

		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: 0053835

Facility Name: The Grove of Skokie

Address: 9000 Lavergne Avenue Skokie 60077
Number City Zip Code

County: Cook

Telephone Number: (847) 679-2322 Fax # (847) 679-9325

HFS ID Number:

Date of Initial License for Current Owners: 9/1/2008

Type of Ownership:

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

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

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the
State of Illinois, for the period from 01/01/20 to 12/31/20
and certify to the best of my knowledge and belief that the said contents
are true, accurate and complete statements in accordance with
applicable instructions. Declaration of preparer (other than provider)
is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

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

Paid
Preparer

(Signed) 05/04/2021 (Date)
* Subject to the attached Accountants' Consulting Report
(Print Name and Title) Steven N. Lavenda, CPA Partner
(Firm Name & Address) Marcum, LLP 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

#	0053835	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.)

N/A

None

Yes

YES ☐ NO ☒

YES ☐ NO ☒

Date started 9/1/2008

YES ☒ Date 9/1/2008 NO ☐

YES NO If YES, enter number
of beds certified 98 and days of care provided

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.) **91.14%**

	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	28,782	915	2,800	32,497	8
9	SNF/PED					9
10	ICF	16,027	383	797	17,207	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,809	1,298	3,597	49,704	14

Facility Name & ID Number The Grove of Skokie # 0053835 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	636,216	70,482		706,698		706,698	2,812	709,510			1
2	Food Purchase		418,235		418,235		418,235	2,327	420,562			2
3	Housekeeping	323,211	69,497	3,657	396,365		396,365	1,824	398,189			3
4	Laundry	84,439	20,381		104,820		104,820	124	104,944			4
5	Heat and Other Utilities			109,033	109,033		109,033	(7,843)	101,190			5
6	Maintenance	139,697	19,418	165,170	324,285		324,285	8,165	332,450			6
7	Other (specify):*											7
8	TOTAL General Services	1,183,563	598,013	277,860	2,059,436		2,059,436	7,409	2,066,845			8
	B. Health Care and Programs											
9	Medical Director			56,453	56,453		56,453		56,453			9
10	Nursing and Medical Records	3,440,743	261,002	55,442	3,757,187		3,757,187	82,662	3,839,849			10
10a	Therapy	251,923			251,923		251,923		251,923			10a
11	Activities	192,750	5,558	21	198,329		198,329	7	198,336			11
12	Social Services	329,737		228	329,965		329,965	4,885	334,850			12
13	CNA Training											13
14	Program Transportation			16,301	16,301		16,301		16,301			14
15	Other (specify):*							5,067	5,067			15
16	TOTAL Health Care and Programs	4,215,153	266,560	128,445	4,610,158		4,610,158	92,622	4,702,780			16
	C. General Administration											
17	Administrative	90,241			90,241		90,241	54,383	144,624			17
18	Directors Fees											18
19	Professional Services			268,342	268,342	(50,726)	217,616	(860)	216,756			19
20	Dues, Fees, Subscriptions & Promotions			69,485	69,485		69,485	(34,069)	35,416			20
21	Clerical & General Office Expenses	176,635	2,603	373,613	552,851		552,851	(7,031)	545,820			21
22	Employee Benefits & Payroll Taxes			906,125	906,125		906,125		906,125			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,276	1,276		1,276	121	1,397			24
25	Other Admin. Staff Transportation			843	843		843	4,065	4,908			25
26	Insurance-Prop.Liab.Malpractice			265,006	265,006		265,006	15,741	280,747			26
27	Other (specify):*							21,797	21,797			27
28	TOTAL General Administration	266,876	2,603	1,884,690	2,154,169	(50,726)	2,103,443	54,148	2,157,591			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,665,592	867,176	2,290,995	8,823,763	(50,726)	8,773,037	154,178	8,927,215			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							1,024,506	1,024,506			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,805	21,805		21,805	534,099	555,904			32
33	Real Estate Taxes			77,779	77,779	50,726	128,505	430,369	558,874			33
34	Rent-Facility & Grounds			1,503,221	1,503,221		1,503,221	(1,503,136)	85			34
35	Rent-Equipment & Vehicles			6,760	6,760		6,760	3,949	10,709			35
36	Other (specify):*							77,146	77,146			36
37	TOTAL Ownership			1,609,565	1,609,565	50,726	1,660,291	566,933	2,227,224			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		252,994	763,112	1,016,106		1,016,106	(5,273)	1,010,833			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			367,323	367,323		367,323		367,323			42
43	Other (specify):*			552,372	552,372		552,372	(552,372)				43
44	TOTAL Special Cost Centers		252,994	1,682,807	1,935,801		1,935,801	(557,645)	1,378,156			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,665,592	1,120,170	5,583,367	12,369,129		12,369,129	163,466	12,532,595			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	(8,794)	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	515,018	30		9
10	Interest and Other Investment Income	(14,162)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,914)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(109)	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	(556)	21		18
19	Entertainment	(7,547)	21		19
20	Contributions	(12,206)	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	(215,093)	21		24
25	Fund Raising, Advertising and Promotional	(6,884)	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	(1,864,666)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,617,913)		\$	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)	1,781,379		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,781,379		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 163,466		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Rebates	\$ (1,236)	10	1
2	Patient Personal Items	(2,305)	10	2
3	Bank Charges	(6,991)	21	3
4	Sequestration	(12,103)	21	4
5	Pharmacy Discounts	(4,480)	10	5
6	Bldg Co - Filing Fees	(75)	20	6
7	Bldg Co - Accounting	(19,282)	19	7
8	Bldg Co - Legal Fees	(25,925)	19	8
9	Bldg Co - Amortization	(3,816)	36	9
10	Bldg Co - Prepayment Penalty	(1,202,264)	21	10
11	Capitalized R&M	(3,055)	06	11
12	Swag Store	(51)	21	12
13	Marketing Licenses	(933)	20	13
14	Chamber of Commerce Dues	(715)	20	14
15	Out of Period Dues	(519)	20	15
16	PAC Dues	(14,366)	20	16
17	Non Allowable Legal	(12,349)	19	17
18	Prior Period Licenses	(1,495)	20	18
19	Non Allowable Expense	(552,372)	43	19
20	Misc Income - Bad Debt	(334)	21	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	(1,864,666)		49

Summary A

12/31/20

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Grove of Skokie # 0053835 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	515,018	503,621			5,867							1,024,506	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(14,162)	544,964			3,297							534,099	32
33	Real Estate Taxes		427,374			2,995							430,369	33
34	Rent-Facility & Grounds		(1,503,221)	27,607		(27,522)							(1,503,136)	34
35	Rent-Equipment & Vehicles				3,949								3,949	35
36	Other (specify):*	(3,816)	80,962										77,146	36
37	TOTAL Ownership	497,040	53,700	27,607	3,949	(15,363)							566,933	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers									(5,273)			(5,273)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(552,372)											(552,372)	43
44	TOTAL Special Cost Centers	(552,372)								(5,273)			(557,645)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,617,913)	1,318,635	482,070	9,016	(12,630)	(6,764)	(838)	(2,837)	(5,273)			163,466	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	\$ 1,503,221	Skokie Property Holdings		\$	(1,503,221)	1
2	V	32	Interest	566	Skokie Property Holdings		545,530	544,964	2
3	V	33	Real Estate Taxes		Skokie Property Holdings		427,374	427,374	3
4	V	26	Property Insurance		Skokie Property Holdings		15,395	15,395	4
5	V	36	MIP Expense		Skokie Property Holdings		77,146	77,146	5
6	V	06	Landscaping		Skokie Property Holdings		1,994	1,994	6
7	V	20	Filing Fees		Skokie Property Holdings		75	75	7
8	V	19	Accounting		Skokie Property Holdings		19,282	19,282	8
9	V	19	Legal Fees		Skokie Property Holdings		25,925	25,925	9
10	V	30	Depreciation		Skokie Property Holdings		503,621	503,621	10
11	V	36	Amortization		Skokie Property Holdings		3,816	3,816	11
12	V	21	Prepayment Penalty		Skokie Property Holdings		1,202,264	1,202,264	12
13	V								13
14	Total			\$ 1,503,787			\$ 2,822,422	\$ * 1,318,635	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	Skokie Property Holdings		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			Lagrange Skilled Nursing Facility LLC	Lagrange Park				7
8			Lakefront Skilled Nursing Facility LLC	Chicago				8
9			Lincoln Park Skilled Nursing Facility LLC	Chicago				9
10			Lincolnshire Living & Rehab Center LLC	Lincolnshire				10
11			Northbrook Skilled Nursing Facility LLC	Northbrook				11
12			Peterson Park Associates Limited Partnership	Chicago				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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietician Salary	\$	Legacy Healthcare Financial Services		\$ 2,797	\$ 2,797	15
16	V	01	Dietary Supplies		Legacy Healthcare Financial Services		15	15	16
17	V	02	Food		Legacy Healthcare Financial Services		5,350	5,350	17
18	V	03	Housekeeping		Legacy Healthcare Financial Services		1,824	1,824	18
19	V	04	Linen Replacement		Legacy Healthcare Financial Services		124	124	19
20	V	06	Maintenance Salary		Legacy Healthcare Financial Services		8,630	8,630	20
21	V	06	Repairs & Maintenance		Legacy Healthcare Financial Services		512	512	21
22	V	10	Nursing Salary		Legacy Healthcare Financial Services		71,432	71,432	22
23	V	10	Nurse/Medical Director Consultant		Legacy Healthcare Financial Services		6,742	6,742	23
24	V	10	Medical Supplies		Legacy Healthcare Financial Services		15,347	15,347	24
25	V	12	Social Service Salary		Legacy Healthcare Financial Services		4,866	4,866	25
26	V	11	Activities Program		Legacy Healthcare Financial Services		7	7	26
27	V	12	Social Service Consultant		Legacy Healthcare Financial Services		19	19	27
28	V	17	COO / Administrative Salary		Legacy Healthcare Financial Services		54,383	54,383	28
29	V	19	Professional Fees		Legacy Healthcare Financial Services		17,853	17,853	29
30	V	20	Dues / Licenses / Permits		Legacy Healthcare Financial Services		3,048	3,048	30
31	V	21	Clerical & General Wages		Legacy Healthcare Financial Services		219,422	219,422	31
32	V	21	Clerical & Office Expense		Legacy Healthcare Financial Services		16,001	16,001	32
33	V	24	Education & Seminars		Legacy Healthcare Financial Services		121	121	33
34	V	25	Travel		Legacy Healthcare Financial Services		4,065	4,065	34
35	V	26	Insurance - General		Legacy Healthcare Financial Services		107	107	35
36	V	27	Non-Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		21,797	21,797	36
37	V	34	Rent		Legacy Healthcare Financial Services		27,522	27,522	37
38	V	34	Offsite Storage / Parking		Legacy Healthcare Financial Services		85	85	38
39	Total			\$			\$ 482,070	\$ * 482,070	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		367	\$	367
16	V	35	Auto Rental		Legacy Healthcare Financial Services		3,582		3,582
17	V	15	Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		5,067		5,067
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			\$			9,016	\$ *	9,016

* 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		\$ 951	\$ 951	15
16	V	6	Repairs & Maintenance		CF St. Louis LLC		922	922	16
17	V	19	Property Valuation Fee		CF St. Louis LLC		326	326	17
18	V	19	Accounting Fees		CF St. Louis LLC		74	74	18
19	V	20	Dues & Subscriptions		CF St. Louis LLC		0	0	19
20	V	21	Office Expense		CF St. Louis LLC		221	221	20
21	V	26	Insurance		CF St. Louis LLC		239	239	21
22	V	30	Depreciation		CF St. Louis LLC		5,867	5,867	22
23	V	32	Interest Expense		CF St. Louis LLC		3,297	3,297	23
24	V	33	Real Estate Taxes		CF St. Louis LLC		2,995	2,995	24
25	V								25
26	V	34	Rent	27,522	CF St. Louis LLC			(27,522)	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			\$ 27,522			\$ 14,892	\$ * (12,630)	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	\$ 29,524	ProPay HR		\$ 22,760	\$ (6,764)	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			\$ 29,524			\$ 22,760	\$ * (6,764)	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	\$ 9,408	ReMED Services		\$ 6,571	\$ (2,837)	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			\$ 9,408			\$ 6,571	\$ * (2,837)	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	\$ 12,957	Lifescan Labs of Illinois		\$ 7,684	\$ (5,273)	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			\$ 12,957			\$ 7,684	\$ * (5,273)	39

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

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

Ending: 12/31/20**Fax Number**

Facility Name & ID Number The Grove of Skokie# 0053835

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	54,534	\$ 2,797	1
2	01	Dietary Supplies	Available Bed Days	53	697		54,534	15	2
3	02	Food	Available Bed Days	53	249,220		54,534	5,350	3
4	03	Housekeeping	Available Bed Days	53	84,952		54,534	1,824	4
5	04	Linen Replacement	Available Bed Days	53	5,771		54,534	124	5
6	06	Maintenance Salary	Available Bed Days	53	401,986	401,986	54,534	8,630	6
7	06	Repairs & Maintenance	Available Bed Days	53	23,857		54,534	512	7
8	10	Nursing Salary	Available Bed Days	53	3,327,223	3,327,223	54,534	71,432	8
9	10	Nurse/Medical Director Consultant	Available Bed Days	53	314,035		54,534	6,742	9
10	10	Medical Supplies	Available Bed Days	53	714,824		54,534	15,347	10
11	12	Social Service Salary	Available Bed Days	53	226,662	226,662	54,534	4,866	11
12	11	Activities Program	Available Bed Days	53	335		54,534	7	12
13	12	Social Service Consultant	Available Bed Days	53	893		54,534	19	13
14	17	COO / Administrative Salary	Available Bed Days	53	2,533,078	2,533,078	54,534	54,383	14
15	19	Professional Fees	Available Bed Days	53	831,592		54,534	17,853	15
16	20	Dues / Licenses / Permits	Available Bed Days	53	141,983		54,534	3,048	16
17	21	Clerical & General Wages	Available Bed Days	53	10,220,453	10,220,453	54,534	219,422	17
18	21	Clerical & Office Expense	Available Bed Days	53	745,293		54,534	16,001	18
19	24	Education & Seminars	Available Bed Days	53	5,655		54,534	121	19
20	25	Travel	Available Bed Days	53	189,364		54,534	4,065	20
21	26	Insurance - General	Available Bed Days	53	4,997		54,534	107	21
22	27	Non-Nursing Payroll Taxes / Bene	Available Bed Days	53	1,015,274		54,534	21,797	22
23	34	Rent	Available Bed Days	53	1,281,940		54,534	27,522	23
24	34	Offsite Storage / Parking	Available Bed Days	53	3,949		54,534	85	24
25	TOTALS				\$ 22,454,338	\$ 16,839,706		\$ 482,070	25

Ending: 12/31/20

(847) 683-2900

IL478-2471

Ending: 12/31/20

(847) 676-5348

IL478-2471

Ending: 12/31/20

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Ending: 12/31/20

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Facility Name & ID Number The Grove of Skokie# 0053835

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

ReMED Services LLC

Street Address

3424 Oakton Street, Suite 102

City / State / Zip Code

Skokie, IL

Phone Number

(847) 440-2600

Fax Number

()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Medical Supplies	Direct			\$	\$		\$ 6,571	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					\$	\$		\$ 6,571	25

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 Bank		X	Mortgage Payable			\$	13,210,453			\$	545,530	1
2													2
3													3
4													4
5													5
	Working Capital												
6	CIBC Bank		X	Interest Only								21,805	6
7													7
8													8
9	TOTAL Facility Related						\$	13,210,453			\$	567,335	9
	B. Non-Facility Related*												
10	Interest Income		X									(14,162)	10
11	Interest Income - Bldg Co		X									(566)	11
12	Allocated from CF St. Louis	X										3,297	12
13													13
14	TOTAL Non-Facility Related						\$				\$	(11,431)	14
15	TOTALS (line 9+line14)						\$	13,210,453			\$	555,904	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 77,146 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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	466,817	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.)				\$	477,127	2
3. Under or (over) accrual (line 2 minus line 1).				\$	10,310	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	497,838	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.)				\$	50,726	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.				\$	558,874	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2015	405,789	8		
		2016	452,113	9		
		2017	509,057	10		
		2018	444,587	11		
		2019	474,132	12		
2020 Accrual = \$474,132 x 1.05 = \$497,838						
Allocated form CF St. Louis \$2,995						

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 Skokie COUNTY Cook
FACILITY IDPH LICENSE NUMBER 0053835
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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Grove of Skokie COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053835

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

A. Square Feet:

17,350

B. General Construction Type:

Exterior

Brick

Frame

Number of Stories

2

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			\$ 830,000	1
2	Allocated from CF St. Louis, LLC			4,237	2
3	TOTALS			\$ 834,237	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	149		2015	1976	\$ 16,829,101	\$ 503,621	35	\$ 480,831	\$ (22,790)	\$ 2,884,988	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2009		826,392		20	41,320	41,320	495,835	9
10	Various		2010		18,355		20	918	918	10,095	10
11	Various		2011		38,602		20	1,930	1,930	19,301	11
12	Various		2012		24,021		20	1,201	1,201	10,809	12
13	Various		2013		504,886		20	25,244	25,244	201,954	13
14	Various		2014		168,871		20	8,444	8,444	59,105	14
15	Various		2015		60,971		20	3,049	3,049	17,235	15
16	Various		2016		82,908		20	4,145	4,145	16,582	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 Skokie

0053835

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
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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)		76,478			3,824	3,824	52,891	67
68	Related Party Allocations (Pages 12H & 12I)		199,411	5,409		9,482	4,073	42,418	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		\$ 18,829,996	\$ 509,030		\$ 580,387	\$ 71,358	\$ 3,811,215	70

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

Facility Name & ID Number The Grove of Skokie

0053835

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		\$ 18,829,996	\$ 509,030		\$ 580,387	\$ 71,358	\$ 3,811,215	1
2	Carpet Installation In Office	2017	5,115		20	256	256	1,023	2
3	Install New Piping For Commercial Boiler	2017	15,964		20	798	798	2,262	3
4	Walk-In Cooler (Kitchen) Repair	2017	2,750		20	138	138	367	4
5	Elevator Repair	2017	3,794		20	190	190	569	5
6	Repair Leaking Heating Line In Mechanical Room	2017	7,846		20	392	392	1,308	6
7	Air Handler Repairs	2017	3,018		20	151	151	1,308	7
8	Replacement Of Both Bearings On Air Handler Unit	2017	4,347		20	217	217	1,884	8
9	Replaced Condensing Unit For Walk In Freezer, Rewire Controls	2017	4,050		20	203	203	1,485	9
10	Repaired 2Nd Floor Nursing Station	2017	2,500		20	125	125	500	10
11	Installed New Exhaust Fan	2017	3,500		20	175	175	700	11
12	Repaired Storage Tank And Circulation Pump	2017	8,145		20	407	407	1,629	12
13	Installed Mount Speaker And Amps	2017	4,376		20	219	219	875	13
14	Repair Leak On Chiller Pipe	2017	5,365		20	268	268	1,073	14
15	Insulation Boards (8,282)	2018	7,666		20	383	383	1,595	15
16	Insulation Kits (3,795)	2018	3,513		20	176	176	667	16
17	Faucet Exchange (3,950)	2018	3,656		20	183	183	695	17
18	Unit Heaters (11,000)	2018	10,182		20	509	509	3,218	18
19	Copper Tubing (6,220)	2018	5,757		20	288	288	1,198	19
20	Replaced Leaking Hot Water Heating Piping (21,757)	2018	20,138		20	1,007	1,007	3,021	20
21	Insulation Of Replacement Piping Above Driveway Ceiling (4,818)	2018	4,460		20	223	223	669	21
22	Repair Leaking Heating Piping And Rear Boiler (10,112)	2018	9,360		20	468	468	1,404	22
23	Repair Leaking Piping And Installed Compensators On Chilled / I	2018	14,156		20	708	708	2,123	23
24	Pipes And Tiles Repairs, And Rebuilt Outdoor Support Structure	2018	3,888		20	194	194	583	24
25	Patch & Paint Rehab And Elevator Rooms, Kitchen Area, And Pa	2018	5,183		20	259	259	778	25
26	Building Heating And Chilled Water Furnishings And Installation	2018	215,109		20	10,755	10,755	32,266	26
27	Water Supply Installation (4,485)	2018	4,151		20	208	208	623	27
28	Parking Lot Ceiling Pipe Leaks Repair (3,328)	2018	3,080		20	154	154	462	28
29	New Temperature Controller (2,900)	2018	2,684		20	134	134	413	29
30	Repair Broken Heating Pipe In Kitchen Ceiling (\$4652.32)	2018	4,509		20	225	225	768	30
31	Piping - Repair 2 Riser Leaks, Set Up Welder (\$5415)	2019	5,248		20	262	262	804	31
32	Install 2 Shunt Trip Disconnects For Elevators (\$2770)	2019	2,684		20	134	134	273	32
33	Install 7500Kw Heater In Medical Records Room (\$3300)	2019	3,198		20	160	160	462	33
34	TOTAL (lines 1 thru 33)		\$ 19,229,388	\$ 509,030		\$ 600,357	\$ 91,327	\$ 3,878,218	34

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

Facility Name & ID Number The Grove of Skokie

0053835

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 19,229,388	\$ 509,030		\$ 600,357	\$ 91,327	\$ 3,878,218	1
2	Ac Installation, Repair Exhaust Fans & Door Framing & Hinges (	2019	2,859		20	143	143	266	2
3	Installation Of 2 Delay Egress For Single Doors W/Fire Relay (\$5	2019	4,974		20	249	249	505	3
4	Dual - Temperature Piping Insulation Installation (\$22225)	2019	21,538		20	1,077	1,077	2,559	4
5	Camera Installation (\$3216)	2019	3,117		20	156	156	585	5
6	Repair Infrared Deficiencies (\$3,302.70)	2019	3,201		20	160	160	325	6
7	Repair Elevator Car (\$5,754.66)	2019	5,577		20	279	279	558	7
8	Replace 3 Pump Valves (\$3,704)	2019	3,590		20	179	179	359	8
9	Mill & Pave West Lot (17,960)	2020	17,520		20	876	876	876	9
10	Install Door Controls (9,000)	2020	8,780		20	439	439	439	10
11	Install Fence & Gate (10,500)	2020	10,243		20	512	512	512	11
12	Install Booster Pump (3,120)	2020	3,044		20	152	152	152	12
13	Replace Pump Bearing & Gaskets (3,300)	2020	3,219		20	161	161	161	13
14	Repair Call Server Circuit (3,055)	2020	2,980		20	149	149	149	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)		\$ 19,320,028	\$ 509,030		\$ 604,889	\$ 95,859	\$ 3,885,664	34

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

Facility Name & ID Number The Grove of Skokie

0053835

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		\$ 19,320,028	\$ 509,030		\$ 604,889	\$ 95,859	\$ 3,885,664	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
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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)		\$ 19,320,028	\$ 509,030		\$ 604,889	\$ 95,859	\$ 3,885,664	34

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

Facility Name & ID Number The Grove of Skokie

0053835

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		\$ 19,320,028	\$ 509,030		\$ 604,889	\$ 95,859	\$ 3,885,664	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 19,320,028	\$ 509,030		\$ 604,889	\$ 95,859	\$ 3,885,664	34

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

Facility Name & ID Number The Grove of Skokie

0053835

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	Allocated from Grove HC Properties	2008	60,573		20	3,029	3,029	41,165	9
10	Allocated from Grove HC Properties	2010	15,905		20	795	795	11,726	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)		\$ 76,478	\$		\$ 3,824	\$ 3,824	\$ 52,891	34

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

Facility Name & ID Number The Grove of Skokie

0053835

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 12F, Carried Forward		\$ 76,478	\$		\$ 3,824	\$ 3,824	\$ 52,891	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)		\$ 76,478	\$		\$ 3,824	\$ 3,824	\$ 52,891	34

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

Facility Name & ID Number The Grove of Skokie

0053835

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party								1
2	Buildings:								2
3	Allocated from CF St. Louis, LLC	2016	22,814	1,059	35	652	(407)	3,259	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	141,646	3,494	20	7,082	3,588	35,412	9
10	Allocated from CF St. Louis, LLC	2017	3,288	81	20	164	83	658	10
11	Allocated from CF St. Louis, LLC	2019	29,798	735	20	1,490	755	2,980	11
12	Allocated from CF St. Louis, LLC	2019	1,567	39	20	78	40	78	12
13									13
14	Allocated from Legacy HC	2018	169		20	8	8	25	14
15	Allocated from Legacy HC	2020	128		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)		\$ 199,411	\$ 5,409		\$ 9,482	\$ 4,073	\$ 42,418	34

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

Facility Name & ID Number The Grove of Skokie

0053835

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		\$ 199,411	\$ 5,409		\$ 9,482	\$ 4,073	\$ 42,418	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 199,411	\$ 5,409		\$ 9,482	\$ 4,073	\$ 42,418	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	\$4,184,525	\$457	\$418,453	\$417,996	10	\$2,551,723	71
72	Current Year Purchases	11,639	2	1,164	1,162	10	1,164	72
73	Fully Depreciated Assets	52,301				10	52,301	73
74								74
75	TOTALS	\$4,248,465	\$458	\$419,616	\$419,158		\$2,605,188	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$24,402,731	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$509,488	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$1,024,505	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$515,018	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$6,490,851	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	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				85			5
6								6
7	TOTAL				\$ 85			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: \$ 7,127
- Description:
- See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Legacy Healthcare		\$	\$ 3,582	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 3,582	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	\$		\$ 275,294	\$		\$ 275,294	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			97,524			97,524	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			322,000			322,000	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				149,165		149,165	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					68,294	103,829		172,123	13
14	TOTAL			\$		\$ 763,112	\$ 252,994		\$ 1,016,106	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	\$ 114,818	\$ 996,451	1
2	Cash-Patient Deposits	13,067	13,067	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,392,746	1,392,746	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	243,116	282,009	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	88,705	170,406	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,852,452	\$ 2,854,679	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	23,375	962,025	13
14	Buildings, at Historical Cost	2,138	8,301,875	14
15	Leasehold Improvements, at Historical Cost	504,925	1,968,228	15
16	Equipment, at Historical Cost	218,980	1,623,438	16
17	Accumulated Depreciation (book methods)	(181,904)	(3,077,895)	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	3,097,117	4,381,688	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,664,631	\$ 14,159,359	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,517,083	\$ 17,014,038	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 513,197	\$ 516,423	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		261,728	29
30	Accrued Salaries Payable	402,860	402,860	30
31	Accrued Taxes Payable (excluding real estate taxes)	258,780	258,780	31
32	Accrued Real Estate Taxes(Sch.IX-B)		497,838	32
33	Accrued Interest Payable	33,555	76,489	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,691,376	1,691,376	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,899,768	\$ 3,705,494	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,948,725	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	1,919,975	1,705,040	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,919,975	\$ 14,653,765	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,819,743	\$ 18,359,259	46
47	TOTAL EQUITY(page 18, line 24)	\$ 697,340	\$ (1,345,221)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,517,083	\$ 17,014,038	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,277,607	1
2	Restatements (describe):		2
3	Bad Debts	307,604	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,585,211	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(222,403)	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	(665,468)	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)	\$ (887,871)	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)	\$ 697,340	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The Grove of Skokie

0053835

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	\$ 16,106,937	1
2	Discounts and Allowances for all Levels	(6,794,431)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,312,506	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,580,257	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,580,257	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	142,562	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,038	19
20	Radiology and X-Ray		20
21	Other Medical Services	4,223	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 161,823	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	14,162	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 14,162	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	1,077,978	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,077,978	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,146,726	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,059,436	31
32	Health Care	4,610,158	32
33	General Administration	2,154,169	33
	B. Capital Expense		
34	Ownership	1,609,565	34
	C. Ancillary Expense		
35	Special Cost Centers	1,568,478	35
36	Provider Participation Fee	367,323	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,369,129	40
41	Income before Income Taxes (line 30 minus line 40)**	(222,403)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (222,403)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 8,269,580	44
45	Private Pay - Net Inpatient Revenue	140,447	45
46	Medicare - Net Inpatient Revenue	744,201	46
47	Other-(specify) Insurance	158,278	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,312,506	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	2,024	2,142	\$ 123,702	\$ 57.74	1
2	Assistant Director of Nursing	1,787	2,253	88,917	39.47	2
3	Registered Nurses	20,942	24,806	964,956	38.90	3
4	Licensed Practical Nurses	22,195	25,831	864,460	33.47	4
5	CNAs & Orderlies	58,677	72,890	1,315,800	18.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,786	10,657	251,923	23.64	8
9	Activity Director	1,832	2,080	62,528	30.06	9
10	Activity Assistants	7,669	8,812	130,222	14.78	10
11	Social Service Workers	8,096	8,809	239,789	27.22	11
12	Dietician					12
13	Food Service Supervisor	1,920	2,160	66,954	31.00	13
14	Head Cook	8,647	9,447	184,584	19.54	14
15	Cook Helpers/Assistants	23,575	25,534	384,678	15.07	15
16	Dishwashers					16
17	Maintenance Workers	7,467	8,221	139,697	16.99	17
18	Housekeepers	19,874	21,551	323,211	15.00	18
19	Laundry	4,841	5,449	84,439	15.50	19
20	Administrator	1,856	1,963	90,241	45.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,146	9,910	176,635	17.82	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	1,968	2,504	82,908	33.11	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	6,255	6,632	89,948	13.56	33
34	TOTAL (lines 1 - 33)	218,557	251,650	\$ 5,665,592 *	\$ 22.51	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	56,453	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	49,281	10-03	38
39	Pharmacist Consultant	Monthly	6,161	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	1	21	11-03	44
45	Social Service Consultant	3	228	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	4	\$ 112,144		49

C. CONTRACT NURSES

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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Bryan Panganiban	Administrator	0	\$ 34,770	Workers' Compensation Insurance		\$ 84,652	IDPH License Fee	\$ 2,819	
Louise Dihiansan	Administrator	0	50,276	Unemployment Compensation Insurance		24,095	Advertising: Employee Recruitment	468	
Hina Rehman	Administrator	0	5,195	FICA Taxes		433,418	Health Care Worker Background Check		
				Employee Health Insurance		246,286	(Indicate # of checks performed 171)	1,719	
				Employee Meals			Patient Background Checks 388	3,887	
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions	22,749	
				Union Pension		46,912	Licenses & Fees	725	
				Employee Benefits		23,121			
				401K Expense		20,254			
TOTAL (agree to Schedule V, line 17, col. 1)							See Supplemental Schedule	3,049	
(List each licensed administrator separately.)							Less: Public Relations Expense	()	
B. Administrative - Other							Non-allowable advertising	()	
							Yellow page advertising	()	
Description			Amount						
			\$						
TOTAL (agree to Schedule V, line 17, col. 3)									
(Attach a copy of any management service agreement)									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Marcum LLP	Accounting		\$ 24,000			\$	Out-of-State Travel	\$	
ProPay HR	Payroll Processing		29,524						
Onyx Procurement Solutions	Procurement Services		11,470						
Achieve Accreditation	Accreditation Services		9,564				In-State Travel		
Compliagent	Compliance		3,485						
IIT/Sourcetek	Data Processing		1,200						
MTS Consulting	Tax Consulting		2,906						
Personnel Planners	Unemployment Tax Consult		990				Seminar Expense	1,276	
Prospect Resources	Engery Procurement		667						
Claimex LLC	Claims Consultant		719						
See Attached	Legal		174,110				See Supplemental Schedule	121	
See Supplemental Schedule			9,707				Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)									
(For legal fee disclosure, see page 39 of instructions)									
			\$ 268,342	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,397	

*** Attach copy of IMRF notifications**

****See instructions.**

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?
If YES, give association name and amount.

HCCI \$22,149 ; IHCA \$11,980

(3)

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

Yes
Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
N/A

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
10 Years

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 41,426 Line 10

(7)

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

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
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.
This amount is to be recorded on line 42 of Schedule V.

\$ 367,323

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No
- (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?
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.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ N/A
Indicate the amount. \$

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No
\$ 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?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

No
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.
Attach invoices and a summary of services for all architect and appraisal fees.

Yes