

		FOR BHF USE					

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

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

<p><b>I. IDPH License ID Number:</b> <u>0055038</u></p> <p><b>Facility Name:</b> <u>Grove of St Charles</u></p> <p><b>Address:</b> <u>611 Allen Lane</u> <u>St Charles</u> <u>60174</u>  Number City Zip Code</p> <p><b>County:</b> <u>Kane</u></p> <p><b>Telephone Number:</b> <u>(630) 377-2211</u> Fax # <u>(630) 377-4060</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>10/1/2018</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/20</u> to <u>12/31/20</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="3"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) _____ (Date) _____</td> </tr> <tr> <td>(Title) _____</td> </tr> <tr> <td rowspan="5"><b>Paid Preparer</b></td> <td>(Signed) _____</td> </tr> <tr> <td>* Subject to the attached Accountants' Consulting Report (Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name &amp; Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u></td> </tr> <tr> <td>(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td> </tr> </table>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) _____ (Date) _____	(Title) _____	<b>Paid Preparer</b>	(Signed) _____	* Subject to the attached Accountants' Consulting Report (Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																	
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	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>																																		
<p>In the event there are further questions about this report, please contact:  Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u>  Email Address: _____</p>	<p>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</p>																																		

Facility Name & ID Number Grove of St Charles

# 0055038 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,920	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,920	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	26,239	3,539	4,666	34,444	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,239	3,539	4,666	34,444	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.42%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

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

I. On what date did you start providing long term care at this location?  
Date started 10/1/2018

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 10/1/2018 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 120 and days of care provided 3,670

Medicare Intermediary National Government Services

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number Grove of St Charles # 0055038 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary		3,144	777,582	780,726		780,726	2,265	782,991		1
2	Food Purchase		1,029		1,029		1,029	4,309	5,338		2
3	Housekeeping		2,839	286,577	289,416		289,416	1,469	290,885		3
4	Laundry	30,860	17,620	52,776	101,256		101,256	100	101,356		4
5	Heat and Other Utilities			168,835	168,835		168,835	(9,894)	158,941		5
6	Maintenance	66,140	8,184	102,153	176,477		176,477	5,140	181,617		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	97,000	32,816	1,387,923	1,517,739		1,517,739	3,389	1,521,128		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	2,968,387	327,918	279,006	3,575,311		3,575,311	71,324	3,646,635		10
10a	Therapy	88,806			88,806		88,806		88,806		10a
11	Activities	113,601	6,033	1,451	121,085		121,085	6	121,091		11
12	Social Services	256,076		4,566	260,642		260,642	3,935	264,577		12
13	CNA Training										13
14	Program Transportation			40,483	40,483		40,483		40,483		14
15	Other (specify):*							4,081	4,081		15
16	<b>TOTAL Health Care and Programs</b>	3,426,870	333,951	343,506	4,104,327		4,104,327	79,345	4,183,672		16
	<b>C. General Administration</b>										
17	Administrative	174,757			174,757		174,757	43,798	218,555		17
18	Directors Fees										18
19	Professional Services			93,006	93,006	(262)	92,744	2,776	95,519		19
20	Dues, Fees, Subscriptions & Promotions			53,207	53,207		53,207	(22,107)	31,100		20
21	Clerical & General Office Expenses	139,618	1,620	361,015	502,253		502,253	(43,045)	459,208		21
22	Employee Benefits & Payroll Taxes			590,523	590,523		590,523		590,523		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,236	1,236		1,236	98	1,334		24
25	Other Admin. Staff Transportation			2,050	2,050		2,050	3,274	5,324		25
26	Insurance-Prop.Liab.Malpractice			180,380	180,380		180,380	279	180,659		26
27	Other (specify):*							17,555	17,555		27
28	<b>TOTAL General Administration</b>	314,375	1,620	1,281,417	1,597,412	(262)	1,597,150	2,627	1,599,776		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,838,245	368,387	3,012,846	7,219,478	(262)	7,219,216	85,360	7,304,576		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 &amp; ID Number

Grove of St Charles

#0055038

Report Period Beginning:

01/01/20

Ending:

12/31/20

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation							162,497	162,497			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,990	33,990		33,990	321,962	355,952			32
33	Real Estate Taxes			132,000	132,000	262	132,262	2,412	134,675			33
34	Rent-Facility & Grounds			563,067	563,067		563,067	(562,998)	69			34
35	Rent-Equipment & Vehicles			8,623	8,623		8,623	3,181	11,804			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			737,680	737,680	262	737,942	(72,947)	664,996			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		313,505	558,226	871,731		871,731	(10,079)	861,652			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			253,194	253,194		253,194		253,194			42
43	Other (specify):*			448,576	448,576		448,576	(448,576)	0			43
44	<b>TOTAL Special Cost Centers</b>		313,505	1,259,996	1,573,501		1,573,501	(458,655)	1,114,846			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,838,245	681,892	5,010,522	9,530,659		9,530,659	(446,241)	9,084,418			45

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

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(10,660)	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	31,618	30		9
10	Interest and Other Investment Income	(586)	32		10
11	Discounts, Allowances, Rebates & Refunds	(136)	10		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		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	(9,802)	21		18
19	Entertainment	(8,069)	21		19
20	Contributions	(12,250)	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	(194,432)	21		24
25	Fund Raising, Advertising and Promotional	(7,268)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(531,216)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (742,801)		\$	30

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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)	296,559		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 296,559		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (446,242)		37

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

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

		1	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>							
48		49		50		51	

Grove of St Charles

ID# 0055038

Report Period Beginning: 01/01/20

Ending: 12/31/20

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Non-Allowable Expense	\$ (447,829)	43	1
2	Patient Personal Items	(1,146)	10	2
3	Sequestration Expense	(20,523)	21	3
4	Capitalized R&M	(2,965)	06	4
5	Chamber of Commerce	(325)	20	5
6	PAC Dues	(4,200)	20	6
7	Non-Allowable Expense	(747)	43	7
8	Non-Allowable Legal	(7,814)	19	8
9	Out of Period Dues	(519)	20	9
10	Building Co. - State Income Tax	(1,263)	21	10
11	Building Co. - Accounting Fees	(3,191)	19	11
12	Building Co. - Asset Management Fees	(27,500)	06	12
13	Building Co. - Amortization	(13,194)	36	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(531,216)		49



## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Grove of St Charles# 0055038

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			2,265									2,265	1
2	Food Purchase			4,309									4,309	2
3	Housekeeping			1,469									1,469	3
4	Laundry			100									100	4
5	Heat and Other Utilities	(10,660)				766							(9,894)	5
6	Maintenance	(30,465)	27,500	7,363		742							5,140	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(41,125)</b>	<b>27,500</b>	<b>15,506</b>		<b>1,508</b>							<b>3,389</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(1,282)		75,319			(2,713)						71,324	10
10a	Therapy													10a
11	Activities			6									6	11
12	Social Services			3,935									3,935	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				4,081								4,081	15
16	<b>TOTAL Health Care and Programs</b>	<b>(1,282)</b>		<b>79,259</b>	<b>4,081</b>		<b>(2,713)</b>						<b>79,345</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			43,798									43,798	17
18	Directors Fees													18
19	Professional Services	(11,005)	3,191	14,379		322		(4,111)					2,776	19
20	Fees, Subscriptions & Promotions	(24,562)		2,455		0							(22,107)	20
21	Clerical & General Office Expenses	(234,089)	1,263	189,603		178							(43,045)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			98									98	24
25	Other Admin. Staff Transportation			3,274									3,274	25
26	Insurance-Prop.Liab.Malpractice			86		192							279	26
27	Other (specify):*			17,555									17,555	27
28	<b>TOTAL General Administration</b>	<b>(269,656)</b>	<b>4,454</b>	<b>271,247</b>		<b>693</b>		<b>(4,111)</b>					<b>2,627</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(312,063)</b>	<b>31,954</b>	<b>366,011</b>	<b>4,081</b>	<b>2,202</b>	<b>(2,713)</b>	<b>(4,111)</b>					<b>85,360</b>	<b>29</b>



STATE OF ILLINOIS

Summary B

Facility Name & ID Number Grove of St Charles # 0055038 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 (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	31,618	126,154			4,725							162,497	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(586)	319,893			2,655							321,962	32
33	Real Estate Taxes					2,412							2,412	33
34	Rent-Facility & Grounds		(563,067)	22,233		(22,165)							(562,998)	34
35	Rent-Equipment & Vehicles				3,181								3,181	35
36	Other (specify):*	(13,194)	13,194											36
37	<b>TOTAL Ownership</b>	<b>17,838</b>	<b>(103,826)</b>	<b>22,233</b>	<b>3,181</b>	<b>(12,373)</b>							<b>(72,947)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(10,079)				(10,079)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(448,576)											(448,576)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(448,576)</b>							<b>(10,079)</b>				<b>(458,655)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(742,801)</b>	<b>(71,872)</b>	<b>388,245</b>	<b>7,262</b>	<b>(10,171)</b>	<b>(2,713)</b>	<b>(4,111)</b>	<b>(10,079)</b>				<b>(446,241)</b>	<b>45</b>

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 563,067	St Charles Property Holdings, LLC		\$	(563,067)	1
2	V	19 Accounting Fees		St Charles Property Holdings, LLC		3,191	3,191	2
3	V	32 Interest	58,170	St Charles Property Holdings, LLC		378,063	319,893	3
4	V	33 Real Estate Tax	132,000	St Charles Property Holdings, LLC		132,000		4
5	V	21 State Income Tax		St Charles Property Holdings, LLC		1,263	1,263	5
6	V	06 Asset Management Fees		St Charles Property Holdings, LLC		27,500	27,500	6
7	V	30 Depreciation Expense		St Charles Property Holdings, LLC		126,154	126,154	7
8	V	36 Amortization Expense		St Charles Property Holdings, LLC		13,194	13,194	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 753,237			\$ 681,364	\$ * (71,872)	14

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

Facility Name & ID Number

Grove of St Charles

# 0055038

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	42.50%	Astoria Place Skilled Nursing Facility LLC	Chicago	St. Charles Property Holdings LLC		Building Company	1
2	Doros Generation Trust	42.50%	Avantara Arlington	Arlington, SD	Legacy HC & Financial Services	Lincolnwood	Home Office/Bookkeeping	2
3	Oakway Operations LLC	15.00%	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

Grove of St Charles

# 0055038

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			Lagrange Skilled Nursing Facility LLC	Lagrange Park				6
7			Lakefront Skilled Nursing Facility LLC	Chicago				7
8			Lincoln Park Skilled Nursing Facility LLC	Chicago				8
9			Lincolnshire Living & Rehab Center LLC	Lincolnshire				9
10			Northbrook Skilled Nursing Facility LLC	Northbrook				10
11			Peterson Park Associates Limited Partnership	Chicago				11
12			Skokie Skilled Nursing Facility LLC	Skokie				12
13			Valley Skilled Nursing Facility	Billings, MT				13
14			Warren Barr Living And Rehab	Chicago				14
15			Warren Barr North Shore	Highland Park				15
16			Warren Barr South Loop	Chicago				16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	01 Dietician Salary	\$	Legacy Healthcare Financial Services		\$ 2,253	\$	2,253	15
16	V	01 Dietary Supplies		Legacy Healthcare Financial Services		12		12	16
17	V	02 Food		Legacy Healthcare Financial Services		4,309		4,309	17
18	V	03 Housekeeping		Legacy Healthcare Financial Services		1,469		1,469	18
19	V	04 Linen Replacement		Legacy Healthcare Financial Services		100		100	19
20	V	06 Maintenance Salary		Legacy Healthcare Financial Services		6,951		6,951	20
21	V	06 Repairs & Maintenance		Legacy Healthcare Financial Services		413		413	21
22	V	10 Nursing Salary		Legacy Healthcare Financial Services		57,529		57,529	22
23	V	10 Nurse/Medical Director Consultant		Legacy Healthcare Financial Services		5,430		5,430	23
24	V	10 Medical Supplies		Legacy Healthcare Financial Services		12,360		12,360	24
25	V	12 Social Service Salary		Legacy Healthcare Financial Services		3,919		3,919	25
26	V	11 Activities Program		Legacy Healthcare Financial Services		6		6	26
27	V	12 Social Service Consultant		Legacy Healthcare Financial Services		15		15	27
28	V	17 COO / Administrative Salary		Legacy Healthcare Financial Services		43,798		43,798	28
29	V	19 Professional Fees		Legacy Healthcare Financial Services		14,379		14,379	29
30	V	20 Dues / Licenses / Permits		Legacy Healthcare Financial Services		2,455		2,455	30
31	V	21 Clerical & General Wages		Legacy Healthcare Financial Services		176,716		176,716	31
32	V	21 Clerical & Office Expense		Legacy Healthcare Financial Services		12,886		12,886	32
33	V	24 Education & Seminars		Legacy Healthcare Financial Services		98		98	33
34	V	25 Travel		Legacy Healthcare Financial Services		3,274		3,274	34
35	V	26 Insurance - General		Legacy Healthcare Financial Services		86		86	35
36	V	27 Non-Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		17,555		17,555	36
37	V	34 Rent		Legacy Healthcare Financial Services		22,165		22,165	37
38	V	34 Offsite Storage / Parking		Legacy Healthcare Financial Services		68		68	38
39	<b>Total</b>		\$			\$ 388,245	\$ *	388,245	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	35 Equipment Rental		Legacy Healthcare Financial Services		296	\$	296	15
16	V	35 Auto Rental		Legacy Healthcare Financial Services		2,885		2,885	16
17	V	15 Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		4,081		4,081	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		\$			7,262	\$ *	7,262	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 Utilities	\$	CF St. Louis LLC		\$ 766	\$	766	15
16	V	6 Repairs & Maintenance		CF St. Louis LLC		742		742	16
17	V	19 Property Valuation Fee		CF St. Louis LLC		262		262	17
18	V	19 Accounting Fees		CF St. Louis LLC		60		60	18
19	V	20 Dues & Subscriptions		CF St. Louis LLC		0		0	19
20	V	21 Office Expense		CF St. Louis LLC		178		178	20
21	V	26 Insurance		CF St. Louis LLC		192		192	21
22	V	30 Depreciation		CF St. Louis LLC		4,725		4,725	22
23	V	32 Interest Expense		CF St. Louis LLC		2,655		2,655	23
24	V	33 Real Estate Taxes		CF St. Louis LLC		2,412		2,412	24
25	V								25
26	V	34 Rent	22,165	CF St. Louis LLC				(22,165)	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		\$ 22,165			\$ 11,994	\$ *	(10,171)	39

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

VII. RELATED PARTIES (continued)

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

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

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

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



VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Payroll Services	\$ 17,943	ProPay HR LLC		\$ 13,832	\$ (4,111)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 17,943			\$ 13,832	\$ * (4,111)

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 Laboratory	\$ 24,764	Lifescan Labs of Illinois		\$ 14,685	\$ (10,079)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	<b>Total</b>		\$ 24,764			\$ 14,685	\$ * (10,079)

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

Facility Name & ID Number Grove of St Charles # 0055038 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Grove of St Charles

# 0055038

Report Period Beginning:

01/01/20

Ending: 12/31/20

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

Facility Name & ID Number Grove of St Charles

# 0055038

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	01	Dietician Salary	Available Bed Days	2,540,133	53	\$ 130,303	\$ 130,303	43,920	\$ 2,253	1
2	01	Dietary Supplies	Available Bed Days	2,540,133	53	697		43,920	12	2
3	02	Food	Available Bed Days	2,540,133	53	249,220		43,920	4,309	3
4	03	Housekeeping	Available Bed Days	2,540,133	53	84,952		43,920	1,469	4
5	04	Linen Replacement	Available Bed Days	2,540,133	53	5,771		43,920	100	5
6	06	Maintenance Salary	Available Bed Days	2,540,133	53	401,986	401,986	43,920	6,951	6
7	06	Repairs & Maintenance	Available Bed Days	2,540,133	53	23,857		43,920	413	7
8	10	Nursing Salary	Available Bed Days	2,540,133	53	3,327,223	3,327,223	43,920	57,529	8
9	10	Nurse/Medical Director Consultant	Available Bed Days	2,540,133	53	314,035		43,920	5,430	9
10	10	Medical Supplies	Available Bed Days	2,540,133	53	714,824		43,920	12,360	10
11	12	Social Service Salary	Available Bed Days	2,540,133	53	226,662	226,662	43,920	3,919	11
12	11	Activities Program	Available Bed Days	2,540,133	53	335		43,920	6	12
13	12	Social Service Consultant	Available Bed Days	2,540,133	53	893		43,920	15	13
14	17	COO / Administrative Salary	Available Bed Days	2,540,133	53	2,533,078	2,533,078	43,920	43,798	14
15	19	Professional Fees	Available Bed Days	2,540,133	53	831,592		43,920	14,379	15
16	20	Dues / Licenses / Permits	Available Bed Days	2,540,133	53	141,983		43,920	2,455	16
17	21	Clerical & General Wages	Available Bed Days	2,540,133	53	10,220,453	10,220,453	43,920	176,716	17
18	21	Clerical & Office Expense	Available Bed Days	2,540,133	53	745,293		43,920	12,886	18
19	24	Education & Seminars	Available Bed Days	2,540,133	53	5,655		43,920	98	19
20	25	Travel	Available Bed Days	2,540,133	53	189,364		43,920	3,274	20
21	26	Insurance - General	Available Bed Days	2,540,133	53	4,997		43,920	86	21
22	27	Non-Nursing Payroll Taxes / Bene	Available Bed Days	2,540,133	53	1,015,274		43,920	17,555	22
23	34	Rent	Available Bed Days	2,540,133	53	1,281,940		43,920	22,165	23
24	34	Offsite Storage / Parking	Available Bed Days	2,540,133	53	3,949		43,920	68	24
25	TOTALS					\$ 22,454,338	\$ 16,839,706		\$ 388,245	25



Facility Name & ID Number Grove of St Charles

# 0055038 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	35	Equipment Rental	Available Bed Days	2,540,133	53	17,109	43,920	296	1
2	35	Auto Rental	Available Bed Days	2,540,133	53	166,843	43,920	2,885	2
3	15	Nursing Payroll Taxes / Benefits	Available Bed Days	2,540,133	53	236,021	43,920	4,081	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 419,973	\$	\$ 7,262	25

Facility Name & ID Number Grove of St Charles

# 0055038

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 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Available Bed Days	2,540,133	53	\$ 44,301	\$ 43,920	\$ 766	1
2	6	Repairs & Maintenance	Available Bed Days	2,540,133	53	42,932	43,920	742	2
3	19	Property Valuation Fee	Available Bed Days	2,540,133	53	15,181	43,920	262	3
4	19	Accounting Fees	Available Bed Days	2,540,133	53	3,453	43,920	60	4
5	20	Dues & Subscriptions	Available Bed Days	2,540,133	53	23	43,920	0	5
6	21	Office Expense	Available Bed Days	2,540,133	53	10,298	43,920	178	6
7	26	Insurance	Available Bed Days	2,540,133	53	11,124	43,920	192	7
8	30	Depreciation	Available Bed Days	2,540,133	53	273,261	43,920	4,725	8
9	32	Interest Expense	Available Bed Days	2,540,133	53	153,558	43,920	2,655	9
10	33	Real Estate Taxes	Available Bed Days	2,540,133	53	139,524	43,920	2,412	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	\$	\$ 11,994	25

Facility Name & ID Number Grove of St Charles

# 0055038

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

( )

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

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

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

# 0055038

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

ProPay HR LLC

Street Address

2201 W. Main St.

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

(847) 905 3268

Fax Number

( )

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct		\$	\$		\$ 13,832	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				\$	\$		\$ 13,832	25

Facility Name & ID Number Grove of St Charles

# 0055038

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization LIFESCAN LABS OF ILLINOIS, LLC  
 Street Address 5255 GOLF RD  
 City / State / Zip Code SKOKIE, IL 60077  
 Phone Number (847) 663 - 8300  
 Fax Number ( )

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Laboratory	Direct		\$	\$		\$ 14,685	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				\$	\$		\$ 14,685	25

Facility Name & ID Number Grove of St Charles

# 0055038 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Grove of St Charles

# 0055038 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Grove of St Charles

# 0055038

Report Period Beginning:

01/01/20

Ending: 12/31/20

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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



Facility Name & ID Number

Grove of St Charles

# 0055038

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	CIBC Bank		X	Mortgage Payable			\$	\$ 6,480,000		\$ 304,823	1									
2											2									
3											3									
4											4									
5											5									
<b>Working Capital</b>																				
6	CIBC Bank		X	Note Payable				1,355,000		33,990	6									
7	CIBC Bank		X	Line of Credit				654,373		73,240	7									
8	Allocated from CF St. Louis		X							2,655	8									
9	<b>TOTAL Facility Related</b>						\$	\$ 8,489,373		\$ 414,708	9									
<b>B. Non-Facility Related*</b>																				
10	Interest Income		X							(586)	10									
11	Interest Income - Bldg Co.		X							(58,170)	11									
12											12									
13											13									
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$ (58,756)	14									
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 8,489,373		\$ 355,952	15									

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

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

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

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

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2019 report.		\$	<b>246,491</b>	<b>1</b>
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.)		\$	<b>98,297</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(148,194)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>282,607</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>262</b>	<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>134,675</b>	<b>7</b>
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2015	<b>114,335</b>	<b>8</b>	
	2016	<b>111,283</b>	<b>9</b>	
	2017	<b>70,136</b>	<b>10</b>	
	2018	<b>108,424</b>	<b>11</b>	
	2019	<b>95,884</b>	<b>12</b>	
<b>2020 Accrual = \$95,884 x 2.94 = \$282,607 (rounded)</b>				
<b>Allocated from CF St. Louis LLC: \$2,412</b>				

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

**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 Grove of St Charles COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0055038

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)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>09-27-206-005</u>	<u>Long Term Care Property</u>	\$ <u>95,884.30</u>	\$ <u>95,884.30</u>
2. <u>10-23-406-034-0000</u>	<u>Home Office Allocation</u>	\$ <u>459,532.44</u>	\$ <u>2,412.43</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>555,416.74</u></u>	\$ <u><u>98,296.73</u></u>

**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 Grove of St Charles COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0055038

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

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

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

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

**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 Grove of St Charles

# 0055038

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 \_\_\_\_\_ Number of Stories 2

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

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

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>			\$ <u>304,000</u>	<u>1</u>
2	<u>Allocated from CF St. Louis, LLC</u>			<u>3,412</u>	<u>2</u>
3	TOTALS			\$ <u>307,412</u>	<u>3</u>

Facility Name & ID Number Grove of St Charles

# 0055038

Report Period Beginning:

01/01/20

Ending:

12/31/20

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	120		2018	1978	\$ 3,336,000	\$ 126,154	35	\$ 95,314	\$ (30,840)	\$ 160,852	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
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											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 Grove of St Charles

# 0055038

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68			160,599	4,356		7,636	3,280	34,162
69								69
70			\$ 3,496,599	\$ 130,510		\$ 102,951	\$ (27,559)	\$ 195,015

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

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,496,599	\$ 130,510		\$ 102,951	\$ (27,559)	\$ 195,015	1
2	Installation Of New Cabling/Wire Lines (\$15491.2)	2018	15,013		20	751	751	2,816	2
3	Power Throughout Building And Installation Of Led Light Bulbs	2018	2,999		20	150	150	511	3
4	Repaired Walls/Basement Drains/Studs (\$4700)	2018	4,555		20	228	228	815	4
5	Fire Sprinkler System (\$4850)	2019	4,700		20	235	235	680	5
6	Repaired Wall Drains And Valves (\$7519.81)	2019	7,287		20	364	364	803	6
7	Installed Cables Through Wall Plates (\$9713.24)	2019	9,413		20	471	471	1,442	7
8	Installed Boiler (\$18249.25)	2019	17,685		20	884	884	2,709	8
9	Repaired Plumbing - Pumps/Pipes/Valves (\$22500)	2019	21,805		20	1,090	1,090	1,653	9
10	Electrical Work For Basins/Walls/Ceilings (\$6350)	2019	6,154		20	308	308	414	10
11	Monument Sign (\$14368.37)	2019	13,924		20	696	696	1,095	11
12	Repaired Drainage Pipes On West Side Of Building (\$3600)	2019	3,489		20	174	174	324	12
13	Repaired The Storage Tank Hot Water Pump (\$3,606.72)	2019	3,789		20	189	189	385	13
14	Water Softener Pipes Leak Repair, And Boiler Repair (\$3,910)	2019	3,495		20	175	175	355	14
15	Hvac - Spark/Flame Rods For Eclipse Burner (\$4,193)	2020	4,090		20	204	204	204	15
16	Install A/C In 6 Rooms (\$5,200)	2020	5,073		20	254	254	254	16
17	Roof Work - Tuckpointing, Air Handler Repair (\$2,980)	2020	2,907		20	145	145	145	17
18	Roof Top Unit # 5 Repair (\$3,207)	2020	3,129		20	156	156	160	18
19	Replace Compressors (\$10,304)	2020	10,052		20	503	503	515	19
20	Repair Rooftop Exhaust,Parking Lot Potholes,3 Fire Doors, Eject	2020	2,892		20	145	145	145	20
21	Resident Rms,Exterior,Lobby,Corridor,Pt Gym,Dialysis Reno-	2020	1,692,623		20				21
22	Millwork,Electricity,Roof Repairs,Paiting,Piping (\$1,746,593)	2020			20				22
23	Dialysis Rm Project-Plumbing,Electrical,Millwork	2020	93,678		20				23
24	Architect Fees - Dialysis Room	2020	7,268		20				24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,432,620	\$ 130,510		\$ 110,073	\$ (20,437)	\$ 210,441	34

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



XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 5,432,620	\$ 130,510		\$ 110,073	\$ (20,437)	\$ 210,441	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		\$ 5,432,620	\$ 130,510		\$ 110,073	\$ (20,437)	\$ 210,441	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,432,620	\$ 130,510		\$ 110,073	\$ (20,437)	\$ 210,441	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)		\$ 5,432,620	\$ 130,510		\$ 110,073	\$ (20,437)	\$ 210,441	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 5,432,620	\$ 130,510		\$ 110,073	\$ (20,437)	\$ 210,441	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		\$ 5,432,620	\$ 130,510		\$ 110,073	\$ (20,437)	\$ 210,441	34

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

Facility Name & ID Number Grove of St Charles

# 0055038

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									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)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Grove of St Charles

# 0055038

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	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34		\$	\$		\$	\$	\$

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

Facility Name & ID Number Grove of St Charles

# 0055038

Report Period Beginning:

01/01/20

Ending:

12/31/20

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party								1
2	Buildings:								2
3	Allocated from CF St. Louis, LLC	2016	18,374	853	35	525	(328)	2,625	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	114,077	2,814	20	5,704	2,890	28,519	9
10	Allocated from CF St. Louis, LLC	2017	2,648	65	20	132	67	530	10
11	Allocated from CF St. Louis, LLC	2019	23,999	592	20	1,200	608	2,400	11
12	Allocated from CF St. Louis, LLC	2019	1,262	31	20	63	32	63	12
13									13
14	Allocated from Legacy HC	2018	136		20	7	7	20	14
15	Allocated from Legacy HC	2020	103		20	5	5	5	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)		\$ 160,599	\$ 4,356		\$ 7,636	\$ 3,280	\$ 34,162	34

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

Facility Name & ID Number Grove of St Charles

# 0055038

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 160,599	\$ 4,356		\$ 7,636	\$ 3,280	\$ 34,162	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)	\$ 160,599	\$ 4,356		\$ 7,636	\$ 3,280	\$ 34,162	34

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

Facility Name & ID Number Grove of St Charles

# 0055038

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	\$ 498,454	\$ 368	\$ 49,845	\$ 49,478	10	\$ 158,475	71
72	Current Year Purchases	25,786	1	2,579	2,577	10	2,579	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 524,240	\$ 369	\$ 52,424	\$ 52,055		\$ 161,053	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)	\$ 6,264,272	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 130,879	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 162,497	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 31,618	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 371,494	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.



**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	<u>Allocated from Legacy Financial</u>				<u>68</u>			5
6								6
7	TOTAL				\$ <u>68</u>			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 8,919 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	<u>Allocated from Legacy Financial</u>		\$	\$ <u>2,885</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>2,885</u>	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2021 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2022 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2023 \$ \_\_\_\_\_

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

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

**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.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5	6	7	8		
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)						Total Cost (Col. 3 + 5 + 6)
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	194,079	\$			\$	194,079	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				86,500					86,500	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	39 - 03	hrs				208,415					208,415	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						210,605			210,605	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Other (specify): _____												12	
13	Other (specify): <u>See Attached</u>						69,232		102,900			172,132	13	
14	TOTAL			\$			\$	558,226	\$	313,505		\$	871,731	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 750	\$ 352,959	1
2	Cash-Patient Deposits	(147,658)	(147,658)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,925,771	1,925,771	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,014	6,014	6
7	Other Prepaid Expenses	182,855	182,855	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached</u>	72,878	2,428,115	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,040,610	\$ 4,748,056	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		304,000	13
14	Buildings, at Historical Cost		2,736,000	14
15	Leasehold Improvements, at Historical Cost	123,935	723,935	15
16	Equipment, at Historical Cost	172,430	532,430	16
17	Accumulated Depreciation (book methods)	(35,827)	(335,902)	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): <u>See Attached</u>	2,067,058	2,158,955	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,327,596	\$ 6,119,418	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,368,206	\$ 10,867,474	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 103,747	\$ 303,747	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,355,000	1,355,000	29
30	Accrued Salaries Payable	225,087	225,087	30
31	Accrued Taxes Payable (excluding real estate taxes)	173,705	173,705	31
32	Accrued Real Estate Taxes(Sch.IX-B)		282,607	32
33	Accrued Interest Payable		22,698	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached</u>	724,307	782,740	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,581,846	\$ 3,145,584	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable		654,373	39
40	Mortgage Payable		6,480,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Attached</u>	2,441,715	687,977	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,441,715	\$ 7,822,350	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 5,023,561	\$ 10,967,934	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (655,355)	\$ (100,460)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,368,206	\$ 10,867,474	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(790,811)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Equity Restatement</b>	<b>(244,699)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(1,035,510)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>380,155</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>380,155</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(655,355)</b>	<b>24</b> *

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

Facility Name &amp; ID Number Grove of St Charles

# 0055038

Report Period Beginning: 01/01/20

Ending: 12/31/20

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 12,420,529	1
2	Discounts and Allowances for all Levels	(5,438,124)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,982,405	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,722,352	6
7	Oxygen	252	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,722,604	8
<b>C. Other Operating Revenue</b>			
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	195,966	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	31,023	19
20	Radiology and X-Ray	325	20
21	Other Medical Services	29,880	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 257,194	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	586	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 586	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Attached</u>	948,025	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 948,025	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,910,814	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,517,739	31
32	Health Care	4,104,327	32
33	General Administration	1,597,412	33
<b>B. Capital Expense</b>			
34	Ownership	737,680	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,320,307	35
36	Provider Participation Fee	253,194	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 9,530,659	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	380,155	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 380,155	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 5,119,453	44
45	Private Pay - Net Inpatient Revenue	522,936	45
46	Medicare - Net Inpatient Revenue	1,161,555	46
47	Other-(specify) <u>Insurance</u>	178,461	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 6,982,405	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.

Facility Name & ID Number Grove of St Charles

# 0055038

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,042	2,185	\$ 123,802	\$ 56.66	1
2	Assistant Director of Nursing	2,046	2,166	89,906	41.51	2
3	Registered Nurses	30,001	32,629	1,252,651	38.39	3
4	Licensed Practical Nurses	14,189	16,806	563,565	33.53	4
5	CNAs & Orderlies	48,047	51,086	910,670	17.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,308	4,563	88,806	19.46	8
9	Activity Director	1,408	1,440	26,005	18.06	9
10	Activity Assistants	4,940	5,580	87,596	15.70	10
11	Social Service Workers	5,220	5,560	156,639	28.17	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,850	2,180	66,140	30.34	17
18	Housekeepers					18
19	Laundry	2,098	2,408	30,860	12.82	19
20	Administrator	2,120	2,200	148,223	67.37	20
21	Assistant Administrator	880	936	26,534	28.35	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,890	7,432	139,618	18.79	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	7,179	7,567	127,229	16.81	33
34	TOTAL (lines 1 - 33)	133,218	144,738	\$ 3,838,244 *	\$ 26.52	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 777,582	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	48,948	10-03	38
39	Pharmacist Consultant	Monthly	2,127	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,451	11-03	44
45	Social Service Consultant	Monthly	4,566	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 852,674		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	6,917	227,931	10-03	52
53	TOTAL (lines 50 - 52)	6,917	\$ 227,931		53







Facility Name & ID Number Grove of St Charles# 0055038

Report Period Beginning:

01/01/20

Ending:

12/31/20**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. HCCI - \$8,400
- (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. \$ 33,327 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 253,194  
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. \$ N/A 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 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.