

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: 0053850			II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER		
Facility Name: The Grove of Elmhurst			I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2025 to 12/31/2025 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: 127 West Diversy Ave Elmhurst 60126 Number City Zip Code					
County: Dupage					
Telephone Number: (630) 530-5225 Fax # (630) 530-7775					
HFS ID Number:					
Date of Initial License for Current Owners: 10/01/2010			Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____		
Type of Ownership:					
☐ VOLUNTARY, NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code _____			Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) John Epperson Partner (Firm Name & Address) Miller Cooper & Co., Ltd. 3 Parkway North, Suite 200, Deerfield IL 60015 (Telephone) (312) 344-2883 Fax # () _____		
☒ 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: John Epperson Telephone Number: (312) 344-2883 Email Address: _____			MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630		

Facility Name & ID Number The Grove of Elmhurst # 0053850 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds					
N/A					
1	2	3	4		
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	176	Skilled (SNF)	176	64,240	1
2		Skilled Pediatric (SNF/PED)			2
3	4	Intermediate (ICF)	4	1,460	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	180	TOTALS	180	65,700	7

B. Census-For the entire report period.										
	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF				93		919	451	1,463	8
9	SNF/PED									9
10	ICF	10,553	28,424	2,166		3,949		4,182	49,274	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	10,553	28,424	2,166	93	3,949	919	4,633	50,737	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 77.23%

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 10/01/2010

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 10/01/2010 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 180

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2025 Fiscal Year: 12/31/2025

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

Facility Name & ID Number The Grove of Elmhurst # 0053850 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	670,663	79,899	62,090	812,652		812,652	251	812,903			1
2	Food Purchase		454,302		454,302		454,302	(12,127)	442,175			2
3	Housekeeping	433,924	45,768		479,692		479,692	567	480,259			3
4	Laundry	52,612	27,398	305,750	385,760		385,760		385,760			4
5	Heat and Other Utilities			390,027	390,027		390,027	(14,065)	375,962			5
6	Maintenance	197,007	20,283	111,744	329,034		329,034	11,258	340,292			6
7	Other (specify):*							912	912			7
8	TOTAL General Services	1,354,206	627,650	869,611	2,851,467		2,851,467	(13,204)	2,838,263			8
	B. Health Care and Programs											
9	Medical Director			60,000	60,000		60,000	5,616	65,616			9
10	Nursing and Medical Records	4,644,256	151,837	1,548,845	6,344,938		6,344,938	91,763	6,436,701			10
10a	Therapy	302,790			302,790		302,790	2,548	305,338			10a
11	Activities	236,751	15,172	731	252,654		252,654	106	252,760			11
12	Social Services	168,107		1,213	169,320		169,320	2,081	171,401			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							15,937	15,937			15
16	TOTAL Health Care and Programs	5,351,904	167,009	1,610,789	7,129,702		7,129,702	118,051	7,247,753			16
	C. General Administration											
17	Administrative	310,453			310,453		310,453	47,618	358,071			17
18	Directors Fees											18
19	Professional Services			166,768	166,768		166,768	65,537	232,305			19
20	Dues, Fees, Subscriptions & Promotions			70,292	70,292		70,292	(35,011)	35,281			20
21	Clerical & General Office Expenses	315,657	2,653	988,048	1,306,358		1,306,358	(519,992)	786,366			21
22	Employee Benefits & Payroll Taxes			1,000,900	1,000,900		1,000,900		1,000,900			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,400	3,400		3,400	844	4,244			24
25	Other Admin. Staff Transportation							3,201	3,201			25
26	Insurance-Prop.Liab.Malpractice			554,026	554,026		554,026	7,194	561,220			26
27	Other (specify):*							29,203	29,203			27
28	TOTAL General Administration	626,110	2,653	2,783,434	3,412,197		3,412,197	(401,407)	3,010,791			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,332,220	797,312	5,263,834	13,393,366		13,393,366	(296,560)	13,096,807			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			82,531	82,531		82,531	887,268	969,799			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			154,747	154,747		154,747	1,101,984	1,256,731			32
33	Real Estate Taxes			94,056	94,056		94,056	(857)	93,199			33
34	Rent-Facility & Grounds			1,397,814	1,397,814		1,397,814	(1,381,920)	15,894			34
35	Rent-Equipment & Vehicles			17,217	17,217		17,217	1,493	18,710			35
36	Other (specify):*											36
37	TOTAL Ownership			1,746,365	1,746,365		1,746,365	607,968	2,354,333			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	962,735	666,298	539,352	2,168,385		2,168,385		2,168,385			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*			945,976	945,976		945,976	(945,976)				43
44	TOTAL Special Cost Centers	962,735	666,298	1,485,328	3,114,361		3,114,361	(945,976)	2,168,385			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,294,955	1,463,610	8,495,527	18,254,092		18,254,092	(634,568)	17,619,525			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	(15,107)	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	724,516	30		9
10	Interest and Other Investment Income	(6,937)	32		10
11	Discounts, Allowances, Rebates & Refunds	(9,788)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,339)	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	(425,620)	21		18
19	Entertainment	(1,728)	21		19
20	Contributions	(14,500)	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	(315,807)	21		24
25	Fund Raising, Advertising and Promotional	(6,873)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees	(8,121)			27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See page 5A	(1,079,320)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,161,624)		\$	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)	558,908		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 558,908		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (602,716)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (15,312)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Non-Allowable Expense	(945,976)	43	3
4	Bank Charges	(12,296)	21	4
5	Patient Personal Items	(2,607)	10	5
6	Sequestration Expense	(19,047)	21	6
7	Non-Allowable Legal	5,162	19	7
8	Building Co. - Professional Fees	(3,126)	19	8
9	Building Co. - Bank Charges	0	21	9
10	Building Co. - Amortization	(84,807)	36	10
11	Building Co. - Insurance	(1,310)	26	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				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	(1,079,320)		49

Summary A

12/31/2025

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS	
	A. General Services												(to Sch V, col.7)	
1	Dietary	0	0	251	0	0	0	0	0	0	0	0	251	1
2	Food Purchase	(12,127)	0	0	0	0	0	0	0	0	0	0	(12,127)	2
3	Housekeeping	0	0	567	0	0	0	0	0	0	0	0	567	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(15,107)	0	587	455	0	0	0	0	0	0	0	(14,065)	5
6	Maintenance	0	0	10,768	572	(82)	0	0	0	0	0	0	11,258	6
7	Other (specify):*	0	0	912	0	0	0	0	0	0	0	0	912	7
8	TOTAL General Services	(27,234)	0	13,085	1,027	(82)	0	0	0	0	0	0	(13,204)	8
	B. Health Care and Programs													
9	Medical Director	0	0	5,616	0	0	0	0	0	0	0	0	5,616	9
10	Nursing and Medical Records	(2,607)	0	97,025	0	0	(2,655)	0	0	0	0	0	91,763	10
10a	Therapy	0	0	2,548	0	0	0	0	0	0	0	0	2,548	10a
11	Activities	0	0	106	0	0	0	0	0	0	0	0	106	11
12	Social Services	0	0	2,081	0	0	0	0	0	0	0	0	2,081	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	15,937	0	0	0	0	0	0	0	0	15,937	15
16	TOTAL Health Care and Programs	(2,607)	0	123,313	0	0	(2,655)	0	0	0	0	0	118,051	16
	C. General Administration													
17	Administrative	0	0	47,618	0	0	0	0	0	0	0	0	47,618	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	2,036	3,126	67,658	46	0	0	(7,329)	0	0	0	0	65,537	19
20	Fees, Subscriptions & Promotions	(36,685)	0	1,674	0	0	0	0	0	0	0	0	(35,011)	20
21	Clerical & General Office Expenses	(774,498)	0	254,467	39	0	0	0	0	0	0	0	(519,992)	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	0	844	0	0	0	0	0	0	0	0	844	24
25	Other Admin. Staff Transportation	0	0	3,201	0	0	0	0	0	0	0	0	3,201	25
26	Insurance-Prop.Liab.Malpractice	(1,310)	1,310	7,058	136	0	0	0	0	0	0	0	7,194	26
27	Other (specify):*	0	0	29,203	0	0	0	0	0	0	0	0	29,203	27
28	TOTAL General Administration	(810,458)	4,436	411,723	221	0	0	(7,329)	0	0	0	0	(401,407)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(840,299)	4,436	548,121	1,248	(82)	(2,655)	(7,329)	0	0	0	0	(296,560)	29

Summary B

12/31/2025

	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	724,516	160,753	0	1,999	0	0	0	0	0	0	0	887,268	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,937)	1,110,190	(2,525)	1,256	0	0	0	0	0	0	0	1,101,984	32
33	Real Estate Taxes	0	(2,345)	0	1,488	0	0	0	0	0	0	0	(857)	33
34	Rent-Facility & Grounds	0	(1,397,814)	15,894	0	0	0	0	0	0	0	0	(1,381,920)	34
35	Rent-Equipment & Vehicles	0	0	1,493	0	0	0	0	0	0	0	0	1,493	35
36	Other (specify):*	(84,807)	84,807	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	632,772	(44,409)	14,862	4,743	0	0	0	0	0	0	0	607,968	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):*	(945,976)	0	0	0	0	0	0	0	0	0	0	(945,976)	43
44	TOTAL Special Cost Centers	(945,976)	0	0	0	0	0	0	0	0	0	0	(945,976)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,153,503)	(39,973)	562,983	5,991	(82)	(2,655)	(7,329)	0	0	0	0	(634,568)	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 Ownership Listing-1		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 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	34	Rent	\$ 1,397,814	Elmbrook HC Properties		\$	(1,397,814)	1
2	V	32	Interest	154,747	Elmbrook HC Properties		1,264,937	1,110,190	2
3	V	33	Real Estate Tax	94,056	Elmbrook HC Properties		91,711	(2,345)	3
4	V	19	Professional Fees		Elmbrook HC Properties		3,126	3,126	4
5	V	30	Depreciation		Elmbrook HC Properties		160,753	160,753	5
6	V	21	Bank Fees		Elmbrook HC Properties		0		6
7	V	36	Amortization		Elmbrook HC Properties		84,807	84,807	7
8	V	26	Prop Insurance		Elmbrook HC Properties		1,310	1,310	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,646,617			\$ 1,606,644	\$ * (39,973)	14

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

Facility Name & ID Number

The Grove of Elmhurst

0053850

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

VII. RELATED PARTIES

A. (Continued)

Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Astoria Place Living and Rehab	Chicago, IL	Bella Terra Streamwood	Streamwood, IL	Elmbrook Real Properties		Building Company	1
2	Avantara Arrowhead	Rapid City, SD	Bella Terra Wheeling	Wheeling, IL	Legacy HC & Financial	Lincolnwood	Home Office/Book	2
3	Avantara Aurora	Aurora, IL	Carlton at the Lake	Chicago, IL	CF St. Louis LLC	Skokie	Building Company	3
4	Avantara Chicago Ridge	Chicago Ridge, IL	Chalet Living and Rehab	Chicago, IL	ML Group Design & Interiors	Skokie	Asset Management	4
5	Avantara Clark City	Clark, SD	Cardinal Grove Independent & Assisted Living	Garner, IA	ReMED Services LLC	Lincolnwood	Nursing Equipment	5
6	Avantara of Elgin	Elgin, IL	Glenview Terrace	Glenview, IL	Propay HR	Evanston	Payroll Processing	6
7	Avantara Evergreen Park	Evergreen Park, IL	Harmony Cedar Rapids	Cedar Rapids, IA				7
8	Avantara Groton	Groton, SD	Harmony Davenport	Davenport, IA				8
9	Avantara Huron	Huron, SD	Harmony Dubuque	Dubuque, IA				9
10	Avantara Lake Norden	Lake Norden, SD	Harmony Marshalltown	Marshalltown, IA				10
11	Avantara Lake Zurich	Lake Zurich, IL	Harmony Healthcare & Rehabilitation Center	Chicago, IL				11
12	Avantara Libertyville	Libertyville, IL	Harmony Palos	Palos Heights, IL				12
13	Avantara Lincoln Park	Chicago, IL	Harmony Utica Ridge	Davenport, IA				13
14	Avantara Long Grove	Long Grove, IL	Harmony Waterloo	Waterloo, IA				14
15	Avantara Milbank	Milbank, SD	Harmony West Des Moines	West Des Moines, IA				15
16	Avantara Mountain View	Rapid City, SD	Lakefront	Chicago, IL				16
17	Avantara North	Rapid City, SD	Peterson Park Health Care Center	Chicago, IL				17
18	Avantara Norton	Rapid City, SD	Grove at the Lake	Zion, IL				18
19	Avantara Palos Heights	Palos Heights, IL	Harmony House Care Center ICF	Waterloo, IA				19
20	Avantara Park Ridge	Park Ridge, IL	The Grove of Elmhurst	Elmhurst, IL				20
21	Avantara Pierre	Pierre, SD	The Grove of Evanston	Evanston, IL				21
22	Avantara Redfield	Redfield, SD	The Grove of Fox Valley	Aurora, IL				22
23	Avantara Saint Cloud	St. Cloud, MN	The Grove of La Grange Park	La Grange Park, IL				23
24	Avantara Watertown	Watertown, SD	The Grove of Northbrook	Northbrook, IL				24
25	Bella Terra Bloomingdale	Bloomington, IL	The Grove of Skokie	Skokie, IL				25
26	Bella Terra Elmhurst	Elmhurst, IL	Grove of St. Charles	St. Charles, IL				26
27	Bella Terra La Grange	La Grange, IL	Vistas Fox Valley	Aurora, IL				27
28	Bella Terra Lombard	Lombard, IL	Vistas of Lincoln Park	Chicago, IL				28
29	Bella Terra Morton Grove	Morton Grove, IL	Wellshire Morton Grove	Morton Grove, IL				29
30	Bella Terra Schaumburg	Schaumburg, IL	Warren Barr Buffalo Grove	Buffalo Grove, IL				30

Facility Name & ID Number

The Grove of Elmhurst

0053850

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

VII. RELATED PARTIES

A. (Continued)

Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Warren Barr Gold Coast	Chicago, IL	Nora Springs Care Center	Nora Springs, IA				1
2	Warren Barr Lieberman	Skokie, IL	Grandview Care Center	Oelwein, IA				2
3	Warren Barr Lincoln Park	Chicago, IL	Oelwein Healthcare Center	Oelwein, IA				3
4	Warren Barr North Shore	Highland Park, IL	Park View Care Center	Sac City, IA				4
5	Whitehall	Deerfield, IL	Manor House Care Center	Sigourney, IA				5
6	Warren Barr Orland Park	Orland Park, IL	Main Street Manor	Swea City, IA				6
7	Warren Barr South Loop	Chicago, IL	Harmony House Care Center SNF	Waterloo, IA				7
8	Wellshire Huron	Huron, SD	Northgate Care Center	Waukon, IA				8
9	Wellshire Park Place	Milbank, SD	Southfield Wellness Community	Webster City, IA				9
10	Warren Barr Oak Lawn	Oak Lawn, IL	Avantara Joliet	Joliet, IL				10
11	Rehab Center Of Allison	Allison, IA	Harmony Park Ridge	Park Ridge, IL				11
12	Maple Manor Village	Aplington, IA	Mulberry Place Independent & Assisted Living	Bloomfield, IA				12
13	Valley Vue Care Center	Armstrong, IA	Afton Oaks Independent & Assisted Living Apar	Elma, IA				13
14	Willow Dale Wellness Village	Battle Creek, IA	Southfield Wellness Community Independent & Webster City, IA					14
15	Rehab Center Of Belmond	Belmond, IA	Emerald Oaks Independent & Assisted Living A	Emmetsburg, IA				15
16	Bloomfield Care Center	Bloomfield, IA	Eagle Ridge Assisted Living Apartments	Guttenberg, IA				16
17	Westview Care Center	Britt, IA	Cherry Ridge Independent & Assisted Living A	Mount Vernon, IA				17
18	Oakwood Care Center	Clear Lake, IA	Mills Harbor Assisted Living Lake	Lake Mills, IA				18
19	Colonial Manor Of Elma	Elma, IA	Deer View Manor Independent & Assisted Livin	Sigourney, IA				19
20	Emmetsburg Care Center	Emmetsburg, IA	Maple Manor Village Independent & Assisted L	Aplington, IA				20
21	Concord Care Center	Garner, IA	Summit Heights	Nora Springs, IA				21
22	Guttenberg Care Center	Guttenberg, IA	Southerest Manor II Assisted Living	Waukon, IA				22
23	Rehab Center Of Hampton	Hampton, IA	The Courtyard	West Des Moines, IA				23
24	Rehab Center Of Independence-West	Independence, IA	Park Place Independent & Assisted Living Apar	Sac City, IA				24
25	Westview Of Indianola	Indianola, IA	Elm Springs	Arkansas, IA				25
26	Rehab Center Of Lisbon	Lisbon, IA	Belle Haven Independent & Assisted Living Apa	Blemond, IA				26
27	Lake Mills Care Center	Lake Mills, IA	Leahy Grove Independent & Assisted Living	Hampton, IA				27
28	Heritage Health & Rehab Center	Cedar Rapids, IA	Indian Creek Independent & Assisted Living Ap	Nevada, IA				28
29	Hallmark Care Center	Mt Vernon, IA	Spring Creek Independent & Assisted Living Ap	Armstrong, IA				29
30	Rolling Green Village	Nevada, IA	Clark SNF	Clark St, IL				30

VII. RELATED PARTIES

A. (Continued)

Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Elmbrook SNF	Elmhurst, IL						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

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	1	Dietary	\$	Legacy Healthcare Financial Services		\$ 251	\$ 251	15
16	V	3	Housekeeping		Legacy Healthcare Financial Services		567	567	16
17	V	5	Heat and other Utilities		Legacy Healthcare Financial Services		587	587	17
18	V	6	Maintenece		Legacy Healthcare Financial Services		10,768	10,768	18
19	V	7	Other (specify):*Employee Benefits		Legacy Healthcare Financial Services		912	912	19
20	V	9	Medical Director		Legacy Healthcare Financial Services		5,616	5,616	20
21	V	10	Nursing and Medical Records		Legacy Healthcare Financial Services		97,025	97,025	21
22	V	10A	Therapy		Legacy Healthcare Financial Services		2,548	2,548	22
23	V	11	Activities		Legacy Healthcare Financial Services		106	106	23
24	V	12	Social Services		Legacy Healthcare Financial Services		2,081	2,081	24
25	V	15	Other (specify):*Employee Benefits		Legacy Healthcare Financial Services		15,937	15,937	25
26	V	17	Administrative		Legacy Healthcare Financial Services		47,618	47,618	26
27	V	19	Professional Services		Legacy Healthcare Financial Services		67,658	67,658	27
28	V	20	Dues, Fees, Subscriptions & Promotions		Legacy Healthcare Financial Services		1,674	1,674	28
29	V	21	Clerical & General Office Expenses		Legacy Healthcare Financial Services		254,467	254,467	29
30	V	24	Travel and Seminar		Legacy Healthcare Financial Services		844	844	30
31	V	25	Other Admin. Staff Transportation		Legacy Healthcare Financial Services		3,201	3,201	31
32	V	26	Insurance-Prop.Liab.Malpractice		Legacy Healthcare Financial Services		7,058	7,058	32
33	V	27	Other (specify):* Employee Benefits		Legacy Healthcare Financial Services		29,203	29,203	33
34	V	32	Interest		Legacy Healthcare Financial Services		(2,525)	(2,525)	34
35	V	34	Rent-Facility & Grounds		Legacy Healthcare Financial Services		15,894	15,894	35
36	V	35	Equipment Rental		Legacy Healthcare Financial Services		183	183	36
37	V	35	Auto Rental		Legacy Healthcare Financial Services		1,310	1,310	37
38	V								38
39	Total			\$			\$ 562,983	\$ * 562,983	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	5	Utilities	\$	CF St. Louis LLC		\$ 455	\$ 455	15
16	V	6	Repairs and Maintenance		CF St. Louis LLC		572	572	16
17	V	19	Real Estate Appraisal Fee		CF St. Louis LLC		46	46	17
18	V	21	Office Expense		CF St. Louis LLC		39	39	18
19	V	26	Insurance		CF St. Louis LLC		136	136	19
20	V	30	Depreciation		CF St. Louis LLC		1,999	1,999	20
21	V	32	Interest Expense		CF St. Louis LLC		1,256	1,256	21
22	V	33	Real Estate Taxes		CF St. Louis LLC		1,488	1,488	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			\$			\$ 5,991	\$ * 5,991	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	\$ 6,000	ML Group Design and Development		\$ 5,918	\$ (82)	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			\$ 6,000			\$ 5,918	\$ * (82)	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	\$ 39,213	ReMED Services		\$ 36,558	\$ (2,655)	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			\$ 39,213			\$ 36,558	\$ * (2,655)	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 Service	\$ 32,173	ProPay HR LLC		\$ 24,844	\$ (7,329)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 32,173			\$ 24,844	\$ * (7,329)	39

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

STATE OF ILLINOIS					Ownership Listing-1			
The Grove of Elmhurst								
ID#		0053850						
Report Period Beginning:		01/01/2025			Legacy Healthcare FS			
Ending:		12/31/2025			Elmbrook HC Properties			
-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)					Management			
-Owners of companies must be listed instead of company names.					Operator/Licensee	Building Co.	Co./Home Office	
-Names of trust beneficiaries must be listed.					Ownership	Ownership	Ownership	
First Name		M.I.	Last Name	City	State	Percentage	Percentage	Percentage
1	GPN Family Trust							1
2	Beneficiary							2
3	Rivka		Rajchenbach	Chicago	IL	12.50000	6.44500	3
4	Bella		Rajchenbach	Chicago	IL	12.50000	6.44500	4
5	Yitzchok		Rajchenbach	Chicago	IL	12.50000	6.44500	5
6	Ziskind		Rajchenbach	Chicago	IL	12.50000	6.44500	6
7								7
8	Doros Generation Trust							8
9	Beneficiary							9
10	Ahuva		Shabat	Lincolnwood	IL	10.00000	6.18800	10
11	Eliana		Shabat	Lincolnwood	IL	10.00000	6.18800	11
12	Ayalet		Shabat	Lincolnwood	IL	10.00000	6.18800	12
13	Ashira		Shabat	Lincolnwood	IL	10.00000	6.18800	13
14	Leora			Lincolnwood	IL	10.00000	6.18800	14
15								15
16								16
17	Legacy Healthcare Financial Service							17
18	Chaim		Rajchenbach	Chicago	IL		8.60000	50.00000
19	Menachem		Shabat	Lincolnwood	IL		3.44000	50.00000
20								20
21	Ronald N. Shabat Descendants Trust							21
22	Ronald N. Shabat	N	Shabat	Lincolnwood	IL		15.60000	22
23								23
24								24
25	Yoseph		Rajchenbach	Chicago	IL		3.13000	25
26	Avrohom		Rajchenbach	Chicago	IL		3.13000	26
27	Shlomo		Zalman	Chicago	IL		3.13000	27
28	Moshe		Schwartz	Chicago	IL		3.13000	28
29								29
30	RFT Capital Holdings, LLC							30
31	Avrum Rajchenbach Discretionary Trust							31
32	Avrum		Rajchenbach	Chicago	IL		0.27500	32
33	Moshe Rajchenbach Discretionary Trust							33
34	Moshe		Rajchenbach	Chicago	IL		0.58500	34
35	Yosef Rajchenbach Discretionary Trust							35
36	Yosef		Rajchenbach	Chicago	IL		0.27500	36
37	Chaim Rajchenbach Discretionary Trust							37
38	Chaim		Rajchenbach	Chicago	IL		0.58500	38
39	Ester Rajchenbach Discretionary Trust							39
40	Ester		Rajchenbach	Chicago	IL		0.27500	40
41	Leah Rajchenbach Discretionary Trust							41
42	Leah		Rajchenbach	Chicago	IL		0.27500	42
43	Nahma Rajchenbach Discretionary Trust							43
44	Nahma		Rajchenbach	Chicago	IL		0.27500	44
45	Chaya Rajchenbach Discretionary Trust							45
46	Chaya		Rajchenbach	Chicago	IL		0.27500	46
47	Aliza Rajchenbach Discretionary Trust							47
48	Aliza		Rajchenbach	Chicago	IL		0.27500	48
49	Sheldon		Hollander				0.02100	49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
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70								70
71								71
72								72
73								73
74								74
75								75

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: 2/31/2025

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						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number The Grove of Elmhurst# 0053850

Report Period Beginning:

01/01/2025Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Census Days / Direct Allocation		121	\$ 17,417	\$ 188,860		\$ 251	1
2	3	Housekeeping	Census Days / Direct Allocation		121	39,313			567	2
3	5	Heat and other Utilities	Census Days / Direct Allocation		121	40,732			587	3
4	6	Maintenece	Census Days / Direct Allocation		121	1,086,339			10,768	4
5	7	Other (specify):*Employee Benefit	Census Days / Direct Allocation		121	115,823			912	5
6	9	Medical Director	Census Days / Direct Allocation		121	389,400	1,007,031		5,616	6
7	10	Nursing and Medical Records	Census Days / Direct Allocation		121	7,945,861	12,523,114		97,025	7
8	10A	Therapy	Census Days / Direct Allocation		121	176,684	152,483		2,548	8
9	11	Activities	Census Days / Direct Allocation		121	7,371			106	9
10	12	Social Services	Census Days / Direct Allocation		121	144,309	144,309		2,081	10
11	15	Other (specify):*Employee Benefit	Census Days / Direct Allocation		121	1,241,625			15,937	11
12	17	Administrative	Census Days / Direct Allocation		121	5,453,317			47,618	12
13	19	Professional Services	Census Days / Direct Allocation		121	4,691,102	5,453,317		67,658	13
14	20	Dues, Fees, Subscriptions & Prom	Census Days / Direct Allocation		121	116,052			1,674	14
15	21	Clerical & General Office Expense	Census Days / Direct Allocation		121	20,639,396	19,821,678		254,467	15
16	24	Travel and Seminar	Census Days / Direct Allocation		121	58,495			844	16
17	25	Other Admin. Staff Transportation	Census Days / Direct Allocation		121	221,955			3,201	17
18	26	Insurance-Prop.Liab.Malpractice	Census Days / Direct Allocation		121	489,395			7,058	18
19	27	Other (specify):* Employee Benefit	Census Days / Direct Allocation		121	2,646,369			29,203	19
20	32	Interest	Census Days / Direct Allocation		121	(175,042)			(2,525)	20
21	34	Rent-Facility & Grounds	Census Days / Direct Allocation		121	1,102,008			15,894	21
22	35	Equipment Rental	Census Days / Direct Allocation		121	12,712			183	22
23	35	Auto Rental	Census Days / Direct Allocation		121	90,802			1,310	23
24										24
25	TOTALS					\$ 46,551,435	\$ 39,290,792		\$ 562,983	25

Facility Name & ID Number The Grove of Elmhurst # 0053850 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

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 CF St. Louis LLC
Street Address 3450 Oakton Street
City / State / Zip Code Skokie, IL 60076
Phone Number (847) 676-5300
Fax Number (847) 676-5348

	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	5	Utilities	Census Days	3,517,851	121	\$ 31,540	\$	50,737	\$ 455	1
2	6	Repairs and Maintenance	Census Days	3,517,851	121	39,680		50,737	572	2
3	19	Real Estate Appraisal Fee	Census Days	3,517,851	121	3,155		50,737	46	3
4	21	Office Expense	Census Days	3,517,851	121	2,733		50,737	39	4
5	26	Insurance	Census Days	3,517,851	121	9,443		50,737	136	5
6	30	Depreciation	Census Days	3,517,851	121	138,584		50,737	1,999	6
7	32	Interest Expense	Census Days	3,517,851	121	87,057		50,737	1,256	7
8	33	Real Estate Taxes	Census Days	3,517,851	121	103,201		50,737	1,488	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					\$ 415,393	\$		\$ 5,991	25

Facility Name & ID Number The Grove of Elmhurst # 0053850 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

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 ML Group Design and Development
Street Address 3424 Oakton St
City / State / Zip Code Skokie, IL 60076
Phone Number (847) 676-5300
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	6	Maintenance	Direct			\$	\$		\$ 5,918	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					\$	\$		\$ 5,918	25

Facility Name & ID Number The Grove of Elmhurst # 0053850 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

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 ☐

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 ()

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

	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			\$	\$		\$ 36,558	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					\$	\$		\$ 36,558	25

Facility Name & ID Number The Grove of Elmhurst # 0053850 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

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 ProPay HR LLC

Street Address 2201 W. Main St.

City / State / Zip Code Evanston, IL 60202

Phone Number (847) 905-3268

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	19	Payroll Services	Direct		\$	\$		\$ 24,844	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				\$	\$		\$ 24,844	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	Forbright		X	Mortgage		1/15/2020	\$ 18,900,000	\$ 17,260,356	7/3/2027	0.0774	\$ 1,264,937
2											
3											
4											
5											
	Working Capital										
6	Forbright		X	Revolving Line of Credit				1,986,303			154,395
7	IPFS Corporation		X	Prepaid Insurance - Interest Only							352
8											
9	TOTAL Facility Related						\$ 18,900,000	\$ 19,246,659			\$ 1,419,684
	B. Non-Facility Related*										
10	Interest Income		X								(6,937)
11											
12	Allocated from CF St. Louis	X									1,256
13											
14	TOTAL Non-Facility Related						\$	\$			\$ (5,681)
15	TOTALS (line 9+line14)						\$ 18,900,000	\$ 19,246,659			\$ 1,414,003

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2024 report.			\$	<u>76,557</u>	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.)			\$	<u>93,199</u>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	<u>16,642</u>	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<u>76,557</u>	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.)			\$		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.			\$	<u>93,199</u>	7
Assessed Value from Real Estate Tax Bill:		2024	<u>1,497,564</u>		<u>8</u>
Real Estate Tax Bill for Calendar Year:		2020	<u>71,528</u>		<u>9</u>
		2021	<u>75,873</u>		<u>10</u>
		2022	<u>79,109</u>		<u>11</u>
		2023	<u>84,965</u>		<u>12</u>
		2024	<u>91,711</u>		<u>13</u>
<u>2025 Accrual = Same as PY</u>					
<u>Allocated from CF St. Louis: \$1,488</u>					

	FOR BHF USE ONLY		
<u>14</u>	FROM R. E. TAX STATEMENT FOR 2024	\$	<u>14</u>
<u>15</u>	PLUS APPEAL COST FROM LINE 5	\$	<u>15</u>
<u>16</u>	LESS REFUND FROM LINE 6	\$	<u>16</u>
<u>17</u>	AMOUNT TO USE FOR RATE CALCULATIONS	\$	<u>17</u>

- 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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

The Grove of Elmhurst

COUNTY

Dupage

FACILITY IDPH LICENSE NUMBER

0053850

CONTACT PERSON REGARDING THIS REPORT

John Epperson

TELEPHONE

(312) 344-2883

FAX #:

()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1.	03-26-207-025	Long Term Care Property	\$ 84,495.52	\$ 84,495.52
2.	03-26-207-022	Long Term Care Property	\$ 7,215.30	\$ 7,215.30
3.	10-23-406-034-0000	Home Office Allocation	\$ 733,268.49	\$ 1,488.00
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 824,979.31	\$ 93,198.82

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? X 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 copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:44,800

B. General Construction Type:ExteriorBrickFrame

Number of Stories4

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. List the bed capacity for the building if it differs from the licensed total.

N/A

G. Have you properly capitalized all major repairs and equipment purchases?

Yes

H. Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A

I. Are you presently operating under a sublease agreement?

No

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

YESNO

☒ 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

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

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	67,000	2010	\$1,309,500	1
2	Allocated from CF St. Lous LLC			1,275	2
3	TOTALS	67,000		\$1,310,775	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	180		2010	1977	\$ 7,403,102	\$ 160,753	35	\$ 211,517	\$ 50,764	\$ 3,384,275	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Various			2011	831,792		20	41,590	41,590	623,844	9	
10	Various			2012	243,002		20	12,150	12,150	170,101	10	
11	Various			2013	155,927		20	7,796	7,796	101,353	11	
12	Various			2014	79,902		20	3,995	3,995	47,941	12	
13	Various			2015	31,411		20	1,571	1,571	17,276	13	
14	Various			2016	62,037		20	3,102	3,102	31,019	14	
15	Various			2017	142,956		20	7,148	7,148	64,330	15	
16	Various			2018	39,006		20	1,950	1,950	15,602	16	
17	Various			2019	6,023		20	301	301	2,108	17	
18	Various			2020	23,179		20	1,159	1,159	6,954	18	
19	Various			2021	47,063		20	2,353	2,353	11,766	19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36											36	

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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)	\$ 9,065,400	\$ 160,753		\$ 294,632	\$ 133,879	\$ 4,476,569	70

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

Facility Name & ID Number The Grove of Elmhurst# 0053850

Report Period Beginning:

01/01/2025

Ending:

12/31/2025**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 12A, Carried Forward		\$ 9,065,400	\$ 160,753		\$ 294,632	\$ 133,879	\$ 4,476,569	1
2	Install 12 Waunder Gaurds For 8 Exit Doors,2 Elevators,2 1St Flr	2022	52,552		20	2,628	2,628	10,510	2
3	Thermo-Pak Boilers #1 & #2 - New Tubes,Gaskets,Valves (\$8,215)	2022	7,992		20	400	400	1,598	3
4	Plumbing - Repair 4" Cast Underground Kitchen Drain Pipe	2022	6,032		20	302	302	1,206	4
5	7 Resident Rms - Patch Walls, New Light Fixtures, Painting	2022	23,836		20	1,192	1,192	4,767	5
6	Replace Tramco Ejector Pump,Pump Motor,Starter (\$12,060)	2022	11,733		20	587	587	2,347	6
7	Water Heater #1-New Valves,New Relief Valves On Storage Tank	2022	6,827		20	341	341	1,365	7
8	Cooling Tower - Replace Tower Fan Motor	2022	12,618		20	631	631	2,524	8
9	Plumbing-2 New Faucets And Sinks, Repair Hot Water Piping For	2023	14,148		20	707	707	2,122	9
10	Replace Flooring & Paint Walls In 3Rd Flr Activity Room (\$3,950)	2023	3,821		20	191	191	573	10
11	Replace Flooring & Paint Walls In 1St Flr Social Services Office	2023	3,434		20	172	172	515	11
12	Replace Flooring & Paint Walls In 2Nd Flr Respiratory Office	2023	3,434		20	172	172	515	12
13	Cooling Tower Repairs - Replace Cracked Ball Valve,Oil Filter As	2023	4,114		20	206	206	617	13
14	Repair Cracks On Roof & Repair Kitchen Exhaust (\$2,675)	2023	2,588		20	129	129	388	14
15	Piping and generator circuts in basement, 2nd and 3rd floors	2024	11,335		20	567	567	1,134	15
16	Replaced valves on boiler suppy and draining system	2024	9,940		20	497	497	994	16
17	Water pump repair and replacement	2024	13,000		20	650	650	1,300	17
18	Furnish and install new burner an dpilot assemplay and ignitor	2024	4,941		20	247	247	494	18
19	Pothole repairs	2024	3,800		20	190	190	380	19
20	Boiler pump #1 assembly of electrical and pump and valves	2024	3,291		20	165	165	329	20
21	Boiler room pilot ignitor and flame sensor replacement	2024	4,823		20	241	241	482	21
22	72 new tubes and new gaskets installed into boiler	2024	22,700		20	1,135	1,135	2,270	22
23	Replacement of lead free circulating pump	2024	2,834		20	142	142	283	23
24	Pump taco one replacements and installation	2024	10,182		20	509	509	1,018	24
25	HVAC repair and maintence and vent repair	2024	3,090		20	155	155	309	25
26	Kitchen tile flooring renovation	2024	4,496		20	225	225	450	26
27	Mechanical & Suppression Regular Labor, Truck Charge, Protect	2025	9,468		20	473	473	473	27
28	Rebuild brick pliers, concrete patio, replace brick & 9 lintels	2025	47,400		20	2,370	2,370	2,370	28
29	Repair insulation on piping	2025	4,900		20	245	245	245	29
30	Furnish and install door protection system and one elevator	2025	4,860		20	243	243	243	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,379,589	\$ 160,753		\$ 310,342	\$ 149,589	\$ 4,518,392	34

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

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

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 9,481,348	\$ 211,553		\$ 315,430	\$ 103,877	\$ 4,523,480	1
2									2
3									3
4	Related Party								4
5	Buildings:								5
6	Allocated from CF St. Louis, LLC	2016	6,865	136	35	196	60	1,961	6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	95,157	654	20	4,758	4,104	47,579	9
10	Allocated from CF St. Louis, LLC	2017	2,209	57	20	110	53	994	10
11	Allocated from CF St. Louis, LLC	2019	20,018	514	20	1,001	487	7,006	11
12	Allocated from CF St. Louis, LLC	2020	1,053	27	20	53	26	316	12
13	Allocated from CF St. Louis, LLC	2021	3,738	96	20	187	91	935	13
14	Allocated from CF St. Louis, LLC	2022	6,179	159	20	309	150	1,236	14
15	Allocated from CF St. Louis, LLC	2023	861	22	20	43	21	129	15
16									16
17	Allocated from Legacy HC	2018	114		20	6	6	45	17
18	Allocated from Legacy HC	2020	86		20	4	4	26	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,617,628	\$ 213,218		\$ 322,097	\$ 108,879	\$ 4,583,707	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	\$ 6,444,288	\$ 30,984	\$ 644,426	\$ 613,442	10	\$ 5,593,019	71
72	Current Year Purchases	42,620	2,067	4,262	2,195		4,262	72
73	Fully Depreciated Assets	2,190,299					2,190,299	73
74								74
75	TOTALS	\$ 8,677,207	\$ 33,051	\$ 648,688	\$ 615,637		\$ 7,787,580	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)	\$ 19,605,610	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 246,269	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 970,785	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 724,516	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 12,371,287	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.

Grove of Elmhurst
0053850
Moveable Equipment Schedule
01/01/2025
12/31/2025

Company Name	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Accumulated Straight Line Depreciation
Line 28: Prior Years					
Grove of Elmhurst	3,496,996	29,664	349,696	320,032	3,236,423
Elmbrook Real Properties	2,941,007	1,000	294,101	293,101	2,352,804
Allocated from Legacy HC	48	-	5	5	14
Allocated from CF St. Louis, LLC	6,237	320	624	304	3,778
Total	6,444,288	30,984	644,426	613,442	5,593,019

Line 29: Current Year

Grove of Elmhurst	42,620	2,067	4,262	2,195	4,262
Elmbrook Real Properties	-	-	-	-	-
Allocated from Legacy HC	-	-	-	-	-
Allocated from CF St. Louis, LLC	-	-	-	-	-
Total	42,620	2,067	4,262	2,195	4,262

Line 30: Fully Depreciated

Grove of Elmhurst	2,186,614	-	-	-	2,186,614
Elmbrook Real Properties	-	-	-	-	-
Allocated from Legacy HC	3,685	-	-	-	3,685
Allocated from CF St. Louis, LLC	-	-	-	-	-
Total	2,190,299	-	-	-	2,190,299

Total (Should tie to page 13)

Grove of Elmhurst	5,726,230	31,731	353,958	322,227	5,427,299
Elmbrook Real Properties	2,941,007	1,000	294,101	293,101	2,352,804
Allocated from Legacy HC	3,733	-	5	5	3,699
Allocated from CF St. Louis, LLC	6,237	320	624	304	3,778
Total	8,677,207	33,051	648,688	615,637	7,787,580

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	Allocated from Legacy HC				15,894			6
7	TOTAL				\$ 15,894			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: \$ 17,400
- Description: See Supplemental Schedule Attached
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Legacy HC		\$	\$ 1,310	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 1,310	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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

* 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.

Supplemental Schedule of Equipment Rental		12/31/2025
Special Services - Supplies (Column 6 - Other)		Amount
16A	Copiers	17,217
16B	Air Fresheners	-
16C	Allocation from Legacy HC	183
16D		
16E		
16F		
16G		
16 H		
16I		
16J		
		17,400

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 - 03	hrs	\$		\$ 107,041	\$		\$ 107,041	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			68,891			68,891	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			151,363			151,363	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				277,060		277,060	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Attached			962,735		212,057	389,238		1,564,030	12
13	Other (specify): 									13
14	TOTAL			\$ 962,735		\$ 539,352	\$ 666,298		\$ 2,168,385	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.

SPECIAL SERVICES - SUPPLEMENTAL SCHEDULE

Special Services - Supplies (Column 6 - Other)			Amount	Special Services - Salary (Column 3 - Staff)			Amount
13A	Supplies - Medical	39-2	178,531	13U	Respiratory Therapist - Regular	39-1	962,735
13B	Supplies - G-Tube	39-2	92,917	13V			
13C	Oxygen	39-2	9,820	13W			
13D	Supplies - Vent	39-2	107,970	13X			
13E				13Y			
13F				13Z			
13G							962,735
13 H							
13I							
13J							
			389,238				
	Special Services - Outside (Column 5 - Other)						
13K	Durable Medical Equipment	39-3	61,043				
13L	Oxygen Equipment Rental	39-3	15,240				
13M	Radiology	39-3	18,099				
13N	Laboratory	39-3	66,195				
13O	Vent Equipment Rental	39-3	51,480				
13P							
13Q							
13R							
13S							
13T			212,057				

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	\$ (3,967)	\$ 337,217	1
2	Cash-Patient Deposits	3,577	3,577	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,133,581	2,133,581	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,424	1,424	6
7	Other Prepaid Expenses	4,336	4,336	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	152,502	7,203,694	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,291,453	\$ 9,683,829	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	90,591	1,400,091	13
14	Buildings, at Historical Cost		5,180,335	14
15	Leasehold Improvements, at Historical Cost	526,043	1,196,174	15
16	Equipment, at Historical Cost	450,795	465,795	16
17	Accumulated Depreciation (book methods)	(589,318)	(3,291,435)	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	12,048,866	7,987,790	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 12,526,977	\$ 12,938,750	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 14,818,430	\$ 22,622,579	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,126,894	\$ 1,129,864	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,167	14,167	28
29	Short-Term Notes Payable	2,016,525	2,016,525	29
30	Accrued Salaries Payable	486,083	486,083	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,039	12,039	31
32	Accrued Real Estate Taxes(Sch.IX-B)		76,557	32
33	Accrued Interest Payable		101,972	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	94,958	94,958	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,750,666	\$ 3,932,165	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		17,260,356	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	17,859,843	17,859,843	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 17,859,843	\$ 35,120,199	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 21,610,509	\$ 39,052,364	46
47	TOTAL EQUITY(page 18, line 24)	\$ (6,792,079)	\$ (16,429,785)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 14,818,430	\$ 22,622,579	48

*(See instructions.)

STATE OF ILLINOIS

Page 17 - SUPP

Facility Name & ID Number	The Grove of Elmhurst	#	0053850	Report Period Beginning:	1/1/2025	Ending:	12/31/2025
Supplemental Schedule Of Other Assets And Liabilities			As of 12/31/2025				
	Other Current Assets	Amount	Amount		Other Current Liabilities	Amount	Amount
09A	Refund	46,233	46,233	36A	Accrued Accounting Fees	10,307	10,307
09B	Exchange	(11,861)	(11,861)	36B	Accrued Monthly Assessment Fee	72,220	72,220
09C	Insurance Refund Exchange	(217,373)	(217,373)	36C	Union Dues Payable	-	-
09D	Accounts Receivable - Quality Incentive	(445,824)	(445,824)	36D	Due To/From Medicare	(32,746)	(32,746)
09E	C.N.A. Tenure Program	772,971	772,971	36E	Due To Bcbs - Upp	18,196	18,196
09F	Employee Loans	5,438	5,438	36F			
09E	Due to/from Medicaid	2,918	2,918	36G			
09H	Bad Debt Part A - MMAI	-	-	36H			
09I	Capex Reserve Fund & Principal Sinking Fund		7,051,192	36I			
09J				36J			
		152,502	7,203,694			67,977	67,977
	Other Non-Current Assets:	Amount	Amount		Other Non-Current Liabilities	Amount	Amount
23A	Right Of Use Asset	10,345,606	10,345,606	43A	Due To/From Propco	1,326,866	1,326,866
23B	Security Deposit	338	338	43B	Due To/From Others	6,421,946	6,421,946
23C	Due To/From Others	3,447,454	(707,375)	43C	Right Of Use Lease Liability	10,111,031	10,111,031
23D	Accrued Management Fees Entities	(1,744,532)	(1,744,532)	43D			
23E	Deferred Rent		(137,305)	43E			
23F	Financing Fees		179,592	43F			
23G	Interest Rate Cap		37,055	43G			
23H	Prepaid Property Insurance		14,411	43H			
23I				43I			
23J				43J			
		12,048,866	7,987,790			17,859,843	17,859,843

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (6,883,393)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (6,883,393)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	91,314	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 91,314	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)	\$ (6,792,079)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The Grove of Elmhurst

0053850

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

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	\$ 21,040,948	1
2	Discounts and Allowances for all Levels	(5,487,192)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 15,553,756	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,138,081	6
7	Oxygen	1,884,558	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,022,639	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	226,097	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	23,984	19
20	Radiology and X-Ray	9,925	20
21	Other Medical Services	93,368	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 353,374	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,937	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,937	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Discounts and Rebates (adj on Pg 5)	314,482	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 314,482	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 19,251,188	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,851,467	31
32	Health Care	7,129,702	32
33	General Administration	3,412,197	33
	B. Capital Expense		
34	Ownership	1,746,365	34
	C. Ancillary Expense		
35	Special Cost Centers	3,114,361	35
36	Provider Participation Fee	905,782	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 19,159,874	40
41	Income before Income Taxes (line 30 minus line 40)**	91,314	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 91,314	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 2,857,851.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	7,697,484.00	45
46	MMAI-Medicaid is the Primary Payer	586,573.00	46
47	MMAI-Medicare is the Primary Payer	37,317.00	47
48	Private Pay	1,263,373.00	48
49	Medicare Part A	368,760.00	49
50	Other-(specify) Insurance	385,875.00	50
51	Other-(specify) Veterans	2,356,523.00	51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 15,553,756	56

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	1,912	2,028	\$ 179,305	\$ 88.41	1
2	Assistant Director of Nursing	1,872	2,120	115,648	54.55	2
3	Registered Nurses	19,727	22,168	1,158,658	52.27	3
4	Licensed Practical Nurses	26,497	31,345	1,363,036	43.48	4
5	CNAs & Orderlies	55,168	68,362	1,779,258	26.03	5
6	CNA Trainees					6
7	Licensed Therapist	15,642	18,417	962,735	52.27	7
8	Rehab/Therapy Aides	9,508	10,393	302,790	29.13	8
9	Activity Director	1,904	2,079	68,803	33.09	9
10	Activity Assistants	7,500	8,809	167,948	19.07	10
11	Social Service Workers	5,880	6,240	168,107	26.94	11
12	Dietician					12
13	Food Service Supervisor	1,896	2,080	91,988	44.23	13
14	Head Cook	9,634	11,305	249,947	22.11	14
15	Cook Helpers/Assistants	14,842	17,201	328,728	19.11	15
16	Dishwashers					16
17	Maintenance Workers	5,880	6,335	197,007	31.10	17
18	Housekeepers	18,782	22,884	433,924	18.96	18
19	Laundry	2,061	2,624	52,612	20.05	19
20	Administrator	1,968	2,120	196,811	92.84	20
21	Assistant Administrator	2,024	2,120	113,642	53.60	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,047	10,789	315,657	29.26	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,920	2,080	48,351	23.25	31
32	Other Health Care(specify)					32
33	Other(specify)			0		33
34	TOTAL (lines 1 - 33)	214,664	251,499	\$ 8,294,955 *	\$ 32.98	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 62,090	01-03	35
36	Medical Director	Monthly	60,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	430	10-03	38
39	Pharmacist Consultant	Monthly	22,374	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	731	11-03	44
45	Social Service Consultant	Monthly	663	12-03	45
46	Other(specify)				46
47	Psychiatrist	Per Visit	550	12-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 146,838		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	7,355	\$ 747,501	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	14,766	765,280	10-03	52
53	TOTAL (lines 50 - 52)	22,121	\$ 1,512,781		53

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

** See instructions.

Facility Name & ID Number		The Grove of Elmhurst		STATE OF ILLINOIS		# 0053850		Report Period Beginning:		01/01/2025		Page 21		Ending: 12/31/2025									
XIX. SUPPORT SCHEDULES																							
A. Administrative Salaries				Ownership				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions											
Name		Function		%		Amount		Description		Amount		Description		Amount									
Margaux Morris		Administrator		0		\$ 182,902		Workers' Compensation Insurance		\$ 110,607		IDPH License Fee		\$ 1,990									
Jonathan Madison		Assistant Admin		0		127,551		Unemployment Compensation Insurance		25,564		Advertising: Employee Recruitment											
								FICA Taxes		600,862		Health Care Worker Background Check											
								Employee Health Insurance		41,122		(Indicate # of checks performed 88)		884									
								Employee Meals				Patient Background Checks 876		8,755									
								Illinois Municipal Retirement Fund (IMRF)*				Association Dues (total from pg 22, #4)		30,624									
								401K Expense		34,014		Other Dues & Subscriptions		5,730									
TOTAL (agree to Schedule V, line 17, col. 1)								Union Pension				114,360		Licenses & Permits		936							
(List each licensed administrator separately.)				\$ 310,453				Other Employee Benefits				45,610		Allocation from Legacy Healthcare Financial				1,674					
B. Administrative - Other								Voluntary Benefit Contribution				20,870											
								Employee Physical Exams				7,891											
														Less: Public Relations Expense ()									
														PAC and Lobbying payments (15,312)									
														All non-allowable advertising ()									
								TOTAL (agree to Schedule V, line 22, col.8)				\$ 1,000,900		TOTAL (agree to Sch. V, line 20, col. 8)				\$ 35,281					
TOTAL (agree to Schedule V, line 17, col. 3)				\$				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**											
(Attach a copy of any management service agreement)																							
C. Professional Services																							
Vendor/Payee		Type				Amount		Description		Line #		Amount		Description		Amount							
See Attached		Legal				\$ 13,311						\$		Out-of-State Travel		\$							
Legacy Healthcare Financial Service		Accounting				50,877																	
Propay HR LLC		Payroll Software				29,610																	
Integra Scripts LLC		Cost Containment Solution				19,126								In-State Travel									
Onyx Procurement Solutions, LLC		Procurement Services				10,300																	
Achieve Accreditation LLC		Accreditation Services				8,956																	
Apploi Corp		Labor Management Consultant				8,569																	
Medicaid Done Right		MDR Platform Consulting				6,250								Seminar Expense		3,400							
AR Proactive Workflows		Billing Consultant				5,364																	
Compliagent		Compliance				2,654																	
PR Paycor		Payroll Software				2,563								Allocation from Legacy HC		844							
See Supplemental Schedule 1 and 2						9,189								Entertainment Expense ()									
TOTAL (agree to Schedule V, line 19, column 3)								TOTAL				\$		(agree to Sch. V, line 24, col. 8)									
(For legal fee disclosure, see page 39 of instructions)				\$ 166,768										TOTAL				\$ 4,244					
* Attach copy of IMRF notifications																**See instructions.							

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
			\$	Workers' Compensation Insurance		\$	IDPH License Fee	\$
				Unemployment Compensation Insurance			Advertising: Employee Recruitment	
				FICA Taxes			Health Care Worker Background Check	
				Employee Health Insurance			(Indicate # of checks performed)	
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$					
B. Administrative - Other								
Description			Amount					
			\$				Less: Public Relations Expense	()
							PAC and Lobbying payments	()
							All non-allowable advertising	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)		\$	TOTAL (agree to Sch. V, line 20, col. 8)	\$
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
Vital Records Control	Information Mngmt Solution		\$ 70			\$	Out-of-State Travel	\$
TAP Innovations, LLC	Data Analytics		66					
							In-State Travel	
							Seminar Expense	
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 136	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$

* Attach copy of IMRF notifications

**See instructions.

The Grove of Elmhurst
0053850
Legal Schedule
01/01/2025 - 12/31/2025

Date	G/L Account No.	Payee/Vendor	Type of Service Provided	Amount	Adjustment	Adjusted Amount
9/27/2024	580063	Neal Gerber Eisenberg	General Counsel	(122)	(122)	-
1/31/2025	580063	Stone Pogrund & Korey LLC	General Counsel	1,198	1,198	-
2/8/2025	580063	Corporation Service Company	Statutory Representation	104	-	104
2/28/2025	580063	Stone Pogrund & Korey LLC	General Counsel	1,738	1,738	-
3/31/2025	580063	Stone Pogrund & Korey LLC	General Counsel	400	400	-
4/23/2025	580063	Neal Gerber Eisenberg	General Counsel	48	-	48
4/30/2025	580063	Stone Pogrund & Korey LLC	General Counsel	3,497	-	3,497
5/31/2025	580063	Stone Pogrund & Korey LLC	General Counsel	860	860	-
5/31/2025	580063	Forbright	RLOC retainage	343	343	-
6/9/2025	580063	Corporation Service Company	Statutory Representation	198	198	-
6/30/2025	580063	Stone Pogrund & Korey LLC	General Counsel	934	-	934
7/31/2025	580063	Stone Pogrund & Korey LLC	General Counsel	690	-	690
8/25/2025	580063	Law Hesselbaum	General Counsel	85	-	85
8/31/2025	580063	Stone Pogrund & Korey LLC	General Counsel	622	-	622
8/31/2025	580063	Forbright	RLOC retainage	264	264	-
9/30/2025	580063	Stone Pogrund & Korey LLC	General Counsel	922	-	922
9/30/2025	580063	Forbright	RLOC retainage	36	36	-
11/21/2025	580063	Neal Gerber Eisenberg	General Counsel	38	-	38
11/30/2025	580063	Stone Pogrund & Korey LLC	General Counsel	127	-	127
12/17/2025	580063	Neal Gerber Eisenberg	General Counsel	90	-	90
12/31/2025	580063	Stone Pogrund & Korey LLC	General Counsel	248	248	-
1/7/2025	580063	Meyer Magence	General Counsel	700	-	700
8/12/2025	580063	Meyer Magence	General Counsel	88	-	88
12/12/2025	580063	Meyer Magence	General Counsel	206		206
						-
						-
						-
						-
						-
						-
						-
						-
Total				13,311	5,162	8,150

XX. GENERAL INFORMATION:

- (1)

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

No
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
HEALTH CARE COUNCIL OF IL (HCCI)	15,312
	15,312 Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

HEALTH CARE COUNCIL OF IL (HCCI)	15,312
	15,312 Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

HEALTH CARE COUNCIL OF IL (HCCI)	30,624
	30,624 Total
- (5)

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

\$ 74,304

Line 10
- (6)

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

Yes

If NO, attach a complete explanation.
- (7)

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

\$ 905,782

This amount is to be recorded on line 42 of Schedule V.
- (8)

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.

- (9)

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
- (10)

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.
- (11)

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

\$ None

Has any meal income been offset against related costs?

N/A

Indicate the amount.

\$
- (12)

Travel and Transportation

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

No

If YES, attach a complete explanation.

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

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$ N/A

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

100% LN1

d. Have vehicle usage logs been maintained?

Yes

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
- (13)

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

No

Firm Name:

N/A
- (14)

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

Yes
- (15)

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

See page 39 of the instructions for details.

Yes

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