		FOR BHF USE					

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0053918

Facility Name: The Grove of Northbrook

Address: 263 Skokie Boulevard (Number) Northbrook (City) 60062 (Zip Code)

County: Cook

Telephone Number: (847) 564-0505 **Fax #** (847) 564-3775

HFS ID Number:

Date of Initial License for Current Owners: 11/1/2012

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) 04/30/2021 (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title) Steven N. Lavenda, CPA — Partner
(Firm Name & Address) Marcum, LLP — 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	88	Skilled (SNF)	88	32,208	1
2		Skilled Pediatric (SNF/PED)			2
3	46	Intermediate (ICF)	46	16,836	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	134	TOTALS	134	49,044	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,385	317	1,819	5,521	8
9	SNF/PED					9
10	ICF	34,205	855	1,175	36,235	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,590	1,172	2,994	41,756	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.14%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/2012

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/2012 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 83 and days of care provided 1,511

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	456,722	46,202		502,924		502,924	2,529	505,453			1
2	Food Purchase		233,853		233,853		233,853	2,782	236,635			2
3	Housekeeping	119,709	25,524	1,025	146,258		146,258	1,640	147,898			3
4	Laundry	55,431	9,411	79,815	144,657		144,657	111	144,768			4
5	Heat and Other Utilities			126,336	126,336		126,336	(20,711)	105,625			5
6	Maintenance	98,894	14,840	106,515	220,249		220,249	1,846	222,095			6
7	Other (specify):*											7
8	TOTAL General Services	730,756	329,830	313,691	1,374,277		1,374,277	(11,802)	1,362,475			8
	B. Health Care and Programs											
9	Medical Director			20,000	20,000		20,000		20,000			9
10	Nursing and Medical Records	3,112,979	177,727	45,904	3,336,610		3,336,610	79,792	3,416,402			10
10a	Therapy	223,732			223,732		223,732		223,732			10a
11	Activities	147,884	4,157	21	152,062		152,062	6	152,068			11
12	Social Services	334,744		8,704	343,448		343,448	4,394	347,842			12
13	CNA Training											13
14	Program Transportation			24,508	24,508		24,508		24,508			14
15	Other (specify):*							4,557	4,557			15
16	TOTAL Health Care and Programs	3,819,339	181,884	99,137	4,100,360		4,100,360	88,749	4,189,109			16
	C. General Administration											
17	Administrative	163,130			163,130		163,130	48,908	212,038			17
18	Directors Fees											18
19	Professional Services			191,165	191,165	(38,508)	152,657	9,123	161,780			19
20	Dues, Fees, Subscriptions & Promotions			60,408	60,408		60,408	(29,034)	31,374			20
21	Clerical & General Office Expenses	205,203	1,361	287,910	494,474		494,474	41,420	535,894			21
22	Employee Benefits & Payroll Taxes			739,505	739,505		739,505		739,505			22
23	Inservice Training & Education											23
24	Travel and Seminar			393	393		393	109	502			24
25	Other Admin. Staff Transportation			178	178		178	3,656	3,834			25
26	Insurance-Prop.Liab.Malpractice			216,095	216,095		216,095	8,622	224,717			26
27	Other (specify):*							19,603	19,603			27
28	TOTAL General Administration	368,333	1,361	1,495,654	1,865,348	(38,508)	1,826,840	102,406	1,929,246			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,918,428	513,075	1,908,482	7,339,985	(38,508)	7,301,477	179,353	7,480,830			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.

Facility Name & ID Number The Grove of Northbrook #0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							226,763	226,763			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,311	12,311		12,311	320,885	333,196			32
33	Real Estate Taxes			243,575	243,575	38,508	282,083	145,124	427,207			33
34	Rent-Facility & Grounds			805,425	805,425		805,425	(805,349)	76			34
35	Rent-Equipment & Vehicles			3,120	3,120		3,120	3,392	6,512			35
36	Other (specify):*							44,926	44,926			36
37	**TOTAL Ownership**			1,064,431	1,064,431	38,508	1,102,939	(64,259)	1,038,680			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		280,699	448,591	729,290		729,290	(4,222)	725,068			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			329,125	329,125		329,125		329,125			42
43	Other (specify):*			439,602	439,602		439,602	(439,602)				43
44	**TOTAL Special Cost Centers**		280,699	1,217,318	1,498,017		1,498,017	(443,824)	1,054,193			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,918,428	793,774	4,190,231	9,902,433		9,902,433	(328,730)	9,573,703			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Reference	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	(21,566)	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	116,272	30		9
10	Interest and Other Investment Income	(12,554)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,964)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(66)	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	(418)	21		18
19	Entertainment	(121)	21		19
20	Contributions	(12,211)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(149,539)	21		24
25	Fund Raising, Advertising and Promotional	(4,974)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,545)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,264,490)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,356,176)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,027,447		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,027,447		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (328,729)		37

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

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

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

The Grove of Northbrook

ID# 0053918

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non Allowable Expense	$ (439,602)	43	1
2	Rebates	(936)	10	2
3	Patient Personal Items	(665)	10	3
4	Bank Charges	(6,991)	21	4
5	Sequestration	(8,888)	21	5
6	PAC Dues	(12,648)	20	6
7	Bldg Co - Filing Fees	(75)	20	7
8	Bldg Co - Accounting	(17,414)	19	8
9	Bldg Co - Legal Fees	(63,405)	19	9
10	Bldg Co - Amortization	(2,775)	36	10
11	Bldg Co - Prepayment Penalty	(700,142)	21	11
12	Capitalized R&M	(6,764)	06	12
13	Non Allowable Dues	(1,104)	20	13
14	Marketing Licenses	(839)	20	14
15	Non Allowable Legal	(2,083)	19	15
16	Prior Period Equipment Rental	(159)	35	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**	(1,264,490)		49

Detail lines 29 and 35 of Page 5 starting in C12. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 5B**

The Grove of Northbrook

IDF 0053918

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		b		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

Reference 1 Reference 2 Reference 3 Reference 4 Reference 5 Reference 6 Reference 7 Reference 9 Reference 10 Reference 10a Reference 11 Reference 12 Reference 13 Reference 14 Reference 15 Reference 17 Reference 18 Reference 19 Reference 20 Reference 21 Reference 22 Reference 23 Reference 24 Reference 25 Reference 26 Reference 27 Reference 30 Reference 31 Reference 32 Reference 33 Reference 34 Reference 35 Reference 36 Reference 38 Reference 39 Reference 40 Reference 41 Reference 42 Reference 43

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	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 (to Sch V, col.7)	
	A. General Services													
1	Dietary			2,529									2,529	1
2	Food Purchase	(2,030)		4,812									2,782	2
3	Housekeeping			1,640									1,640	3
4	Laundry			111									111	4
5	Heat and Other Utilities	(21,566)				855							(20,711)	5
6	Maintenance	(6,764)		8,222		829		(441)					1,846	6
7	Other (specify):*													7
8	**TOTAL General Services**	(30,360)		17,315		1,684		(441)					(11,802)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,601)		84,106					(2,713)				79,792	10
10a	Therapy													10a
11	Activities			6									6	11
12	Social Services			4,394									4,394	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				4,557								4,557	15
16	**TOTAL Health Care and Programs**	(1,601)		88,506	4,557				(2,713)				88,749	16
	C. General Administration													
17	Administrative			48,908									48,908	17
18	Directors Fees													18
19	Professional Services	(82,902)	80,819	16,056		360	(5,210)						9,123	19
20	Fees, Subscriptions & Promotions	(31,851)	75	2,741		0							(29,034)	20
21	Clerical & General Office Expenses	(870,644)	700,142	211,723		199							41,420	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			109									109	24
25	Other Admin. Staff Transportation			3,656									3,656	25
26	Insurance-Prop.Liab.Malpractice		8,311	96		215							8,622	26
27	Other (specify):*			19,603									19,603	27
28	**TOTAL General Administration**	(985,397)	789,347	302,892		774	(5,210)						102,406	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,017,358)	789,347	408,713	4,557	2,458	(5,210)	(441)	(2,713)				179,353	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Grove of Northbrook # 0053918 **Report Period Beginning:** 01/01/20 **Ending:** 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	116,272	105,215			5,276							226,763	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(12,554)	330,474			2,965							320,885	32
33	Real Estate Taxes		142,430			2,694							145,124	33
34	Rent-Facility & Grounds		(805,425)	24,827		(24,751)							(805,349)	34
35	Rent-Equipment & Vehicles	(159)			3,552								3,392	35
36	Other (specify):*	(2,775)	47,701										44,926	36
37	**TOTAL Ownership**	100,784	(179,605)	24,827	3,552	(13,816)							(64,259)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers										(4,222)		(4,222)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(439,602)											(439,602)	43
44	**TOTAL Special Cost Centers**	(439,602)									(4,222)		(443,824)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,356,176)	609,742	433,540	8,109	(11,358)	(5,210)	(441)	(2,713)		(4,222)		(328,730)	45

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 805,425	Brook Properties, LLC		$	$ (805,425)	1
2	V	32	Interest	268	Brook Properties, LLC		330,742	330,474	2
3	V	33	RE Taxes		Brook Properties, LLC		142,430	142,430	3
4	V	26	Property Insurance		Brook Properties, LLC		8,311	8,311	4
5	V	36	MIP Expense		Brook Properties, LLC		44,926	44,926	5
6	V	20	Filing Fees		Brook Properties, LLC		75	75	6
7	V	19	Accounting		Brook Properties, LLC		17,414	17,414	7
8	V	19	Legal Fees		Brook Properties, LLC		63,405	63,405	8
9	V	30	Depreciation		Brook Properties, LLC		105,215	105,215	9
10	V	36	Amortization		Brook Properties, LLC		2,775	2,775	10
11	V	21	Prepayment Penalty		Brook Properties, LLC		700,142	700,142	11
12	V								12
13	V								13
14	Total			$ 805,693			$ 1,415,435	$ * 609,742	14

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	GPN Family Trust	50.00%	Astoria Place Skilled Nursing Facility LLC	Chicago	Brook Properties, LLC		Building Company	1
2	DOROS Generation Trust	50.00%	Avantara Arlington	Arlington, SD	Legacy HC & Financial Services	Lincolnwood	Home Office/Bookkeeping	2
3			Avantara Armour	Armour, SD	CF St. Louis LLC	Skokie	Building Company	3
4			Avantara Arrowhead	Rapid City, SD	ML Group Design & Development	Skokie	Asset Management	4
5			Avantara Aurora	Aurora	ReMED Services LLC	Lincolnwood	Nursing Equipment	5
6			Avantara Billings	Billings, MT	Propay HR	Evanston	Payroll Processing	6
7			Avantara Clark	Clark, SD	Ecobrite Linen	Skokie	Laundry Supplies	7
8			Avantara Elgin	Elgin	Aurora Supportive Living	Aurora	Supportive Living	8
9			Avantara Evergreen Park	Evergreen Park	Terrace Gardens	Morton Grove	Assisted Living	9
10			Avantara Groton	Groton, SD	Lincolnshire Assisted Living Center	Lincolnshire	Assisted Living	10
11			Avantara Huron	Huron, SD	Wellshire Park Place	Milbank, SD	Assisted Living	11
12			Avantara Ipswich	Ipswich, SD	Wellshire Huron	Huron, SD	Assisted Living	12
13			Avantara Lake Norden	Lake Norden, SD	Lifescan Labs of Illinois	Skokie	Laboratory	13
14			Avantara Long Grove	Long Grove				14
15			Avantara Milbank	Milbank, SD				15
16			Avantara Mountainview	Rapid City, SD				16
17			Avantara North	Rapid City, SD				17
18			Avantara Norton	Sioux Falls, SD				18
19			Avantara Park Ridge	Park Ridge				19
20			Avantara Pierre	Pierre, SD				20
21			Avantara Redfield	Redfield, SD				21
22			Avantara Salem	Salem, SD				22
23			Avantara St. Cloud	Rapid City, SD				23
24			Avantara Watertown	Watertown, SD				24
25			Bella Terra Streamwood	Streamwood				25
26			Bella Terra Wheeling	Wheeling				26
27			Bethany Terrace	Morton Grove				27
28			Carlton Skilled Nursing Facility LLC	Chicago				28
29			Chalet Skilled Nursing Facility LLC	Chicago				29
30			Clark Skilled Nursing Facility	Chicago				30

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietician Salary	$	Legacy Healthcare Financial Services		$ 2,516	$ 2,516	15
16	V	01	Dietary Supplies		Legacy Healthcare Financial Services		13	13	16
17	V	02	Food		Legacy Healthcare Financial Services		4,812	4,812	17
18	V	03	Housekeeping		Legacy Healthcare Financial Services		1,640	1,640	18
19	V	04	Linen Replacement		Legacy Healthcare Financial Services		111	111	19
20	V	06	Maintenance Salary		Legacy Healthcare Financial Services		7,761	7,761	20
21	V	06	Repairs & Maintenance		Legacy Healthcare Financial Services		461	461	21
22	V	10	Nursing Salary		Legacy Healthcare Financial Services		64,241	64,241	22
23	V	10	Nurse/Medical Director Consultant		Legacy Healthcare Financial Services		6,063	6,063	23
24	V	10	Medical Supplies		Legacy Healthcare Financial Services		13,802	13,802	24
25	V	12	Social Service Salary		Legacy Healthcare Financial Services		4,376	4,376	25
26	V	11	Activities Program		Legacy Healthcare Financial Services		6	6	26
27	V	12	Social Service Consultant		Legacy Healthcare Financial Services		17	17	27
28	V	17	COO / Administrative Salary		Legacy Healthcare Financial Services		48,908	48,908	28
29	V	19	Professional Fees		Legacy Healthcare Financial Services		16,056	16,056	29
30	V	20	Dues / Licenses / Permits		Legacy Healthcare Financial Services		2,741	2,741	30
31	V	21	Clerical & General Wages		Legacy Healthcare Financial Services		197,333	197,333	31
32	V	21	Clerical & Office Expense		Legacy Healthcare Financial Services		14,390	14,390	32
33	V	24	Education & Seminars		Legacy Healthcare Financial Services		109	109	33
34	V	25	Travel		Legacy Healthcare Financial Services		3,656	3,656	34
35	V	26	Insurance - General		Legacy Healthcare Financial Services		96	96	35
36	V	27	Non-Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		19,603	19,603	36
37	V	34	Rent		Legacy Healthcare Financial Services		24,751	24,751	37
38	V	34	Offsite Storage / Parking		Legacy Healthcare Financial Services		76	76	38
39	Total			$			$ 433,540	$ * 433,540	39

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Equipment Rental		Legacy Healthcare Financial Services		330	$ 330	15
16	V	35	Auto Rental		Legacy Healthcare Financial Services		3,221	3,221	16
17	V	15	Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		4,557	4,557	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			$			$ 8,109	$ * 8,109	39

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	CF St. Louis LLC		$ 855	$ 855	15
16	V	6	Repairs & Maintenance		CF St. Louis LLC		829	829	16
17	V	19	Property Valuation Fee		CF St. Louis LLC		293	293	17
18	V	19	Accounting Fees		CF St. Louis LLC		67	67	18
19	V	20	Dues & Subscriptions		CF St. Louis LLC		0	0	19
20	V	21	Office Expense		CF St. Louis LLC		199	199	20
21	V	26	Insurance		CF St. Louis LLC		215	215	21
22	V	30	Depreciation		CF St. Louis LLC		5,276	5,276	22
23	V	32	Interest Expense		CF St. Louis LLC		2,965	2,965	23
24	V	33	Real Estate Taxes		CF St. Louis LLC		2,694	2,694	24
25	V								25
26	V	34	Rent	24,751	CF St. Louis LLC			(24,751)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 24,751			$ 13,393	$ * (11,358)	39

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	$ 22,740	ProPay HR LLC		$ 17,530	$ (5,210)	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			$ 22,740			$ 17,530	$ * (5,210)	39

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance	$ 18,000	ML Group Design & Development		$ 17,559	$ (441)	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			$ 18,000			$ 17,559	$ * (441)	39

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

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

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

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	04	Laundry Services	$ 68,968	EcoBrite Linen		$ 68,968	$	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			$ 68,968			$ 68,968	$ *	39

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Laboratory	$ 10,373	Lifescan Labs of Illinois		$ 6,151	$ (4,222)	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			$ 10,373			$ 6,151	$ * (4,222)	39

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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

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

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 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 Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

Name of Related Organization: Legacy Healthcare Financial Services
Street Address: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 679-9797
Fax Number: (847) 683-2900

	1 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	01	Dietician Salary	Available Bed Days	2,540,133	53	$ 130,303	$ 130,303	49,044	$ 2,516	1
2	01	Dietary Supplies	Available Bed Days	2,540,133	53	697		49,044	13	2
3	02	Food	Available Bed Days	2,540,133	53	249,220		49,044	4,812	3
4	03	Housekeeping	Available Bed Days	2,540,133	53	84,952		49,044	1,640	4
5	04	Linen Replacement	Available Bed Days	2,540,133	53	5,771		49,044	111	5
6	06	Maintenance Salary	Available Bed Days	2,540,133	53	401,986	401,986	49,044	7,761	6
7	06	Repairs & Maintenance	Available Bed Days	2,540,133	53	23,857		49,044	461	7
8	10	Nursing Salary	Available Bed Days	2,540,133	53	3,327,223	3,327,223	49,044	64,241	8
9	10	Nurse/Medical Director Consultan	Available Bed Days	2,540,133	53	314,035		49,044	6,063	9
10	10	Medical Supplies	Available Bed Days	2,540,133	53	714,824		49,044	13,802	10
11	12	Social Service Salary	Available Bed Days	2,540,133	53	226,662	226,662	49,044	4,376	11
12	11	Activities Program	Available Bed Days	2,540,133	53	335		49,044	6	12
13	12	Social Service Consultant	Available Bed Days	2,540,133	53	893		49,044	17	13
14	17	COO / Administrative Salary	Available Bed Days	2,540,133	53	2,533,078	2,533,078	49,044	48,908	14
15	19	Professional Fees	Available Bed Days	2,540,133	53	831,592		49,044	16,056	15
16	20	Dues / Licenses / Permits	Available Bed Days	2,540,133	53	141,983		49,044	2,741	16
17	21	Clerical & General Wages	Available Bed Days	2,540,133	53	10,220,453	10,220,453	49,044	197,333	17
18	21	Clerical & Office Expense	Available Bed Days	2,540,133	53	745,293		49,044	14,390	18
19	24	Education & Seminars	Available Bed Days	2,540,133	53	5,655		49,044	109	19
20	25	Travel	Available Bed Days	2,540,133	53	189,364		49,044	3,656	20
21	26	Insurance - General	Available Bed Days	2,540,133	53	4,997		49,044	96	21
22	27	Non-Nursing Payroll Taxes / Bene	Available Bed Days	2,540,133	53	1,015,274		49,044	19,603	22
23	34	Rent	Available Bed Days	2,540,133	53	1,281,940		49,044	24,751	23
24	34	Offsite Storage / Parking	Available Bed Days	2,540,133	53	3,949		49,044	76	24
25	TOTALS					$ 22,454,338	$ 16,839,706		$ 433,540	25

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

Name of Related Organization: Legacy Healthcare Financial Services
Street Address: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 679-9797
Fax Number: (847) 683-2900

	1 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	35	Equipment Rental	Available Bed Days	2,540,133	53	17,109		49,044	330	1
2	35	Auto Rental	Available Bed Days	2,540,133	53	166,843		49,044	3,221	2
3	15	Nursing Payroll Taxes / Benefits	Available Bed Days	2,540,133	53	236,021		49,044	4,557	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 419,973	$		$ 8,109	25

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] 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	Available Bed Days	2,540,133	53	$ 44,301	$	49,044	$ 855	1
2	6	Repairs & Maintenance	Available Bed Days	2,540,133	53	42,932		49,044	829	2
3	19	Property Valuation Fee	Available Bed Days	2,540,133	53	15,181		49,044	293	3
4	19	Accounting Fees	Available Bed Days	2,540,133	53	3,453		49,044	67	4
5	20	Dues & Subscriptions	Available Bed Days	2,540,133	53	23		49,044	0	5
6	21	Office Expense	Available Bed Days	2,540,133	53	10,298		49,044	199	6
7	26	Insurance	Available Bed Days	2,540,133	53	11,124		49,044	215	7
8	30	Depreciation	Available Bed Days	2,540,133	53	273,261		49,044	5,276	8
9	32	Interest Expense	Available Bed Days	2,540,133	53	153,558		49,044	2,965	9
10	33	Real Estate Taxes	Available Bed Days	2,540,133	53	139,524		49,044	2,694	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					$ 693,655	$		$ 13,393	25

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] 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, Illinois 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			$	$		$ 17,530	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					$	$		$ 17,530	25

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] 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 60077
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			$	$		$ 17,559	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					$	$		$ 17,559	25

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

Name of Related Organization: ReMED Services LLC
Street Address: 3424 Oakton Street, Suite 102
City / State / Zip Code: Skokie, IL
Phone Number: (847) 440-2600
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Medical Supplies	Direct			$	$		$ 6,287	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 6,287	25

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

Name of Related Organization: EcoBrite Linen
Street Address: 3712 Jarvis Avenue
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 582-4000
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	04	Laundry Services	Direct			$	$		$ 68,968	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					$	$		$ 68,968	25

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

Name of Related Organization: Lifescan Labs of Illinois, LLC
Street Address: 5255 Golf Road
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 663 - 8300
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	39	Laboratory	Direct			$	$		$ 6,151	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 6,151	25

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 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 Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	CIBC		X	Mortgage			$	$ 7,696,689			$ 330,742	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CIBC		X	Note Payable				13,488			12,311	6
7												7
8												8
9	TOTAL Facility Related						$	$ 7,710,177			$ 343,053	9
	B. Non-Facility Related*											
10	Interest Income		X								(12,554)	10
11	Interest Income - Bldg Co		X								(268)	11
12	Allocated from CF St. Louis	X									2,965	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (9,857)	14
15	TOTALS (line 9+line14)						$	$ 7,710,177			$ 333,196	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 44,926 Line # 36

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

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 386,514	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.)		$ 353,509	2
3. Under or (over) accrual (line 2 minus line 1).		$ (33,005)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 421,704	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.)		$ 38,508	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.		$ 427,207	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	281,261	8
	2016	325,300	9
	2017	358,593	10
	2018	368,109	11
	2019	350,815	12

2020 Accrual = $350,815 x 1.20 = $421,704

Allocated from CF St. Louis $2,694

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

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** This denial must be no more than four years old at the time the cost report is filed.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Grove of Northbrook COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053918

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ( )

A. **Summary of Real Estate Tax Cost**

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-02-202-047-0000	Long Term Care Property	$ 350,815.39	$ 350,815.39
2.	10-23-406-034-0000	Home Office Allocation	$ 459,532.44	$ 2,693.88
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 810,347.83	$ 353,509.27

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

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

IMPORTANT NOTICE

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

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

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

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Grove of Northbrook COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053918

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

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

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame Brick Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 667,000	1
2	Allocated from CF St. Louis, LLC			3,810	2
3	TOTALS			$ 670,810	3

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	134		2012	1976	$ 4,410,000	$ 105,215	35	$ 126,000	$ 20,785	$ 1,008,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2012	5,642		20	282	282	1,998	9
10	Various			2013	27,362		20	1,368	1,368	10,475	10
11	Various			2014	114,877		20	5,744	5,744	75,266	11
12	Various			2015	30,549		20	1,527	1,527	7,637	12
13	Various			2016	123,045		20	6,152	6,152	30,761	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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		17,904			895	895	8,055	67
68	Related Party Allocations (Pages 12H & 12I)		179,336	4,864		8,527	3,663	38,148	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 4,908,714	$ 110,079		$ 150,496	$ 40,417	$ 1,180,341	70

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,908,714	$ 110,079		$ 150,496	$ 40,417	$ 1,180,341	1
2	Removal Of Wallpaper And Painting In Common Areas	2017	9,130		20	457	457	1,521	2
3	Repaired A/C Unit	2017	9,457		20	473	473	1,734	3
4	Replacement Of Fan And Exhausting Pipe For The Dishwasher	2017	5,600		20	280	280	794	4
5	Replaced A/C With Air Handler	2017	5,500		20	275	275	1,650	5
6	Replaced Waterguard Systems	2017	3,595		20	180	180	1,080	6
7	Performed Load Bank Test And Repaired Exhaust Problem	2017	9,239		20	462	462	2,156	7
8	Installation Of Light Fixtures	2017	10,600		20	530	530	1,678	8
9	Signage	2017	5,121		20	256	256	1,024	9
10	Installed Passage And Entrance Locks, Lever Handles	2018	5,765		20	288	288	1,105	10
11	Installed New Door Handles, Knobs For Resident Rooms, Baths	2018	3,850		20	193	193	738	11
12	Repaired Awning/Entrance Canopy Over Building	2018	3,658		20	183	183	671	12
13	Installed Kitchen Ventilation System - Piping/Ductwork	2018	14,220		20	711	711	2,370	13
14	Exhaust Duct System	2018	3,101		20	155	155	478	14
15	Roof - Removal And Installation Of Mounted Exhaust Fan (3510)	2018	3,249		20	162	162	501	15
16	Ventilation System Kitchen - Upflow Exhaust Fan Installation (34	2018	3,194		20	160	160	479	16
17	Flooring - Vinyl Tile Installation In Pt Room ($7,271)	2019	6,730		20	337	337	740	17
18	Therapy Rm - Electricity,Flr Tile, Wallpaper, Plumbing ($60,555)	2019	56,050		20	2,802	2,802	6,503	18
19	Installation Of New Call Light System ($19,021)	2019	17,606		20	880	880	1,726	19
20	Hot Water Boiler Leak Repair ($9687)	2019	9,388		20	469	469	792	20
21	Radiator Repair - Replace Hoses,Coolant And Batteries ($2,746.44	2019	2,662		20	133	133	266	21
22	Kitchen - Tile Installation ($6,350)	2019	6,154		20	308	308	615	22
23	Install Exit Door & Frame On Nw Side Of Building (12,500)	2020	12,194		20	610	610	610	23
24	Asphalt Repairs (33,000)	2020	32,192		20	1,610	1,610	1,610	24
25	Replace Pump (11,000)	2020	10,731		20	537	537	537	25
26	Replace Cooling Fan (4,715)	2020	4,599		20	230	230	230	26
27	Replace Basement Water Piping (6,764)	2020	6,598		20	330	330	330	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,168,896	$ 110,079		$ 163,505	$ 53,426	$ 1,212,277	34

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,168,896	$ 110,079		$ 163,505	$ 53,426	$ 1,212,277	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,168,896	$ 110,079		$ 163,505	$ 53,426	$ 1,212,277	34

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 5,168,896	$ 110,079		$ 163,505	$ 53,426	$ 1,212,277	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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17									17
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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)		$ 5,168,896	$ 110,079		$ 163,505	$ 53,426	$ 1,212,277	34

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 5,168,896	$ 110,079		$ 163,505	$ 53,426	$ 1,212,277	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		$ 5,168,896	$ 110,079		$ 163,505	$ 53,426	$ 1,212,277	34

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Boiler repair, pressure gauge, heat pump repair	2013	17,904		20	895	895	8,055	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 17,904	$		$ 895	$ 895	$ 8,055	34

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 17,904	$		$ 895	$ 895	$ 8,055	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 17,904	$		$ 895	$ 895	$ 8,055	34

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party								1
2	Buildings:								2
3	Allocated from CF St. Louis, LLC	2016	20,518	953	35	586	(366)	2,931	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	127,386	3,143	20	6,369	3,227	31,847	9
10	Allocated from CF St. Louis, LLC	2017	2,957	73	20	148	75	591	10
11	Allocated from CF St. Louis, LLC	2019	26,799	661	20	1,340	679	2,680	11
12	Allocated from CF St. Louis, LLC	2019	1,409	35	20	70	36	70	12
13									13
14	Allocated from Legacy HC	2018	152		20	8	8	23	14
15	Allocated from Legacy HC	2020	115		20	6	6	6	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 179,336	$ 4,864		$ 8,527	$ 3,663	$ 38,148	34

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 179,336	$ 4,864		$ 8,527	$ 3,663	$ 38,148	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 179,336	$ 4,864		$ 8,527	$ 3,663	$ 38,148	34

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 632,553	$ 411	$ 63,255	$ 62,845	10	$ 472,940	71
72	Current Year Purchases	27	1	3	1	10	3	72
73	Fully Depreciated Assets	89,853				10	89,853	73
74								74
75	TOTALS	$ 722,433	$ 412	$ 63,258	$ 62,846		$ 562,796	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)	$ 6,562,140	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 110,491	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 226,763	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 116,272	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,775,073	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	Legal Fees - 2012	$ 4,200	$	$	86
87	Legal Fees - 2012	5,036			87
88					88
89					89
90					90
91	TOTALS	$ 9,236	$	$	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.

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Legacy Healthcare				76			5
6								6
7	TOTAL				$ 76 **			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: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 3,291 Description: See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Legacy Healthcare		$	$ 3,221	17
18					18
19					19
20					20
21	TOTAL		$	$ 3,221	21

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

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

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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
   - [X] 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 Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 154,993	$		$ 154,993	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			80,624			80,624	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			159,193			159,193	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				163,577		163,577	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					53,781	117,122		170,903	13
14	TOTAL			$		$ 448,591	$ 280,699		$ 729,290	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.

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/20 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 67,947	$ 556,592	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	327,756	327,756	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	209,776	231,720	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	116,129	142,240	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 721,608	$ 1,258,308	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		667,000	13
14	Buildings, at Historical Cost		3,315,819	14
15	Leasehold Improvements, at Historical Cost	328,354	613,158	15
16	Equipment, at Historical Cost	153,194	1,498,815	16
17	Accumulated Depreciation (book methods)	(144,639)	(2,342,333)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	1,956,792	2,731,960	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,293,701	$ 6,484,419	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,015,309	$ 7,742,727	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 354,418	$ 357,171	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	13,488	159,930	29
30	Accrued Salaries Payable	304,195	304,195	30
31	Accrued Taxes Payable (excluding real estate taxes)	228,511	228,511	31
32	Accrued Real Estate Taxes(Sch.IX-B)	53,348	421,704	32
33	Accrued Interest Payable	7,473	34,091	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	719,202	810,202	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,680,635	$ 2,315,804	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,550,247	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	1,021,793	940,107	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,021,793	$ 8,490,354	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,702,428	$ 10,806,158	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 312,881	$ (3,063,431)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,015,309	$ 7,742,727	48

***(See instructions.)**

Facility Name & ID Number The Grove of Northbrook # 0053918 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 766,055	1
2	Restatements (describe):		2
3	Bad Debts	196,858	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 962,913	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(150,276)	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	(499,756)	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)**	$ (650,032)	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)**	$ 312,881	24 *

*** This must agree with page 17, line 47.**

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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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,590,525	1
2	Discounts and Allowances for all Levels	(6,088,841)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,501,684	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,109,707	6
7	Oxygen	214	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,109,921	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	150,869	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,770	19
20	Radiology and X-Ray		20
21	Other Medical Services	19,066	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 185,705	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,554	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,554	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	942,293	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 942,293	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,752,157	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,374,277	31
32	Health Care	4,100,360	32
33	General Administration	1,865,348	33
	B. Capital Expense		
34	Ownership	1,064,431	34
	C. Ancillary Expense		
35	Special Cost Centers	1,168,892	35
36	Provider Participation Fee	329,125	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,902,433	40
41	**Income before Income Taxes (line 30 minus line 40)****	(150,276)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (150,276)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,631,961	44
45	Private Pay - Net Inpatient Revenue	203,857	45
46	Medicare - Net Inpatient Revenue	436,016	46
47	Other-(specify) Insurance	107,470	47
48	Other-(specify) Veterans	122,380	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,501,684	49

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,014	2,288	$ 131,868	$ 57.63	1
2	Assistant Director of Nursing	2,240	2,309	115,294	49.93	2
3	Registered Nurses	23,021	28,940	1,102,692	38.10	3
4	Licensed Practical Nurses	11,639	13,801	480,889	34.84	4
5	CNAs & Orderlies	44,414	54,243	1,137,987	20.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,654	9,545	223,732	23.44	8
9	Activity Director	2,024	2,228	40,819	18.32	9
10	Activity Assistants	6,763	7,664	107,065	13.97	10
11	Social Service Workers	9,896	10,858	305,116	28.10	11
12	Dietician	594	618	18,388	29.75	12
13	Food Service Supervisor	2,032	2,160	80,033	37.05	13
14	Head Cook	6,514	7,837	170,208	21.72	14
15	Cook Helpers/Assistants	10,592	11,749	188,093	16.01	15
16	Dishwashers					16
17	Maintenance Workers	3,277	3,939	98,894	25.11	17
18	Housekeepers	5,870	6,947	119,709	17.23	18
19	Laundry	1,950	2,890	55,431	19.18	19
20	Administrator	2,016	2,120	163,130	76.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,113	11,182	205,203	18.35	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,880	2,552	97,098	38.05	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	3,914	4,312	76,779	17.81	33
34	TOTAL (lines 1 - 33)	156,417	188,182	$ 4,918,428 *	$ 26.14	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	20,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	42,454	10-03	38
39	Pharmacist Consultant	Monthly	3,450	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	1	21	11-03	44
45	Social Service Consultant	145	8,704	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	146	$ 74,629		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Scott Schayer	Administrator	0	$ 163,130
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 163,130

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 24,000
ProPay HR	Payroll Processing	22,740
Onyx Procurement Solutions	Procurement Services	9,670
Achieve Accreditation	Accreditation	9,315
Allscripts	Healthcare IT	131
Compliagent	Compliance	3,666
Hygieneering, Inc.	Hygiene & Safety Consulting	1,097
IIT/Sourcetech	Data Processing	1,200
Personnel Planners	Unemployment Consultant	630
Prospect Resources	Energy Procurement	750
See Attached	Legal	110,559
See Supplemental Schedule		7,408
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 191,166

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 60,949
Unemployment Compensation Insurance	18,354
FICA Taxes	376,260
Employee Health Insurance	204,184
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	23,760
401K Expense	20,487
Voluntary Benefit Contributions	14,275
Employee Physical Exams	1,459
Other Employee Benefits	19,777
TOTAL (agree to Schedule V, line 22, col.8)	$ 739,505

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,492
Advertising: Employee Recruitment	468
Health Care Worker Background Check	
(Indicate # of checks performed 104)	1,048
Patient Background Checks 78	786
Dues & Subscriptions	24,409
Licenses & Fees	429
See Supplemental Schedule	2,742
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,374

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	393
See Supplemental Schedule	109
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 502

* Attach copy of IMRF notifications

**See instructions.

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI $18,961 ; IHCA $11,524**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **23,344** Line **10**

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

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

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

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Grove of Northbrook Living and Rehab; IDPH #0052050; November 1, 2015

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **329,125**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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