(30,654)	36,912			20
21	Clerical & General Office Expenses	156,849	4,890	353,463	515,202		515,202	(30,560)	484,642			21
22	Employee Benefits & Payroll Taxes			796,657	796,657		796,657		796,657			22
23	Inservice Training & Education											23
24	Travel and Seminar			193	193		193	107	300			24
25	Other Admin. Staff Transportation			1,544	1,544		1,544	3,574	5,118			25
26	Insurance-Prop.Liab.Malpractice			413,969	413,969		413,969	13,149	427,118			26
27	Other (specify):*							19,164	19,164			27
28	TOTAL General Administration	321,754	4,890	1,841,741	2,168,385	(3,537)	2,164,848	24,584	2,189,433			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,881,382	573,859	2,357,174	7,812,415	(3,537)	7,808,878	114,461	7,923,339			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							287,020	287,020			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,499	17,499		17,499	456,507	474,006			32
33	Real Estate Taxes			12,812	12,812	3,537	16,349	290,169	306,517			33
34	Rent-Facility & Grounds			1,272,189	1,272,189		1,272,189	(1,272,114)	75			34
35	Rent-Equipment & Vehicles			18,966	18,966		18,966	3,472	22,438			35
36	Other (specify):*							85,273	85,273			36
37	TOTAL Ownership			1,321,466	1,321,466	3,537	1,325,003	(149,673)	1,175,329			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		365,948	803,325	1,169,273		1,169,273	(8,078)	1,161,195			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			294,149	294,149		294,149		294,149			42
43	Other (specify):*			517,763	517,763		517,763	(517,763)	(0)			43
44	TOTAL Special Cost Centers		365,948	1,615,237	1,981,185		1,981,185	(525,841)	1,455,344			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,881,382	939,807	5,293,877	11,115,066		11,115,066	(561,054)	10,554,012			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	(6,069)	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	197,708	30		9
10	Interest and Other Investment Income	(13,659)	32		10
11	Discounts, Allowances, Rebates & Refunds	(797)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(229)	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	(2,133)	21		18
19	Entertainment	(286)	21		19
20	Contributions	(12,211)	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	(204,475)	21		24
25	Fund Raising, Advertising and Promotional	(6,319)	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	(608,235)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (656,705)		\$	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)	95,651		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 95,651		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (561,054)		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	\$ (517,763)	43	1
2	Rebates	(243)	10	2
3	Patient Personal Items	(701)	10	3
4	Bank Charges	(6,991)	21	4
5	Sequestration	(23,852)	21	5
6	Pharmacy Discounts	(285)	10	6
7	Bldg Co - Processing Fees	(1,500)	21	7
8	Bldg Co - Accounting	(17,394)	19	8
9	Bldg Co - Legal Fees	(4,356)	19	9
10	Bldg Co - Amortization	(3,659)	36	10
11	Capitalized R&M	(7,934)	06	11
12	Marketing License	(821)	20	12
13	PAC Dues	(13,114)	20	13
14	Prior Period Dues	(869)	20	14
15	Non Allowable Legal	(8,753)	19	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
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32				32
33				33
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36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(608,235)		49

Summary A

12/31/20

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Grove of Lagrange Park # 0053884 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	197,708	84,154			5,158							287,020	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(13,659)	467,268			2,898							456,507	32
33	Real Estate Taxes		287,535			2,634							290,169	33
34	Rent-Facility & Grounds		(1,272,189)	24,272		(24,197)							(1,272,114)	34
35	Rent-Equipment & Vehicles				3,472								3,472	35
36	Other (specify):*	(3,659)	88,932										85,273	36
37	TOTAL Ownership	180,390	(344,300)	24,272	3,472	(13,507)							(149,673)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers										(8,078)		(8,078)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(517,763)											(517,763)	43
44	TOTAL Special Cost Centers	(517,763)									(8,078)		(525,841)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(656,705)	(308,205)	423,834	7,927	(11,104)	(5,304)	(706)	(2,713)		(8,078)		(561,054)	45

VII. RELATED PARTIES

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

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

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 1,272,189	Grove of LaGrange Healthcare Properties LLC		\$	(1,272,189)	1
2	V	32	Interest	25,222	Grove of LaGrange Healthcare Properties LLC		492,490	467,268	2
3	V	33	RE Taxes		Grove of LaGrange Healthcare Properties LLC		287,535	287,535	3
4	V	26	Property Insurance		Grove of LaGrange Healthcare Properties LLC		12,845	12,845	4
5	V	36	MIP Expense		Grove of LaGrange Healthcare Properties LLC		85,273	85,273	5
6	V	21	Processing Fees		Grove of LaGrange Healthcare Properties LLC		1,500	1,500	6
7	V	19	Accounting		Grove of LaGrange Healthcare Properties LLC		17,394	17,394	7
8	V	19	Legal Fees		Grove of LaGrange Healthcare Properties LLC		4,356	4,356	8
9	V	30	Depreciation		Grove of LaGrange Healthcare Properties LLC		84,154	84,154	9
10	V	36	Amortization		Grove of LaGrange Healthcare Properties LLC		3,659	3,659	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,297,411			\$ 989,206	\$ * (308,205)	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	Grove of LaGrange Healthcare Pro		Building Company	1
2	Doros Generation Trust	50.00 %	Avantara Arlington	Arlington, SD	Legacy HC & Financial Services	Lincolnwood	Home Office/Bookkeeping	2
3			Avantara Armour	Armour, SD	CF St. Louis LLC	Skokie	Building Company	3
4			Avantara Arrowhead	Rapid City, SD	ML Group Design & Development	Skokie	Asset Management	4
5			Avantara Aurora	Aurora	ReMED Services LLC	Lincolnwood	Nursing Equipment	5
6			Avantara Billings	Billings, MT	Propay HR	Evanston	Payroll Processing	6
7			Avantara Clark	Clark, SD	Ecobrite Linen	Skokie	Laundry Supplies	7
8			Avantara Elgin	Elgin	Aurora Supportive Living	Aurora	Supportive Living	8
9			Avantara Evergreen Park	Evergreen Park	Terrace Gardens	Morton Grove	Assisted Living	9
10			Avantara Groton	Groton, SD	Lincolnshire Assisted Living Center	Lincolnshire	Assisted Living	10
11			Avantara Huron	Huron, SD	Wellshire Park Place	Milbank, SD	Assisted Living	11
12			Avantara Ipswich	Ipswich, SD	Wellshire Huron	Huron, SD	Assisted Living	12
13			Avantara Lake Norden	Lake Norden, SD	Lifescan Labs of Illinois	Skokie	Laboratory	13
14			Avantara Long Grove	Long Grove				14
15			Avantara Milbank	Milbank, SD				15
16			Avantara Mountainview	Rapid City, SD				16
17			Avantara North	Rapid City, SD				17
18			Avantara Norton	Sioux Falls, SD				18
19			Avantara Park Ridge	Park Ridge				19
20			Avantara Pierre	Pierre, SD				20
21			Avantara Redfield	Redfield, SD				21
22			Avantara Salem	Salem, SD				22
23			Avantara St. Cloud	Rapid City, SD				23
24			Avantara Watertown	Watertown, SD				24
25			Bella Terra Streamwood	Streamwood				25
26			Bella Terra Wheeling	Wheeling				26
27			Bethany Terrace	Morton Grove				27
28			Carlton Skilled Nursing Facility LLC	Chicago				28
29			Chalet Skilled Nursing Facility LLC	Chicago				29
30			Clark Skilled Nursing Facility	Chicago				30

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Elmbrook Skilled Nursing Facility LLC	Elmhurst				1
2			Evanston Skilled Nursing Facility LLC	Evanston				2
3			Grove at the Lake Skilled Nursing Facility LLC	Zion				3
4			Grove of Berwyn	Berwyn				4
5			Grove of Fox Valley	Aurora				5
6			Grove of St. Charles	St. Charles				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. ☒ YES ☐ NO

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	01 Dietician Salary	\$	Legacy Healthcare Financial Services		\$ 2,460	\$ 2,460	15
16	V	01 Dietary Supplies		Legacy Healthcare Financial Services		13	13	16
17	V	02 Food		Legacy Healthcare Financial Services		4,704	4,704	17
18	V	03 Housekeeping		Legacy Healthcare Financial Services		1,604	1,604	18
19	V	04 Linen Replacement		Legacy Healthcare Financial Services		109	109	19
20	V	06 Maintenance Salary		Legacy Healthcare Financial Services		7,588	7,588	20
21	V	06 Repairs & Maintenance		Legacy Healthcare Financial Services		450	450	21
22	V	10 Nursing Salary		Legacy Healthcare Financial Services		62,803	62,803	22
23	V	10 Nurse/Medical Director Consultant		Legacy Healthcare Financial Services		5,928	5,928	23
24	V	10 Medical Supplies		Legacy Healthcare Financial Services		13,493	13,493	24
25	V	12 Social Service Salary		Legacy Healthcare Financial Services		4,278	4,278	25
26	V	11 Activities Program		Legacy Healthcare Financial Services		6	6	26
27	V	12 Social Service Consultant		Legacy Healthcare Financial Services		17	17	27
28	V	17 COO / Administrative Salary		Legacy Healthcare Financial Services		47,813	47,813	28
29	V	19 Professional Fees		Legacy Healthcare Financial Services		15,697	15,697	29
30	V	20 Dues / Licenses / Permits		Legacy Healthcare Financial Services		2,680	2,680	30
31	V	21 Clerical & General Wages		Legacy Healthcare Financial Services		192,915	192,915	31
32	V	21 Clerical & Office Expense		Legacy Healthcare Financial Services		14,068	14,068	32
33	V	24 Education & Seminars		Legacy Healthcare Financial Services		107	107	33
34	V	25 Travel		Legacy Healthcare Financial Services		3,574	3,574	34
35	V	26 Insurance - General		Legacy Healthcare Financial Services		94	94	35
36	V	27 Non-Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		19,164	19,164	36
37	V	34 Rent		Legacy Healthcare Financial Services		24,197	24,197	37
38	V	34 Offsite Storage / Parking		Legacy Healthcare Financial Services		75	75	38
39	Total		\$			\$ 423,834	\$ * 423,834	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		323	\$	323
16	V	35	Auto Rental		Legacy Healthcare Financial Services		3,149		3,149
17	V	15	Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		4,455		4,455
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			\$			7,927	\$ *	7,927

* 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		\$ 836	\$ 836	15
16	V	6	Repairs & Maintenance		CF St. Louis LLC		810	810	16
17	V	19	Property Valuation Fee		CF St. Louis LLC		287	287	17
18	V	19	Accounting Fees		CF St. Louis LLC		65	65	18
19	V	20	Dues & Subscriptions		CF St. Louis LLC		0	0	19
20	V	21	Office Expense		CF St. Louis LLC		194	194	20
21	V	26	Insurance		CF St. Louis LLC		210	210	21
22	V	30	Depreciation		CF St. Louis LLC		5,158	5,158	22
23	V	32	Interest Expense		CF St. Louis LLC		2,898	2,898	23
24	V	33	Real Estate Taxes		CF St. Louis LLC		2,634	2,634	24
25	V								25
26	V	34	Rent	24,197	CF St. Louis LLC			(24,197)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 24,197			\$ 13,093	\$ * (11,104)	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	\$ 23,150	ProPay HR		\$ 17,846	\$ (5,304)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 23,150			\$ 17,846	\$ * (5,304)	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	\$ 28,800	ML Group Design & Development		\$ 28,094	\$ (706)	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			\$ 28,800			\$ 28,094	\$ * (706)	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	04	Laundry Services	\$ 97,252	EcoBrite Linen		\$ 97,252	\$	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			\$ 97,252			\$ 97,252	\$ *	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	\$ 19,848	Lifescan Labs of Illinois		\$ 11,770	\$ (8,078)	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			\$ 19,848			\$ 11,770	\$ * (8,078)	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.

Facility Name & ID Number The Grove of Lagrange Park # 0053884 Report Period Beginning: 01/01/20 Ending: 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 _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

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

Facility Name & ID Number The Grove of Lagrange Park# 0053884

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, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	01	Dietician Salary	Available Bed Days	53	\$ 130,303	\$ 130,303	47,946	\$ 2,460	1
2	01	Dietary Supplies	Available Bed Days	53	697		47,946	13	2
3	02	Food	Available Bed Days	53	249,220		47,946	4,704	3
4	03	Housekeeping	Available Bed Days	53	84,952		47,946	1,604	4
5	04	Linen Replacement	Available Bed Days	53	5,771		47,946	109	5
6	06	Maintenance Salary	Available Bed Days	53	401,986	401,986	47,946	7,588	6
7	06	Repairs & Maintenance	Available Bed Days	53	23,857		47,946	450	7
8	10	Nursing Salary	Available Bed Days	53	3,327,223	3,327,223	47,946	62,803	8
9	10	Nurse/Medical Director Consultant	Available Bed Days	53	314,035		47,946	5,928	9
10	10	Medical Supplies	Available Bed Days	53	714,824		47,946	13,493	10
11	12	Social Service Salary	Available Bed Days	53	226,662	226,662	47,946	4,278	11
12	11	Activities Program	Available Bed Days	53	335		47,946	6	12
13	12	Social Service Consultant	Available Bed Days	53	893		47,946	17	13
14	17	COO / Administrative Salary	Available Bed Days	53	2,533,078	2,533,078	47,946	47,813	14
15	19	Professional Fees	Available Bed Days	53	831,592		47,946	15,697	15
16	20	Dues / Licenses / Permits	Available Bed Days	53	141,983		47,946	2,680	16
17	21	Clerical & General Wages	Available Bed Days	53	10,220,453	10,220,453	47,946	192,915	17
18	21	Clerical & Office Expense	Available Bed Days	53	745,293		47,946	14,068	18
19	24	Education & Seminars	Available Bed Days	53	5,655		47,946	107	19
20	25	Travel	Available Bed Days	53	189,364		47,946	3,574	20
21	26	Insurance - General	Available Bed Days	53	4,997		47,946	94	21
22	27	Non-Nursing Payroll Taxes / Bene	Available Bed Days	53	1,015,274		47,946	19,164	22
23	34	Rent	Available Bed Days	53	1,281,940		47,946	24,197	23
24	34	Offsite Storage / Parking	Available Bed Days	53	3,949		47,946	75	24
25	TOTALS				\$ 22,454,338	\$ 16,839,706		\$ 423,834	25

Facility Name & ID Number The Grove of Lagrange Park # 0053884 Report Period Beginning: 01/01/20 Ending: 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	35	Equipment Rental	Available Bed Days	2,540,133	53	17,109		47,946	323	1
2	35	Auto Rental	Available Bed Days	2,540,133	53	166,843		47,946	3,149	2
3	15	Nursing Payroll Taxes / Benefits	Available Bed Days	2,540,133	53	236,021		47,946	4,455	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					\$ 419,973	\$		\$ 7,927	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

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

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

IL478-2471

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			\$	11,792,654			\$	492,490	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6	CIBC		X	Note Payable				1,737,020				17,499	6	
7													7	
8													8	
9	TOTAL Facility Related						\$	13,529,674				\$	509,989	9
	B. Non-Facility Related*													
10	Interest Income		X									(13,659)	10	
11	Interest Income - Bldg Co		X									(25,222)	11	
12	Allocated from CF St. Loius	X										2,898	12	
13													13	
14	TOTAL Non-Facility Related						\$					\$	(35,983)	14
15	TOTALS (line 9+line14)						\$	13,529,674				\$	474,006	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 85,273 Line # 36

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

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

FACILITY NAME The Grove of Lagrange Park COUNTY Cook
FACILITY IDPH LICENSE NUMBER 0053884
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 Lagrange Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053884

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

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.)

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.

A. Square Feet: 43,000

B. General Construction Type: Exterior Brick Frame Number of Stories 3

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	43,000	2015	\$ 750,000	1
2	Allocated from CF St. Louis, LLC			3,725	2
3	TOTALS	43,000		\$ 753,725	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	131		2011	1975	\$ 4,559,403	\$ 84,154	39	\$ 116,908	\$ 32,754	\$ 807,672	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2009	259,604		20	429	429	259,604	9
10	Various			2010	115,636		20	5,081	5,081	101,620	10
11	Various			2011	133,695		20	6,685	6,685	120,506	11
12	Various			2012	37,487		20	1,874	1,874	29,990	12
13	Various			2013	324,851		20	16,243	16,243	227,396	13
14	Various			2014	107,689		20	5,384	5,384	64,613	14
15	Various			2015	108,930		20	5,446	5,446	27,023	15
16	Various			2016	392,961		20	19,648	19,648	78,592	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

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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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)		175,321	4,755		8,336	3,581	37,294	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		\$ 6,215,577	\$ 88,909		\$ 186,035	\$ 97,126	\$ 1,754,309	70

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

Facility Name & ID Number The Grove of Lagrange Park

0053884

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		\$ 6,215,577	\$ 88,909		\$ 186,035	\$ 97,126	\$ 1,754,309	1
2	Hvac Repair	2017	2,655		20	133	133	886	2
3	Flooring In Common Areas	2017	55,646		20	2,782	2,782	22,259	3
4	Roam Alert System	2017	12,000		20	600	600	4,400	4
5	Wall Sconces For 1St Floor	2017	5,438		20	272	272	1,088	5
6	New Vinyl, Drywall, And Tiles In Resident Rooms	2017	33,781		20	1,689	1,689	6,756	6
7	3 Pole 100 Amp Circuit Breaker For Elevator	2017	2,942		20	147	147	588	7
8	New Kitchen Flooring	2017	7,600		20	380	380	1,520	8
9	Electrical Work 1St Floor Rooms	2017	3,500		20	175	175	700	9
10	Repaired Boiler	2017	12,668		20	633	633	2,534	10
11	Bathroom - Tiling And Walls/Drywall	2017	3,355		20	168	168	671	11
12	6" Wilkins Double Detector For Sprinkler	2017	7,298		20	365	365	1,460	12
13	2Nd/3Rd Flr Bathrooms-New Door Knobs, Installation Of New M	2018	3,841		20	192	192	730	13
14	Pipe Insulation, Lever Handle Passage Locks	2018	3,394		20	170	170	645	14
15	Fence/Sign Installation,Fixed Light Pole,Fire Rated Damper	2018	4,026		20	201	201	657	15
16	Lower Level Door Controls	2018	5,739		20	287	287	1,460	16
17	Boiler Installation	2018	2,699		20	135	135	472	17
18	3Rd Flr - Intall New Sheet Metal Panels On P-Tac	2018	2,916		20	146	146	555	18
19	Conference Rm-Flooring,Baseboards,Painting,Mirrors	2018	26,102		20	1,305	1,305	3,915	19
20	Roof Repair - Wooden Soffit,Facia Boards,Paint,Light Fixture Bu	2018	2,638		20	132	132	396	20
21	Install New Piping, Repair 2" Elbow Leaking - Domestic Water B	2018	6,294		20	315	315	944	21
22	2 Garage Heaters - Replace Motor And Blade (\$2,612)	2018	2,417		20	121	121	363	22
23	Domestic Hot Water Heater Replacements	2018	15,624		20	781	781	2,344	23
24	Oversight Of Installation Of Door Graphics/Cabinets - 1St Flr/Bas	2018	7,709		20	385	385	1,156	24
25	Mirror Installation	2018	2,928		20	146	146	439	25
26	Painting - 5 Rooms And Lobby (\$2850)	2019	2,762		20	138	138	281	26
27	Painting 2Nd/3Rd Floor Hallways (\$16000)	2019	15,506		20	775	775	2,242	27
28	Tek Ton Wall Cords` (\$2825)	2019	2,738		20	137	137	372	28
29	Painting Of 2Nd/3Rd Floor Resident Rooms - 42 Rooms (\$35700)	2019	34,597		20	1,730	1,730	2,438	29
30	Painting Of Shower Room/Bathrooms - 2Nd/3Rd Floors (\$4250)	2019	4,119		20	206	206	525	30
31	Installation Of Outlets In Resident Rooms (\$6230)	2019	6,037		20	302	302	665	31
32	Remodel Freezer (\$5000)	2019	4,846		20	242	242	451	32
33	Installed Aluminum Sliding Doors (\$19751)	2019	19,141		20	957	957	1,914	33
34	TOTAL (lines 1 thru 33)		\$ 6,538,532	\$ 88,909		\$ 202,183	\$ 113,273	\$ 1,820,132	34

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

Facility Name & ID Number The Grove of Lagrange Park

0053884

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		\$ 6,538,532	\$ 88,909		\$ 202,183	\$ 113,273	\$ 1,820,132	1
2	Install 2 New Duct Furnaces In Kitchen Air Handler (\$24,250)	2020	23,501		20	1,175	1,175	1,175	2
3	Pipe Repair-Basement,Replace Door Hinge,Exhaust Fans (\$2,984)	2020	2,892		20	145	145	145	3
4	1St Floor Nurse Call System Installation (\$4,950)	2020	4,797		20	240	240	240	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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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)		\$ 6,569,721	\$ 88,909		\$ 203,742	\$ 114,833	\$ 1,821,692	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		\$ 6,569,721	\$ 88,909		\$ 203,742	\$ 114,833	\$ 1,821,692	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,569,721	\$ 88,909		\$ 203,742	\$ 114,833	\$ 1,821,692	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 12D, Carried Forward		\$ 6,569,721	\$ 88,909		\$ 203,742	\$ 114,833	\$ 1,821,692	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,569,721	\$ 88,909		\$ 203,742	\$ 114,833	\$ 1,821,692	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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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
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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	Related Party								1
2	Buildings:								2
3	Allocated from CF St. Louis, LLC	2016	20,058	931	35	573	(358)	2,865	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	124,535	3,072	20	6,227	3,154	31,134	9
10	Allocated from CF St. Louis, LLC	2017	2,890	71	20	145	73	578	10
11	Allocated from CF St. Louis, LLC	2019	26,199	646	20	1,310	664	2,620	11
12	Allocated from CF St. Louis, LLC	2019	1,378	34	20	69	35	69	12
13									13
14	Allocated from Legacy HC	2018	149		20	7	7	22	14
15	Allocated from Legacy HC	2020	112		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)		\$ 175,321	\$ 4,755		\$ 8,336	\$ 3,581	\$ 37,294	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 175,321	\$ 4,755		\$ 8,336	\$ 3,581	\$ 37,294	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 175,321	\$ 4,755		\$ 8,336	\$ 3,581	\$ 37,294	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	\$ 832,752	\$ 401	\$ 83,275	\$ 82,874	10	\$ 671,272	71
72	Current Year Purchases	27	1	3	1	10	3	72
73	Fully Depreciated Assets	84,227				10	84,227	73
74								74
75	TOTALS	\$ 917,006	\$ 403	\$ 83,278	\$ 82,875		\$ 755,501	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)			\$	8,240,452
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	89,312
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	287,020
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	197,708
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	2,577,193

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 Healthcare				75			5
6								6
7	TOTAL				\$75			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: \$8,968
- 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	Facility	2019 Ford Starcraft	\$1,450	\$10,321	17
18	Allocated from Legacy Healthcare			3,149	18
19					19
20					20
21	TOTAL		\$1,450	\$13,470	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 EndingAnnual 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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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

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

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

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

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

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 302,500	\$		\$ 302,500	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			133,819			133,819	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			307,931			307,931	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				255,339		255,339	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					59,075	110,609		169,684	13
14	TOTAL			\$		\$ 803,325	\$ 365,948		\$ 1,169,273	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	\$	414,672	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,639,771	1,639,771	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	304,046	319,688	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	262,825	278,423	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,206,642	\$ 2,652,554	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,535	755,535	13
14	Buildings, at Historical Cost		3,282,000	14
15	Leasehold Improvements, at Historical Cost	701,460	701,460	15
16	Equipment, at Historical Cost	400,751	400,751	16
17	Accumulated Depreciation (book methods)	(431,853)	(1,206,770)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	1,995,106	4,570,255	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,670,999	\$ 8,503,231	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,877,641	\$ 11,155,785	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 231,500	\$ 238,541	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,737,020	1,981,042	29
30	Accrued Salaries Payable	348,130	348,130	30
31	Accrued Taxes Payable (excluding real estate taxes)	226,401	226,401	31
32	Accrued Real Estate Taxes(Sch.IX-B)		312,418	32
33	Accrued Interest Payable		(443,938)	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	857,331	857,331	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,400,382	\$ 3,519,925	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,548,632	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	1,544,112	781,830	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,544,112	\$ 12,330,462	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,944,494	\$ 15,850,387	46
47	TOTAL EQUITY(page 18, line 24)	\$ (66,853)	\$ (4,694,602)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,877,641	\$ 11,155,785	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 188,560	1
2	Restatements (describe):		2
3	Bad Debt	137,691	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 326,251	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	171,013	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	(564,117)	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)	\$ (393,104)	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)	\$ (66,853)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **The Grove of Lagrange Park**# **0053884**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	\$ 12,487,128	1
2	Discounts and Allowances for all Levels	(4,590,754)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,896,374	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,143,079	6
7	Oxygen	61	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,143,140	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	231,211	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	54,723	19
20	Radiology and X-Ray		20
21	Other Medical Services	31,867	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 317,801	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13,659	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13,659	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	915,105	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 915,105	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,286,079	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,463,911	31
32	Health Care	4,180,119	32
33	General Administration	2,168,385	33
	B. Capital Expense		
34	Ownership	1,321,466	34
	C. Ancillary Expense		
35	Special Cost Centers	1,687,036	35
36	Provider Participation Fee	294,149	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,115,066	40
41	Income before Income Taxes (line 30 minus line 40)**	171,013	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 171,013	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 5,359,232	44
45	Private Pay - Net Inpatient Revenue	524,023	45
46	Medicare - Net Inpatient Revenue	1,012,853	46
47	Other-(specify) Insurance	236,070	47
48	Other-(specify) Veterans	764,196	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,896,374	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	2,191	2,461	\$ 150,187	\$ 61.03	1
2	Assistant Director of Nursing	2,000	2,160	101,087	46.81	2
3	Registered Nurses	25,091	33,388	1,231,701	36.89	3
4	Licensed Practical Nurses	13,589	16,148	521,569	32.30	4
5	CNAs & Orderlies	49,829	65,772	1,228,716	18.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,462	5,461	155,901	28.55	8
9	Activity Director	1,984	2,510	48,996	19.52	9
10	Activity Assistants	6,471	7,205	105,824	14.69	10
11	Social Service Workers	5,784	5,956	153,194	25.72	11
12	Dietician	32	32	1,233	38.53	12
13	Food Service Supervisor	1,256	1,405	34,254	24.38	13
14	Head Cook	5,896	6,708	114,199	17.02	14
15	Cook Helpers/Assistants	12,878	15,469	237,876	15.38	15
16	Dishwashers					16
17	Maintenance Workers	1,848	2,056	54,936	26.72	17
18	Housekeepers	13,356	15,448	251,631	16.29	18
19	Laundry	3,193	3,758	67,220	17.89	19
20	Administrator	2,032	2,190	164,905	75.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,339	8,889	156,849	17.65	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	1,616	1,832	52,576	28.70	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	2,577	2,762	48,528	17.57	33
34	TOTAL (lines 1 - 33)	164,422	201,609	\$ 4,881,382 *	\$ 24.21	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	49,063	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	43,810	10-03	38
39	Pharmacist Consultant	Monthly	4,469	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	22	1,321	11-03	44
45	Social Service Consultant	84	5,107	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	105	\$ 103,770		49

C. CONTRACT NURSES

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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Marie Derzsy	Administrator	0	\$ 164,905
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 164,905
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		23,150
Onyx Procurement Solutions	Procurement Services		9,370
Achieve Accreditation	Accreditation		9,878
Allscripts	Healthcare IT		415
Compligent	Compliance		3,761
Cortex Health	Data Processing		9,855
Hygieneering, Inc.	Hygiene & Safety Consulting		1,257
IIT/Sourcetech	IT Consulting		1,200
MTS Consulting	Tax Consulting		1,409
See Attached	Legal		92,427
See Supplemental Schedule			31,626
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 208,349
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	97,375
Unemployment Compensation Insurance			18,929
FICA Taxes			373,426
Employee Health Insurance			230,021
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Union Pension			34,559
Employee Benefits			18,622
401K Expense			10,898
Voluntary Benefit Contribution			6,435
Employee Physical Exams			6,392
TOTAL (agree to Schedule V, line 22, col.8)			\$ 796,657
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		\$	1,809
Advertising: Employee Recruitment			468
Health Care Worker Background Check (Indicate # of checks performed)	27		277
Patient Background Checks	307		3,078
Dues & Subscriptions			28,177
Licenses & Fees			423
See Supplemental Schedule			2,680
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 36,912
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			193
See Supplemental Schedule			107
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	300

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- | | |
|--|---|
| <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>Yes</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 \$20,410 ; IHCA \$10,585</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>33,292</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>294,149</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> |
|--|---|