

		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>0056614</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Thrive of Lisle</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>06/02/2020</u> to <u>12/31/2020</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>2850 Odgen Avenue</u> <u>Lisle</u> <u>60532</u>																									
Number City Zip Code																									
County: <u>DuPage</u>																									
Telephone Number: <u>(331) 249-6200</u> Fax # <u>(331) 213-2943</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Andrew B. Cutler</u> <u>Managing Director, Healthcare</u></td></tr><tr><td>(Firm Name & Address) <u>FGMK, LLC</u> <u>2801 Lakeside Dr., 3rd Floor, Bannockburn, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 940-3269</u> Fax # <u>(847) 964-5469</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) <u>Andrew B. Cutler</u> <u>Managing Director, Healthcare</u>	(Firm Name & Address) <u>FGMK, LLC</u> <u>2801 Lakeside Dr., 3rd Floor, Bannockburn, IL 60015</u>	(Telephone) <u>(847) 940-3269</u> Fax # <u>(847) 964-5469</u>												
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Date of Initial License for Current Owners: <u>06/02/2020</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☒ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>Andrew B. Cutler</u> Telephone Number: <u>(847) 940-3269</u>																									
Email Address: _____																									

Facility Name & ID Number Thrive of Lisle

0056614 Report Period Beginning: 06/02/2020 Ending: 12/31/2020

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds <u>N/A</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>68</u>	Skilled (SNF)	<u>68</u>	<u>14,484</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>68</u>	TOTALS	<u>68</u>	<u>14,484</u>	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>15</u>	<u>45</u>	<u>3,126</u>	<u>3,186</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15</u>	<u>45</u>	<u>3,126</u>	<u>3,186</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 22.00%

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 06/02/2020

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 06/02/2020 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 68 and days of care provided 2,063

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

Facility Name & ID Number Thrive of Lisle # 0056614 Report Period Beginning: 06/02/2020 Ending: 12/31/2020

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	141,969	12,342		154,311		154,311		154,311			1
2	Food Purchase		49,928		49,928		49,928		49,928			2
3	Housekeeping	67,049	26,737		93,786		93,786		93,786			3
4	Laundry		3,913		3,913		3,913		3,913			4
5	Heat and Other Utilities			43,351	43,351		43,351		43,351			5
6	Maintenance	68,694		69,677	138,371		138,371		138,371			6
7	Other (specify):*											7
8	TOTAL General Services	277,712	92,920	113,028	483,660		483,660		483,660			8
	B. Health Care and Programs											
9	Medical Director			175	175		175		175			9
10	Nursing and Medical Records	1,017,943	248,309	30,160	1,296,412		1,296,412		1,296,412			10
10a	Therapy											10a
11	Activities	36,150	963		37,113		37,113		37,113			11
12	Social Services	39,243			39,243		39,243		39,243			12
13	CNA Training											13
14	Program Transportation			60	60		60		60			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,093,336	249,272	30,395	1,373,003		1,373,003		1,373,003			16
	C. General Administration											
17	Administrative	90,782		109,303	200,085		200,085	20,501	220,586			17
18	Directors Fees											18
19	Professional Services			136,624	136,624		136,624	3,543	140,167			19
20	Dues, Fees, Subscriptions & Promotions			80,082	80,082		80,082	(3,855)	76,227			20
21	Clerical & General Office Expenses	160,190		65,586	225,776		225,776	56,567	282,343			21
22	Employee Benefits & Payroll Taxes			543,702	543,702		543,702		543,702			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,007	3,007		3,007	4,628	7,635			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			89,375	89,375		89,375	1,059	90,434			26
27	Other (specify):*							23,261	23,261			27
28	TOTAL General Administration	250,972		1,027,679	1,278,651		1,278,651	105,704	1,384,355			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,622,020	342,192	1,171,102	3,135,314		3,135,314	105,704	3,241,018			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 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	
	D. Ownership											
30	Depreciation			21,000	21,000		21,000	558,401	579,401			30
31	Amortization of Pre-Op. & Org.							1,700	1,700			31
32	Interest							413,994	413,994			32
33	Real Estate Taxes							145,732	145,732			33
34	Rent-Facility & Grounds			715,467	715,467		715,467	(711,785)	3,682			34
35	Rent-Equipment & Vehicles			9,185	9,185		9,185		9,185			35
36	Other (specify):*											36
37	TOTAL Ownership			745,652	745,652		745,652	408,042	1,153,694			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	457,684	159,609	135,495	752,788		752,788		752,788			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			28,544	28,544		28,544		28,544			42
43	Other (specify):* Marketing	71,934	11,724		83,658		83,658	(83,658)				43
44	TOTAL Special Cost Centers	529,618	171,333	164,039	864,990		864,990	(83,658)	781,332			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,151,638	513,525	2,080,793	4,745,956		4,745,956	430,088	5,176,044			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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(422,523)	30		9
10	Interest and Other Investment Income	(237)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(7,930)	21		24
25	Fund Raising, Advertising and Promotional	(4,060)	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	(83,840)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (518,590)		\$	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	2	
		Amount	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (518,590)		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	2	3	4	
		Yes	No	Amount	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 Bank and Credit Card Fees	\$ (182)	21	1
2	Non-Allowable Marketing Expense	(83,658)	43	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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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	(83,840)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Thrive of Lisle

0056614

Report Period Beginning:

06/02/2020

Ending:

12/31/2020

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	20,501	0	0	0	0	0	0	0	0	0	20,501	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,263	1,280	0	0	0	0	0	0	0	0	3,543	19
20	Fees, Subscriptions & Promotions	(4,060)	205	0	0	0	0	0	0	0	0	0	(3,855)	20
21	Clerical & General Office Expenses	(8,112)	108,410	0	(43,731)	0	0	0	0	0	0	0	56,567	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	4,628	0	0	0	0	0	0	0	0	0	4,628	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,059	0	0	0	0	0	0	0	0	0	1,059	26
27	Other (specify):*	0	23,261	0	0	0	0	0	0	0	0	0	23,261	27
28	TOTAL General Administration	(12,172)	160,327	1,280	(43,731)	0	0	0	0	0	0	0	105,704	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(12,172)	160,327	1,280	(43,731)	0	0	0	0	0	0	0	105,704	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Thrive of Lisle # 0056614 Report Period Beginning: 06/02/2020 Ending: 12/31/2020

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	(422,523)	273	980,651	0	0	0	0	0	0	0	0	558,401	30
31	Amortization of Pre-Op. & Org.	0	0	1,700	0	0	0	0	0	0	0	0	1,700	31
32	Interest	(237)	0	414,231	0	0	0	0	0	0	0	0	413,994	32
33	Real Estate Taxes	0	0	145,732	0	0	0	0	0	0	0	0	145,732	33
34	Rent-Facility & Grounds	0	3,682	(715,467)	0	0	0	0	0	0	0	0	(711,785)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(422,760)	3,955	826,847	0	0	0	0	0	0	0	0	408,042	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(83,658)	0	0	0	0	0	0	0	0	0	0	(83,658)	43
44	TOTAL Special Cost Centers	(83,658)	0	0	0	0	0	0	0	0	0	0	(83,658)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(518,590)	164,282	828,127	(43,731)	0	0	0	0	0	0	0	430,088	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
IH KCB Lisle, LLC	100%	Thrive of Lake County	Mundelein	Transitional Care Management, LLC		MGMT. Co.
		Thrive of Fox Valley	Aurora	IH KCB Lisle Owner, LLC		Bldg. Partshp.

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	17	Owner Salary Allocated	\$	Transitional Care Management, LLC		\$ 20,501	\$ 20,501	1
2	V	19	Professional Fees		Transitional Care Management, LLC		2,263	2,263	2
3	V	20	Dues & Subscriptions		Transitional Care Management, LLC		205	205	3
4	V	21	A&G		Transitional Care Management, LLC		29,546	29,546	4
5	V	21	A&G Salary - Non-Owner		Transitional Care Management, LLC		78,864	78,864	5
6	V	27	Employee Benefits		Transitional Care Management, LLC		23,261	23,261	6
7	V	24	Travel & Seminar		Transitional Care Management, LLC		4,628	4,628	7
8	V	26	Insurance		Transitional Care Management, LLC		1,059	1,059	8
9	V	30	Depreciation		Transitional Care Management, LLC		273	273	9
10	V	34	Rent		Transitional Care Management, LLC		3,682	3,682	10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 164,282	\$ * 164,282	14

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

VII. RELATED PARTIES (continued)

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

☒ X

 YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rent	\$ 715,467	IH KCB Lisle Owner, LLC		\$	(715,467)	15
16	V	33	Real Estate Tax		IH KCB Lisle Owner, LLC		145,732	145,732	16
17	V	30	Depreciation		IH KCB Lisle Owner, LLC		980,651	980,651	17
18	V	31	Amortization		IH KCB Lisle Owner, LLC		1,700	1,700	18
19	V	32	Interest Expense		IH KCB Lisle Owner, LLC		414,231	414,231	19
20	V	19	Professional Fees		IH KCB Lisle Owner, LLC		1,280	1,280	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			\$ 715,467			\$ 1,543,594	\$ * 828,127	39

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

VII. RELATED PARTIES (continued)

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

X YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Administration	\$ 43,731	IH Asset Management, LLC		\$	\$ (43,731)	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			\$ 43,731			\$ 0	\$ * (43,731)	39

* 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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Thrive of Lisle # 0056614 Report Period Beginning: 06/02/2020 Ending: 12/31/2020

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	Brian Cloch	Owner	Administrative	0.07		5	0.13	Alloc. Salary	\$ 20,501	17-7	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	\$ 20,501		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 Thrive of Lisle # 0056614 Report Period Beginning: 06/02/2020 Ending: 2/31/2020

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 Transitional Care Management, LLC
Street Address 3333 Warrenville Rd., Ste. 200
City / State / Zip Code Lisle, IL 60532
Phone Number (847) 720-8700
Fax Number ()

	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	17	Owner Salary Allocated	Revenue	3,632,382	4	\$ 439,842	\$ 422,230	169,303	\$ 20,501	1
2	19	Professional Fees	Revenue	3,632,382	4	48,554		169,303	2,263	2
3	20	Dues& Subscriptions	Revenue	3,632,382	4	4,400		169,303	205	3
4	21	A&G	Revenue	3,632,382	4	633,908		169,303	29,546	4
5	21	A&G Salary - Non Owner	Revenue	3,632,382	4	1,692,030	1,692,030	169,303	78,864	5
6	27	Employee Benefits	Revenue	3,632,382	4	499,053		169,303	23,261	6
7	24	Travel & Seminar	Revenue	3,632,382	4	99,292		169,303	4,628	7
8	26	Insurance	Revenue	3,632,382	4	22,716		169,303	1,059	8
9	30	Depreciation	Revenue	3,632,382	4	5,855		169,303	273	9
10	34	Rent	Revenue	3,632,382	4	79,004		169,303	3,682	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					\$ 3,524,654	\$ 2,114,260		\$ 164,282	25

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	HUD		X	Construction/Mortgage			\$	14,302,852			\$ 414,231	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$	14,302,852			\$ 414,231	9
	B. Non-Facility Related*											
10	Interest Income Offset		X								(237)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$ (237)	14
15	TOTALS (line 9+line14)						\$	14,302,852			\$ 413,994	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NoneLine # N/A

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

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

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

B. Real Estate Taxes

[illegible]

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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Thrive of Lisle COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0056614

CONTACT PERSON REGARDING THIS REPORT Andrew B. Cutler

TELEPHONE (847) 940-3269 FAX #: (847) 964-5469

A. Summary of Real Estate Tax Cost

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.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. 08-09-100-031	Long-term Care Property	\$ 19,464.68	\$ 19,464.68
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 19,464.68	\$ 19,464.68

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 X 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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,582

B. General Construction Type: Exterior Brick/Siding

Frame Steel

Number of Stories 1

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: 72,000

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

3. Current Period Amortization: 1,700

4. Dates Incurred:

Nature of Costs: Organization 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	Long-Term Care Property	131,925	2016	\$ 935,000	1
2					2
3	TOTALS	131,925		\$ 935,000	3

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	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	68		2020	2020	\$ 15,230,455	\$	27.5	\$ 323,070	\$ 323,070	\$ 323,070
5										
6										
7										
8										
	Improvement Type**									
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36	Current Book Depreciation					1,001,924				

*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
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 15,230,455	\$ 1,001,924		\$ 323,070	\$ 323,070	\$ 323,070	70

**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	\$	\$	\$	\$		\$	71
72	Current Year Purchases	1,281,654		256,331	256,331	5	256,331	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,281,654	\$	\$ 256,331	\$ 256,331		\$ 256,331	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)	\$ 17,447,109	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,001,924	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 579,401	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (422,523)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 579,401	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								5
6								6
7	TOTAL				\$			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: \$ 9,185 Description: Copier/Fax
(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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-1	hrs	\$ 225,096		\$	\$		\$ 225,096	1
2	Licensed Speech and Language Development Therapist	39-1	hrs	57,061					57,061	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-1	hrs	162,771					162,771	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				144,201		144,201	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): Therapy Supplies/O2	39-2					15,408		15,408	12
13	Other (specify): Equip./Lab/Xray/RT	39-3				135,495			135,495	13
14	TOTAL			\$ 444,928		\$ 135,495	\$ 159,609		\$ 740,032	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	\$ 264,849	\$ 275,450	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (7,927))	659,988	659,988	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,679	30,679	6
7	Other Prepaid Expenses	3,596	3,596	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached		1,533,497	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 959,112	\$ 2,503,210	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		927,275	13
14	Buildings, at Historical Cost		12,851,195	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	104,403	4,362,943	16
17	Accumulated Depreciation (book methods)	(21,000)	(1,001,650)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		72,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(1,700)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	6,240	3,115,027	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 89,643	\$ 20,325,090	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,048,755	\$ 22,828,300	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 473,430	\$ 473,430	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	132,687	132,687	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		136,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	3,182,751	3,682,751	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,788,868	\$ 4,424,868	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		14,302,852	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 14,302,852	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,788,868	\$ 18,727,720	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,740,113)	\$ 4,100,580	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,048,755	\$ 22,828,300	48

*(See instructions.)

Thrive of Lisle
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06/02/2020-12/31/2020

A. Current Assets	Operating	After Consolidation
9 Debt Service Reserve Escrow	-	943,016
IOD Escrow	-	243,367
Working Capital Escrow	-	28
Replacement Reserve Escrow	-	57,188
Tax Escrow	-	51,675
MIP Escrow	-	216,897
Insurance Escrow	-	21,326
	-	-
	-	-
	<u>-</u>	<u>1,533,497</u>

B. Long-Term Assets	Amount	
23 Due from OpCo	-	3,103,787
Due from Related Party	-	5,000
Deposits	6,240	6,240
	<u>6,240</u>	<u>3,115,027</u>

Other Current Liabilities	Amount	
36 Capital Lease Payable	71,721	71,721
Accured Expenses	7,243	7,243
Due to Property Co.	3,103,787	3,103,787
Due to Related Party		500,000
	<u>3,182,751</u>	<u>3,682,751</u>

Other Long-Term Liabilities	Amount	
43	-	-
	-	-
	<u>-</u>	<u>-</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,741,687)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	1,574	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (2,740,113)	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)	\$ (2,740,113)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Thrive of Lisle

0056614

Report Period Beginning: 06/02/2020

Ending: 12/31/2020

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	\$ 1,432,800	1
2	Discounts and Allowances for all Levels	(1,020,868)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 411,932	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,127,622	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,127,622	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	274,246	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	133,036	19
20	Radiology and X-Ray	30,070	20
21	Other Medical Services	27,126	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 464,478	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	237	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 237	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,004,269	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	483,660	31
32	Health Care	1,373,003	32
33	General Administration	1,278,651	33
	B. Capital Expense		
34	Ownership	745,652	34
	C. Ancillary Expense		
35	Special Cost Centers	836,446	35
36	Provider Participation Fee	28,544	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,745,956	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,741,687)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,741,687)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,000	44
45	Private Pay - Net Inpatient Revenue	15,750	45
46	Medicare - Net Inpatient Revenue	359,320	46
47	Other-(specify)	15,447	47
48	Other-(specify)	18,415	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 411,932	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Consolidated 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.

Facility Name & ID Number Thrive of Lisle# 0056614Report Period Beginning: 06/02/2020Ending: 12/31/2020

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,360	1,464	\$ 63,484	\$ 43.36	1
2	Assistant Director of Nursing	416	416	26,438	63.55	2
3	Registered Nurses	17,842	18,170	712,461	39.21	3
4	Licensed Practical Nurses	351	351	9,203	26.22	4
5	CNAs & Orderlies	9,868	10,116	171,863	16.99	5
6	CNA Trainees					6
7	Licensed Therapist	10,890	11,184	444,528	39.75	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,350	1,358	35,111	25.85	9
10	Activity Assistants					10
11	Social Service Workers	1,238	1,334	38,115	28.57	11
12	Dietician	295	295	10,549	35.76	12
13	Food Service Supervisor	1,360	1,368	49,966	36.52	13
14	Head Cook					14
15	Cook Helpers/Assistants	3,735	3,798	77,373	20.37	15
16	Dishwashers					16
17	Maintenance Workers	2,343	2,343	66,719	28.48	17
18	Housekeepers	3,996	4,134	65,122	15.75	18
19	Laundry					19
20	Administrator	1,495	1,519	88,173	58.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,750	6,760	220,599	32.63	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	1,480	1,480	71,934	48.60	33
34	TOTAL (lines 1 - 33)	64,769	66,090	\$ 2,151,638 *	\$ 32.56	34

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

** See instructions.

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	1	175	9-3	36
37	Medical Records Consultant	Monthly	1,092	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,477	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Clinical Consulting Software	Monthly	26,591	10-3	47
48					48
49	TOTAL (lines 35 - 48)	1	\$ 30,335		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

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DATE	PAYEE	TOPIC	ATTENDEE	JOB DESCRIPTION	CITY/STATE	FEE
6/10/2020	Kathleen Nevera	Food Saftey Course	Kathleen Nevera	Dietary Supervisor	Web	99
8/25/2020	CE Solutons	CE Library	Various	All	Web	1,447
10/31/2020						395
12/28/2020	LTCNA	LTCNA Nurse Certificate		Clinical	Web	625
12/31/2020	Renee Mills	Administration	Renee Mills	Administrator	Web	175
			Allocated Cost - TCM			556
				Total		<u>3,297</u>

DATE	EMPLOYEE NAME	JOB DESCRIPTION	DESTINATION	PURPOSE OF TRIP	Expense	ADJ	TOTAL	ADJ
7/31/2020	Lindsey Douglas	Exp. Reimb.	Lisle	Consult	266		266	
			Allocation -TCM		4,072		4,072	
				Total			4,338	

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06/02/2020-12/31/2020

DATE	G/L ACCT. #	PAYEE/VENDOR	AMOUNT	ADJ Amount	Adjusted Balance
7/31/2020	80550.000	Polsinelli	3,898	-	3,898
10/19/2020	80550.000	Benesch, Friedlander, Coplan & Aronoff	544	-	544
Total					<u>4,442</u>

XX. GENERAL INFORMATION:

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

No

(2) Are there any dues to nursing home associations included on the cost report?

No

If YES, give association name and amount. N/A

(3) Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report? N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period? 5 Year

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

\$ 0

Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement?

YES

X

NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 28,544

This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

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

Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ 0

Has any meal income been offset against related costs? N/A

Indicate the amount. \$ N/A

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

LN 14

d. Have vehicle usage logs been maintained?

N/A

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

N/A

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

N/A

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm?

No

Firm Name: N/A

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

Yes

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details. N/A

Attach invoices and a summary of services for all architect and appraisal fees.

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IL478-2471