FOR BHF USE

LL1

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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

I. IDPH License ID Number: 0052621

Facility Name: The Grove of Fox Valley

Address: 1601 N Farnsworth Av (Number) Aurora (City) 60505 (Zip Code)

County: Kane

Telephone Number: (630) 898-1180 **Fax #** (630) 898-1208

HFS ID Number:

Date of Initial License for Current Owners: 2/1/2014

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 02/01/14 to 12/31/14 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) (Date)
(Print Name and Title) Kimberley A. Waite, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	158	Skilled (SNF)	158	52,772	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	158	TOTALS	158	52,772	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	31,741	3,170	7,405	42,316	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,741	3,170	7,405	42,316	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.19%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

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

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

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

I. On what date did you start providing long term care at this location?
Date started 2/1/14

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/14 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 158 and days of care provided 6,985

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	306,751	30,957	161,218	498,926		498,926		498,926			1
2	Food Purchase		230,278		230,278		230,278	(438)	229,840			2
3	Housekeeping	197,793	33,726	1,093	232,612		232,612	669	233,281			3
4	Laundry	79,071	5,183	8,866	93,120		93,120		93,120			4
5	Heat and Other Utilities			193,422	193,422		193,422	(16,177)	177,245			5
6	Maintenance	126,122		146,508	272,630		272,630	(244,721)	27,909			6
7	Other (specify):*											7
8	TOTAL General Services	709,737	300,144	511,107	1,520,988		1,520,988	(260,667)	1,260,321			8
	B. Health Care and Programs											
9	Medical Director			48,000	48,000		48,000		48,000			9
10	Nursing and Medical Records	2,642,688	164,142	42,917	2,849,747		2,849,747	1,102	2,850,849			10
10a	Therapy	111,030	307		111,337		111,337		111,337			10a
11	Activities	133,718	7,322		141,040		141,040	273	141,313			11
12	Social Services	331,571		6,695	338,266		338,266	919	339,185			12
13	CNA Training											13
14	Program Transportation			6,072	6,072		6,072	(50)	6,022			14
15	Other (specify):*							125	125			15
16	TOTAL Health Care and Programs	3,219,007	171,771	103,684	3,494,462		3,494,462	2,369	3,496,831			16
	C. General Administration											
17	Administrative	241,200		19,356	260,556		260,556	5,238	265,794			17
18	Directors Fees											18
19	Professional Services			511,851	511,851		511,851	(215,679)	296,172			19
20	Dues, Fees, Subscriptions & Promotions			122,107	122,107		122,107	(105,969)	16,138			20
21	Clerical & General Office Expenses	186,770	11,349	392,799	590,918		590,918	(220,509)	370,409			21
22	Employee Benefits & Payroll Taxes			849,889	849,889		849,889		849,889			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,636	8,636		8,636	391	9,027			24
25	Other Admin. Staff Transportation			11,730	11,730		11,730		11,730			25
26	Insurance-Prop.Liab.Malpractice			119,641	119,641		119,641	637	120,278			26
27	Other (specify):*							26,750	26,750			27
28	TOTAL General Administration	427,970	11,349	2,036,009	2,475,328		2,475,328	(509,141)	1,966,187			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,356,714	483,264	2,650,800	7,490,778		7,490,778	(767,440)	6,723,338			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number The Grove of Fox Valley #0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							43,767	43,767			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			39,963	39,963		39,963	10,169	50,132			32
33	Real Estate Taxes			138,516	138,516		138,516	2,141	140,657			33
34	Rent-Facility & Grounds			500,935	500,935		500,935	114,741	615,676			34
35	Rent-Equipment & Vehicles			6,534	6,534		6,534	23	6,557			35
36	Other (specify):*											36
37	**TOTAL Ownership**			685,948	685,948		685,948	170,841	856,789			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		288,569	1,030,150	1,318,719		1,318,719		1,318,719			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			258,115	258,115		258,115		258,115			42
43	Other (specify):*			174,157	174,157		174,157	(174,157)	0			43
44	**TOTAL Special Cost Centers**		288,569	1,462,422	1,750,991		1,750,991	(174,157)	1,576,834			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,356,714	771,833	4,799,170	9,927,717		9,927,717	(770,756)	9,156,961			45

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(17,510)	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	39,642	30		9
10	Interest and Other Investment Income	(37)	32		10
11	Discounts, Allowances, Rebates & Refunds	(273)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(171)	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	(114)	21		18
19	Entertainment				19
20	Contributions	(74,835)	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	(231,789)	21		24
25	Fund Raising, Advertising and Promotional	(25,148)	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	(500,899)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (811,134)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	40,378		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 40,378		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (770,756)		37

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

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

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

The Grove of Fox Valley

ID# 0052621

Report Period Beginning: 02/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sequestration	$ (65,975)	21	1
2	Patient Personal Items	(1,979)	10	2
3	Chamber of Commerce Dues	(248)	20	3
4	Meals	(9,969)	21	4
5	Bank Charges	(13,365)	21	5
6	PAC Dues	(5,870)	20	6
7	Annual Report	(250)	20	7
8	Professional Fees Refund	(260)	19	8
9	Capitalized R&M	(257,535)	06	9
10	Additional R&M	29,209	06	10
11	Building Company - Professional Fees	(500)	19	11
12	Non-Allowable Expense	(174,157)	43	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(500,899)		49

The Grove of Fox Valley

ID# 0052621

Report Period Beginning: 02/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32

82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Grove of Fox Valley # 0052621 **Report Period Beginning:** 02/01/14 **Ending:** 12/31/14

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(444)		(2)		8							(438)	2
3	Housekeeping			669									669	3
4	Laundry													4
5	Heat and Other Utilities	(17,510)		1,333									(16,177)	5
6	Maintenance	(228,326)		1,553		52				(18,000)			(244,721)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(246,280)		3,553		60				(18,000)			(260,667)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,979)				3,081							1,102	10
10a	Therapy													10a
11	Activities			273									273	11
12	Social Services					919							919	12
13	CNA Training													13
14	Program Transportation							(50)					(50)	14
15	Other (specify):*					125							125	15
16	**TOTAL Health Care and Programs**	(1,979)		273		4,125		(50)					2,369	16
	C. General Administration													
17	Administrative					5,238							5,238	17
18	Directors Fees													18
19	Professional Services	(760)	500	(215,515)	75	362	(341)						(215,679)	19
20	Fees, Subscriptions & Promotions	(106,351)		368		14							(105,969)	20
21	Clerical & General Office Expenses	(321,211)		99,333		1,369							(220,509)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			380		11							391	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			637									637	26
27	Other (specify):*			26,354		396							26,750	27
28	**TOTAL General Administration**	(428,322)	500	(88,443)	75	7,390	(341)						(509,141)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(676,582)	500	(84,617)	75	11,575	(341)	(50)		(18,000)			(767,440)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Grove of Fox Valley # 0052621 **Report Period Beginning:** 02/01/14 **Ending:** 12/31/14

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	39,642		1,696	2,429								43,767	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(37)	8,709	10	1,487								10,169	32
33	Real Estate Taxes			2,141									2,141	33
34	Rent-Facility & Grounds		114,741	7,667	(7,667)								114,741	34
35	Rent-Equipment & Vehicles					23							23	35
36	Other (specify):*													36
37	**TOTAL Ownership**	39,605	123,450	11,514	(3,751)	23							170,841	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(174,157)											(174,157)	43
44	**TOTAL Special Cost Centers**	(174,157)											(174,157)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(811,134)	123,950	(73,103)	(3,676)	11,598	(341)	(50)		(18,000)			(770,756)	45

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 499,289	Prairie Property Holdings LLC	100.00%	$ 614,030	$ 114,741	1
2	V	32	Interest		Prairie Property Holdings LLC	100.00%	8,709	8,709	2
3	V	19	Professional Fees		Prairie Property Holdings LLC	100.00%	500	500	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 499,289			$ 623,239	$ * 123,950	14

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	FOOD	$	Legacy Healthcare Financial Services	100.00%	$ (2)	$ (2)	15
16	V	3	HOUSEKEEPING WAGES		Legacy Healthcare Financial Services	100.00%	598	598	16
17	V	3	HOUSEKEEPING SUPPLIES		Legacy Healthcare Financial Services	100.00%	71	71	17
18	V	5	UTILITIES		Legacy Healthcare Financial Services	100.00%	1,333	1,333	18
19	V	6	GROUNDS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	1,553	1,553	19
20	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services	100.00%	273	273	20
21	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	4,485	4,485	21
22	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	368	368	22
23	V	21	CLERICAL & GENERAL WAGES		Legacy Healthcare Financial Services	100.00%	93,181	93,181	23
24	V	21	CLERICAL & GENERAL OTHER COSTS		Legacy Healthcare Financial Services	100.00%	6,152	6,152	24
25	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	380	380	25
26	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	637	637	26
27	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	19,042	19,042	27
28	V	30	DEPRECIATION		Legacy Healthcare Financial Services	100.00%	1,696	1,696	28
29	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	10	10	29
30	V	33	REAL ESTATE TAXES		Legacy Healthcare Financial Services	100.00%	2,141	2,141	30
31	V	34	RENT		Legacy Healthcare Financial Services	100.00%	7,667	7,667	31
32	V								32
33	V	17	MANAGEMENT FEES	19,356	Legacy Healthcare Financial Services	100.00%		(19,356)	33
34	V	19	BOOKKEEPING FEES	220,000	Legacy Healthcare Financial Services	100.00%		(220,000)	34
35	V	17	MANAGEMENT FEES- C. RAJCHENBACH		Legacy Healthcare Financial Services	100.00%	9,678	9,678	35
36	V	17	MANAGEMENT FEES- M. SHABAT		Legacy Healthcare Financial Services	100.00%	9,678	9,678	36
37	V	27	HEALTH INS/BENEF.- C. RAJCHENBACH		Legacy Healthcare Financial Services	100.00%	3,656	3,656	37
38	V	27	HEALTH INS/BENEF.- M. SHABAT		Legacy Healthcare Financial Services	100.00%	3,656	3,656	38
39	Total			$ 239,356			$ 166,253	$ * (73,103)	39

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	Legacy Real Properties	100.00%	$ 75	$ 75	15
16	V	30	DEPRECIATION		Legacy Real Properties	100.00%	2,429	2,429	16
17	V	32	INTEREST EXPENSE		Legacy Real Properties	100.00%	1,487	1,487	17
18	V								18
19	V	34	RENT	7,667	Legacy Real Properties	100.00%		(7,667)	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			$ 7,667			$ 3,991	$ * (3,676)	39

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	FOOD	$	Progressive Healthcare Consulting	100.00%	$ 8	$ 8	15
16	V	6	BUILDING MAINTENANCE AND R&M		Progressive Healthcare Consulting	100.00%	52	52	16
17	V	10	MEDICAL AND NURSING SUPPLIES		Progressive Healthcare Consulting	100.00%	4	4	17
18	V	10	NURSING SALARIES		Progressive Healthcare Consulting	100.00%	3,077	3,077	18
19	V	12	CLERGY SALARY		Progressive Healthcare Consulting	100.00%	129	129	19
20	V	12	ADMISSIONS SALARY		Progressive Healthcare Consulting	100.00%	3,015	3,015	20
21	V	15	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	125	125	21
22	V	17	ADMIN SALARY- NON OWNER		Progressive Healthcare Consulting	100.00%	5,238	5,238	22
23	V	19	PROFESSIONAL FEES		Progressive Healthcare Consulting	100.00%	362	362	23
24	V	20	FEES, SUBSCRIPTIONS		Progressive Healthcare Consulting	100.00%	14	14	24
25	V	21	CLERICAL & GENERAL		Progressive Healthcare Consulting	100.00%	1,369	1,369	25
26	V	24	SEMINARS		Progressive Healthcare Consulting	100.00%	11	11	26
27	V	27	AUTO AND TRAVEL		Progressive Healthcare Consulting	100.00%	396	396	27
28	V	35	AUTO RENTAL		Progressive Healthcare Consulting	100.00%	23	23	28
29	V								29
30	V								30
31	V	12	CLERGY	2,225	Progressive Healthcare Consulting	100.00%		(2,225)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,225			$ 13,823	$ * 11,598	39

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PAYROLL PROCESSING	$ 1,625	PROPAY HR		$ 1,284	$ (341)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,625			$ 1,284	$ * (341)	39

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	14	AMBULANCE	$ 214	LIFELINE AMBULANCE	100.00%	$ 164	$ (50)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 214			$ 164	$ * (50)	39

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Repairs & Maintenance	$ 755	REMED SERVICES	100.00%	$ 755	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 755			$ 755	$ *	39

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Repairs & Maintenance	$ 18,000	ML GROUP DESIGN AND DEVELOPMENT		$	$ (18,000)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 18,000			$	$ * (18,000)	39

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

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	CHAIM RAJCHENBACH	37.9500%	ASTORIA PLACE	CHICAGO	PRAIRIE PROPERTY HOLDINGS LLC		BUILDING COMPANY	1
2	MENACHEM SHABAT	37.9500%	BETHANY TERRACE	MORTON GROVE	LEGACY REAL PROPERTIES	LINCOLNWOOD	BUILDING COMPANY	2
3	YOSEPH RAJCHENBACH AND NAOMI ZISEL RAJCHENBAC	1.0000%	CHALET LIVING & REHAB	CHICAGO	LEGACY HEALTHCARE FINAN	LINCOLNWOOD	HOME OFFICE/BOOKKEEPI	3
4	THE RAJCHENBACH FAMILY TRUST	4.5000%	ELMBROOK	ELMHURST	PROGRESSIVE HC	LINCOLNWOOD	NURSE CONSULTING	4
5	RONALD SHABAT	4.5000%	THE GROVE OF EVANSTON,LLC	EVANSTON	REMED SERVICES LLC	LINCOLNWOOD	NURSE EQUIPMENT	5
6	YAIR ZUCKERMAN	10.0000%	THE VILLA AT EVERGREEN	EVERGREEN PARK	ML GROUP DESIGN AND DEV	SKOKIE	ASSET MANAGEMENT	6
7	ROSS BOTTNER	4.1000%	THE GROVE OF FOX VALLEY	AURORA	PROPAY	GURNEE	PAYROLL PROCESSING	7
8			THE GROVE OF LAGRANGE PARK LLC	LAGRANGE PARK	LIFELINE AMBULANCE	CHICAGO	AMBULANCE	8
9			THE GROVE AT THE LAKE	ZION	TERRACE GARDENS	MORTON GROVE	ASSISTED LIVING	9
10			LAKEFRONT NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO				10
11			THE GROVE AT LINCOLN PARK LIVING AND REHAB CENTER	CHICAGO				11
12			AVANTARA LONG GROVE	LONG GROVE				12
13			THE GROVE NORTH LIVING AND REHAB CENTER,LLC	SKOKIE				13
14			THE GROVE OF NORTHBROOK	NORTHBROOK				14
15			WARREN BARR NORTH SHORE	HIGHLAND PARK				15
16			AVANTARA PARK RIDGE	PARK RIDGE				16
17			PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO				17
18			WARREN BARR SOUTH LOOP	CHICAGO				18
19			WARREN BARR	CHICAGO				19
20			AURORA SUPPORTIVE LIVING	AURORA				20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Chaim Rajchenbach	Owner	Administrative	37.95%	See Attached	2.42	4.84%	Mgmt Fees	$ 9,678	17-3	1
2	Menachem Shabat	Owner	Administrative	37.95%	See Attached	2.42	4.84%	Mgmt Fees	9,678	17-3	2
3	Yair Zuckerman	Owner	Administrative	10.00%	See Attached	2.22	5.55%	Alloc. Sal.	11,096	17-1	3
4	Ross Bottner	Owner	CFO	4.10%	See Attached	1.94	4.85%	Alloc. Sal.	9,678	21-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 40,130		13

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

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Legacy Healthcare Financial Services
Street Address: 7040 N. Ridgeway
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: (847) 679-9797
Fax Number: (847) 679-1126

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	FOOD	AVAIL. BED DAYS	1,090,513	21	$ (38)	$	52,772	$ (2)	1
2	3	HOUSEKEEPING WAGES	AVAIL. BED DAYS	1,090,513	21	12,349	12,349	52,772	598	2
3	3	HOUSEKEEPING SUPPLIES	AVAIL. BED DAYS	1,090,513	21	1,477		52,772	71	3
4	5	UTILITIES	AVAIL. BED DAYS	1,090,513	21	27,544		52,772	1,333	4
5	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	1,090,513	21	32,093		52,772	1,553	5
6	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,090,513	21	5,642		52,772	273	6
7	17	MANAGEMENT FEES	AVAIL. BED DAYS	1,090,513	21	400,000		52,772		7
8	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,090,513	21	92,690		52,772	4,485	8
9	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,090,513	21	7,596		52,772	368	9
10	21	CLERICAL & GENERAL WAG	AVAIL. BED DAYS	1,090,513	21	1,925,545	1,925,545	52,772	93,181	10
11	21	CLERICAL & GENERAL OTH	AVAIL. BED DAYS	1,090,513	21	127,135		52,772	6,152	11
12	24	SEMINARS	AVAIL. BED DAYS	1,090,513	21	7,856		52,772	380	12
13	26	INSURANCE	AVAIL. BED DAYS	1,090,513	21	13,167		52,772	637	13
14	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	1,090,513	21	393,489		52,772	19,042	14
15	27	EMP BEN- OWNERS	AVAIL. BED DAYS	1,090,513	21	151,094		52,772		15
16	30	DEPRECIATION	AVAIL. BED DAYS	1,090,513	21	35,040		52,772	1,696	16
17	32	INTEREST	AVAIL. BED DAYS	1,090,513	21	199		52,772	10	17
18	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,090,513	21	44,250		52,772	2,141	18
19	34	RENT	AVAIL. BED DAYS	1,090,513	21	158,445		52,772	7,667	19
20										20
21	17	MANAGEMENT FEES- C. RAJ	AVG HOURS WKD	50	21	200,000		2	9,678	21
22	17	MANAGEMENT FEES- M. SHA	AVG HOURS WKD	50	21	200,000		2	9,678	22
23	27	HEALTH INS/BENEF.- C. RAJ	AVG HOURS WKD	50	21	75,547		2	3,656	23
24	27	HEALTH INS/BENEF.- M. SHA	AVG HOURS WKD	50	21	75,547		2	3,656	24
25	TOTALS					$ 3,986,667	$ 1,937,894		$ 166,253	25

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Legacy Real Properties
Street Address: 7040 N. Ridgeway
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: (847) 679-9797
Fax Number: (847) 679-1126

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,090,513	21	1,550		52,772	75	1
2	30	DEPRECIATION	AVAIL. BED DAYS	1,090,513	21	50,196		52,772	2,429	2
3	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,090,513	21	30,719		52,772	1,487	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					$ 82,465	$		$ 3,991	25

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Progressive Healthcare Consulting
Street Address: 7040 N. Ridgeway
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: (847) 679-9797
Fax Number: (847) 679-1126

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	FOOD	AVAIL. BED DAYS	951,147	18	$ 149	$	52,772	$ 8	1
2	6	BUILDING MAINTENANCE A	AVAIL. BED DAYS	951,147	18	943		52,772	52	2
3	10	MEDICAL AND NURSING SUI	AVAIL. BED DAYS	951,147	18	68		52,772	4	3
4	10	NURSING SALARIES	AVAIL. BED DAYS	951,147	18	55,460	55,460	52,772	3,077	4
5	12	CLERGY SALARY	AVAIL. BED DAYS	951,147	18	2,320	2,320	52,772	129	5
6	12	ADMISSIONS SALARY	AVAIL. BED DAYS	951,147	18	54,336	54,336	52,772	3,015	6
7	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	951,147	18	2,247		52,772	125	7
8	17	ADMIN SALARY- NON OWNE	AVAIL. BED DAYS	951,147	18	94,409	94,409	52,772	5,238	8
9	19	PROFESSIONAL FEES	AVAIL. BED DAYS	951,147	18	6,532		52,772	362	9
10	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	951,147	18	250		52,772	14	10
11	21	CLERICAL & GENERAL	AVAIL. BED DAYS	951,147	18	24,680		52,772	1,369	11
12	24	SEMINARS	AVAIL. BED DAYS	951,147	18	199		52,772	11	12
13	27	AUTO AND TRAVEL	AVAIL. BED DAYS	951,147	18	7,129		52,772	396	13
14	35	AUTO RENTAL	AVAIL. BED DAYS	951,147	18	413		52,772	23	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 249,135	$ 206,525		$ 13,823	25

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: ProPay HR
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, IL 60202
Phone Number: (847 905-3268
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PAYROLL PROCESSING	DIRECT ALLOCATION			$	$		$ 1,284	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					$	$		$ 1,284	25

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Lifeline Ambulance LLC
Street Address: 2424 S. Wabash Avenue
City / State / Zip Code: Chicago, IL 60616
Phone Number: (312) 949-9595
Fax Number: (312) 949-9262

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	14	AMBULANCE	DIRECT ALLOCATION			$	$		$ 164	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					$	$		$ 164	25

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: ReMed Services, LLC
Street Address: 7040 N. Ridgeway Avenue
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: ((855) 501-5500
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Repairs & Maintenance	Direct			$	$		$ 755	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					$	$		$ 755	25

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: ML Group Design and Development
Street Address: 7040 N. Ridgeway Avenue
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: (773) 415-3071
Fax Number: ( )

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	The Private Bank		X	Mortgage			$	$ 317,172			$ 8,709	1
2												2
3												3
4												4
5												5
	Working Capital											
6	The Private Bank		X	Line of Credit				1,710,000			39,963	6
7	Allocated from Legacy Financ. Serv.		X								10	7
8	See Supplemental Schedule										1,487	8
9	TOTAL Facility Related						$	$ 2,027,172			$ 50,169	9
	B. Non-Facility Related*											
10	Interest Income		X								(37)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (37)	14
15	TOTALS (line 9+line14)						$	$ 2,027,172			$ 50,132	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.)**

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated from Legacy Real Properties		X				$	$			$ 1,487	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										1,487	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 **Report Period Beginning:** 02/01/14 **Ending:** 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 20,790	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 161,447	2
3. Under or (over) accrual (line 2 minus line 1).		$ 140,657	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 140,657	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	104,388	8
	2010	113,272	9
	2011	115,226	10
	2012	137,371	11
	2013	159,306	12

Allocated from Legacy Real Property: $2,141

Beginnal Accrual Adjusted

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Grove of Fox Valley COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0052621

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-12-151-040	Long Term Care Property	$ 159,305.68	$ 159,305.68
2.	10-35-104-076-0000	Home Office Allocation	$ 38,392.03	$ 1,857.86
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 197,697.71	$ 161,163.54

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 a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. 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 Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Grove of Fox Valley COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0052621

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$

4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 73,911 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

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

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

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

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

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

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2	Allocated from Legacy Real Properties			3,959	2
3	TOTALS			$ 3,959	3

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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 The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		67,144	2,061		2,793	732	12,891	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 67,144	$ 2,061		$ 2,793	$ 732	$ 12,891	70

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 67,144	$ 2,061		$ 2,793	$ 732	$ 12,891	1
2	Security Systems	2014	15,340		20	805	805	805	2
3	Ball Bearing Hinges	2014	5,386		20	90	90	90	3
4	Concrete Work	2014	2,900		20	24	24	24	4
5	Fluorescent Wall Fixture	2014	6,218		20	26	26	26	5
6	Landscaping - Tree Work	2014	22,914		20	1,146	1,146	1,146	6
7	Wings 100,200,300,400 - Handrails,Cornerguards, Flooring	2014	59,130		20	2,957	2,957	2,957	7
8	Kitchen And Room 412-Electrical Wiring And Receptacles	2014	4,653		20	233	233	233	8
9	Elevator Repair	2014	2,556		20	128	128	128	9
10	Exterior Signage	2014	9,505		20	475	475	475	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)		$ 195,746	$ 2,061		$ 8,676	$ 6,615	$ 18,774	34

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 195,746	$ 2,061		$ 8,676	$ 6,615	$ 18,774	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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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)		$ 195,746	$ 2,061		$ 8,676	$ 6,615	$ 18,774	34

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

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		$ 195,746	$ 2,061		$ 8,676	$ 6,615	$ 18,774	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)		$ 195,746	$ 2,061		$ 8,676	$ 6,615	$ 18,774	34

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 195,746	$ 2,061		$ 8,676	$ 6,615	$ 18,774	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)		$ 195,746	$ 2,061		$ 8,676	$ 6,615	$ 18,774	34

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

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 12E, Carried Forward		$	$		$	$	$	1
2	Buildings:								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 The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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22									22
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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 The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

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 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Legacy Real Properties	2009	30,674	1,022	20	1,022		5,624	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from Legacy Financial Services	2012	1,380	96	20	69	(27)	207	9
10	Allocated from Legacy Financial Services	2013	4,414	306	20	221	(85)	441	10
11	Allocated from Legacy Financial Services	2014	431	30	20	22	(8)	22	11
12									12
13	Allocated from Legacy Real Properties	2009	17,419	435	20	871	436	4,137	13
14	Allocated from Legacy Real Properties	2010	5,297	172	20	212	40	954	14
15	Allocated from Legacy Real Properties	2011	7,529		20	376	376	1,506	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)		$ 67,144	$ 2,061		$ 2,793	$ 732	$ 12,891	34

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 67,144	$ 2,061		$ 2,793	$ 732	$ 12,891	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 67,144	$ 2,061		$ 2,793	$ 732	$ 12,891	34

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

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	$ 13,170	$ 1,518	$ 1,317	$ (201)	10	$ 5,148	71
72	Current Year Purchases	344,514	545	33,773	33,228	10	33,773	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 357,684	$ 2,063	$ 35,090	$ 33,027		$ 38,921	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)	$ 557,389	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 4,124	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 43,766	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 39,642	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 57,695	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	Architect Fees	$ 122,807	92
93			93
94			94
95		$ 122,807	95

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

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

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	Storage				1,646			5
6	BNF Venture Fund, LLC				614,030			6
7	TOTAL				$ 615,676 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 6,534 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Progressive HC		$	$ 23	17
18					18
19					19
20					20
21	TOTAL		$	$ 23	21

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

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		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	$		$ 448,469	$		$ 448,469	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			87,430			87,430	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			405,683			405,683	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				257,682		257,682	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					88,568	30,887		119,455	13
14	TOTAL			$		$ 1,030,150	$ 288,569		$ 1,318,719	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.

STATE OF ILLINOIS

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,000	$ 9,146	1
2	Cash-Patient Deposits	1,000	1,000	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,447,790	2,447,790	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,325	5,325	6
7	Other Prepaid Expenses	4,413	4,413	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	25,708	25,708	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,485,236	$ 2,493,382	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	126,431	126,431	15
16	Equipment, at Historical Cost	351,495	351,495	16
17	Accumulated Depreciation (book methods)			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):	200,685	524,278	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 678,611	$ 1,002,204	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,163,847	$ 3,495,586	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 864,301	$ 864,301	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,710,000	2,027,172	29
30	Accrued Salaries Payable	222,655	222,655	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,059	20,059	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	371,234	371,234	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,188,249	$ 3,505,421	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	361,884	361,884	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 361,884	$ 361,884	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,550,133	$ 3,867,305	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (386,286)	$ (371,719)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,163,847	$ 3,495,586	48

***(See instructions.)**

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(386,286)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (386,286)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (386,286)	24 *

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,358,163	1
2	Discounts and Allowances for all Levels	(3,504,603)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,853,560	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,362,106	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,362,106	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	257,282	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	26,105	19
20	Radiology and X-Ray	7,786	20
21	Other Medical Services	34,022	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 325,195	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	37	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 37	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	533	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 533	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,541,431	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,520,988	31
32	Health Care	3,494,462	32
33	General Administration	2,475,328	33
	B. Capital Expense		
34	Ownership	685,948	34
	C. Ancillary Expense		
35	Special Cost Centers	1,492,876	35
36	Provider Participation Fee	258,115	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,927,717	40
41	**Income before Income Taxes (line 30 minus line 40)****	(386,286)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (386,286)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,468,879	44
45	Private Pay - Net Inpatient Revenue	603,947	45
46	Medicare - Net Inpatient Revenue	(264,694)	46
47	Other-(specify) Insurance	45,428	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,853,560	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 The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,874	1,910	$ 118,645	$ 62.12	1
2	Assistant Director of Nursing	1,680	1,712	64,768	37.83	2
3	Registered Nurses	30,553	31,052	830,321	26.74	3
4	Licensed Practical Nurses	32,185	32,702	626,572	19.16	4
5	CNAs & Orderlies	87,445	89,245	933,498	10.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,475	6,605	111,030	16.81	8
9	Activity Director	2,230	2,276	31,932	14.03	9
10	Activity Assistants	11,468	11,781	101,786	8.64	10
11	Social Service Workers	12,576	12,802	331,571	25.90	11
12	Dietician					12
13	Food Service Supervisor	1,538	1,570	38,919	24.79	13
14	Head Cook	5,718	5,835	69,025	11.83	14
15	Cook Helpers/Assistants	21,386	21,823	198,807	9.11	15
16	Dishwashers					16
17	Maintenance Workers	7,104	7,223	126,122	17.46	17
18	Housekeepers	21,301	21,735	197,793	9.10	18
19	Laundry	8,992	9,216	79,071	8.58	19
20	Administrator	5,996	6,056	232,434	38.38	20
21	Assistant Administrator	280	280	8,766	31.31	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,125	14,400	186,770	12.97	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,728	1,760	29,361	16.68	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,843	3,017	39,523	13.10	33
34	TOTAL (lines 1 - 33)	277,497	283,000	$ 4,356,714 *	$ 15.39	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 161,218	01-03	35
36	Medical Director	Monthly	48,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	41,279	10-03	38
39	Pharmacist Consultant	Monthly	1,638	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				44
45	Social Service Consultant	Monthly	4,470	12-03	45
46	Other(specify)				46
47	Clergy	Monthly	2,225	12-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 258,830		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Yair Zuckerman	COO	10.00%	$ 11,096
Patricia A. Long	Administrator	0	206,723
Stephanie Sandor	Administrator	0	14,615
Charles Harper	Asst Admin	0	8,766
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 241,200

B. Administrative - Other

Description	Amount
Chaim Rajchenbach - Management Fees	$ 9,678
Menachem Shabat - Management Fees	9,678
TOTAL (agree to Schedule V, line 17, col. 3)	$ 19,356
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg, & Rothblatt	Accounting	$ 15,910
Ability Network	Data Processing	1,291
American Data	Data Processing	4,434
Creative Technology Solutions	Data Processing	17,487
Emdeon	Data Processing	991
Health Data Systems	Data Processing	4,731
Prime Care Technologies	Data Processing	377
Wescom Solutions	Data Processing	15,196
Achieve Accreditations	Joint Commission Consult	17,508
IIT/Source Tech	Data Processing	100
Partner Eng & Science	Engineering Consultant	8,800
See Supplemental Schedule		425,023
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 511,848

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 130,690
Unemployment Compensation Insurance	120,254
FICA Taxes	333,288
Employee Health Insurance	168,314
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	64,804
Employee Physical Exam	10,083
Other Employee Benefits	22,455
TOTAL (agree to Schedule V, line 22, col.8)	$ 849,889

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,601
Advertising: Employee Recruitment	441
Health Care Worker Background Check	6,932
(Indicate # of checks performed 693.2)	
Patient Background Checks	
Dues and Subscriptions	3,802
License and Permits	1,980
Allocated from Legacy Financial Serv	368
Allocated from Progressive HC	14
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,138

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	8,636
Allocated from Legacy Financial Serv	380
Allocated from Progressive HC	11
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,027

**See instructions.

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 02/01/14 Ending: 12/31/14

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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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. **IL Council on LTC $6,597**

(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. $ **33,345** 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. $ **258,115**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **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? **Yes**
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: **No**

(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.