FOR BHF USE

LL1

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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0052621

Facility Name: Grove Of Fox Valley

Address: 1601 North Farnsworth (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) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/15 to 12/31/15 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)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	57,670	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	57,670	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	39,031	2,527	6,668	48,226	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,031	2,527	6,668	48,226	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.62%

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 02/01/2014

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/2014 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 5,135

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: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Grove Of Fox Valley # 0052621 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	376,275	43,246	40,210	459,731		459,731		459,731			1
2	Food Purchase		282,168		282,168		282,168	(2,341)	279,827			2
3	Housekeeping	173,443	36,050	119	209,612		209,612	106	209,718			3
4	Laundry	111,953	7,607	10,248	129,808		129,808		129,808			4
5	Heat and Other Utilities			221,104	221,104		221,104	(28,052)	193,052			5
6	Maintenance	138,563		287,131	425,694		425,694	(4,066)	421,628			6
7	Other (specify):*											7
8	**TOTAL General Services**	800,234	369,071	558,812	1,728,117		1,728,117	(34,353)	1,693,764			8
	B. Health Care and Programs											
9	Medical Director			52,345	52,345		52,345		52,345			9
10	Nursing and Medical Records	3,158,567	182,599	50,211	3,391,377		3,391,377	10,031	3,401,408			10
10a	Therapy	140,004			140,004		140,004		140,004			10a
11	Activities	148,603	5,869		154,472		154,472	214	154,686			11
12	Social Services	352,886		3,340	356,226		356,226	11,914	368,140			12
13	CNA Training											13
14	Program Transportation			21,827	21,827		21,827		21,827			14
15	Other (specify):*							5,281	5,281			15
16	**TOTAL Health Care and Programs**	3,800,060	188,468	127,723	4,116,251		4,116,251	27,439	4,143,690			16
	C. General Administration											
17	Administrative	221,401		1,620	223,021		223,021	9,740	232,761			17
18	Directors Fees											18
19	Professional Services			424,297	424,297	(100)	424,197	(229,645)	194,552			19
20	Dues, Fees, Subscriptions & Promotions			280,744	280,744		280,744	(239,150)	41,594			20
21	Clerical & General Office Expenses	211,378	14,454	437,216	663,048		663,048	(264,167)	398,881			21
22	Employee Benefits & Payroll Taxes			999,241	999,241		999,241		999,241			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,387	14,387		14,387	1,027	15,414			24
25	Other Admin. Staff Transportation			5,655	5,655		5,655		5,655			25
26	Insurance-Prop.Liab.Malpractice			112,022	112,022		112,022	3,735	115,757			26
27	Other (specify):*							27,064	27,064			27
28	**TOTAL General Administration**	432,779	14,454	2,275,182	2,722,415	(100)	2,722,315	(691,396)	2,030,918			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,033,073	571,993	2,961,717	8,566,783	(100)	8,566,683	(698,310)	7,868,373			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 Grove Of Fox Valley #0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			202,684	202,684		202,684	(12,836)	189,848			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			87,597	87,597		87,597	40,851	128,448			32
33	Real Estate Taxes			151,108	151,108	100	151,208	2,036	153,244			33
34	Rent-Facility & Grounds			679,852	679,852		679,852	94,067	773,919			34
35	Rent-Equipment & Vehicles			5,866	5,866		5,866	2,088	7,954			35
36	Other (specify):*											36
37	TOTAL Ownership			1,127,107	1,127,107	100	1,127,207	126,205	1,253,412			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		251,953	858,081	1,110,034		1,110,034		1,110,034			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			336,801	336,801		336,801		336,801			42
43	Other (specify):*			218,494	218,494		218,494	(259,426)	(40,932)			43
44	TOTAL Special Cost Centers		251,953	1,413,376	1,665,329		1,665,329	(259,426)	1,405,903			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,033,073	823,946	5,502,200	11,359,219		11,359,219	(831,530)	10,527,689			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 Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(29,191)	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	(16,565)	30		9
10	Interest and Other Investment Income	(1,289)	32		10
11	Discounts, Allowances, Rebates & Refunds	(3,702)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(148)	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	(857)	21		18
19	Entertainment				19
20	Contributions	(76,414)	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	(286,491)	21		24
25	Fund Raising, Advertising and Promotional	(158,522)	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	(371,737)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (944,915)		$	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)	113,385		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 113,385		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (831,530)		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

Grove Of Fox Valley

ID# 0052621

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sequestration	$ (62,510)	21	1
2	Patient Personal Items	(2,352)	10	2
3	Bank Charges	(8,708)	21	3
4	Meals	(13,016)	21	4
5	Marketing	(40,931)	43	5
6	PAC Dues	(5,236)	20	6
7	Non-Allowable Legal	(11,558)	19	7
8	Capitalized R&M	(6,652)	06	8
9	Building Co - Legal	(100)	19	9
10	Building Co - Professional Fees	(2,000)	19	10
11	Building Co - Penalty	(45)	21	11
12	Building Co - Accounting	(134)	19	12
13	Non-Allowable Expense	(218,494)	43	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**	(371,737)		49

Grove Of Fox Valley

ID# 0052621

Report Period Beginning: 01/01/15

Ending: 12/31/15

	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			49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Grove Of Fox Valley **#** 0052621 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(3,850)				1,509							(2,341)	2
3	Housekeeping			106									106	3
4	Laundry													4
5	Heat and Other Utilities	(29,191)		1,139									(28,052)	5
6	Maintenance	(6,652)		2,599		(13)							(4,066)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(39,693)		3,844		1,496							(34,353)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,352)				12,383							10,031	10
10a	Therapy													10a
11	Activities			214									214	11
12	Social Services					11,914							11,914	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					5,281							5,281	15
16	**TOTAL Health Care and Programs**	(2,352)		214		29,577							27,439	16
	C. General Administration													
17	Administrative			1,620		8,120							9,740	17
18	Directors Fees													18
19	Professional Services	(13,792)	2,234	(218,591)		504							(229,645)	19
20	Fees, Subscriptions & Promotions	(240,172)		944		78							(239,150)	20
21	Clerical & General Office Expenses	(371,627)	45	117,269		(9,853)							(264,167)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			951		76							1,027	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			720		3,015							3,735	26
27	Other (specify):*			29,363		(2,299)							27,064	27
28	**TOTAL General Administration**	(625,591)	2,279	(67,725)		(360)							(691,396)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(667,636)	2,279	(63,667)		30,714							(698,310)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Grove Of Fox Valley # 0052621 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	(16,565)		1,612	2,117								(12,836)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,289)	40,982	12	1,145								40,851	32
33	Real Estate Taxes			2,036									2,036	33
34	Rent-Facility & Grounds		94,067	7,575	(7,575)								94,067	34
35	Rent-Equipment & Vehicles			1,470		618							2,088	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(17,854)	135,049	12,705	(4,313)	618							126,205	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):*	(259,426)											(259,426)	43
44	**TOTAL Special Cost Centers**	(259,426)											(259,426)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(944,915)	137,328	(50,962)	(4,313)	31,332							(831,530)	45

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 677,770	Prairie Property Holdings LLC	100.00%	$ 771,837	$ 94,067	1
2	V	19	Legal		Prairie Property Holdings LLC	100.00%	100	100	2
3	V	19	Professional Fees		Prairie Property Holdings LLC	100.00%	2,000	2,000	3
4	V	21	Penalty		Prairie Property Holdings LLC	100.00%	45	45	4
5	V	19	Accounting		Prairie Property Holdings LLC	100.00%	134	134	5
6	V	32	Interest		Prairie Property Holdings LLC	100.00%	40,982	40,982	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 677,770			$ 815,098	$ * 137,328	14

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

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	3	HOUSEKEEPING SUPPLIES	$	Legacy Healthcare Financial Services	100.00%	$ 106	$ 106	15
16	V	5	UTILITIES		Legacy Healthcare Financial Services	100.00%	1,139	1,139	16
17	V	6	GROUNDS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	2,599	2,599	17
18	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services	100.00%	214	214	18
19	V	17	MANAGEMENT FEES - Y. ZUCKERMAN		Legacy Healthcare Financial Services	100.00%	1,620	1,620	19
20	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	21,409	21,409	20
21	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	944	944	21
22	V	21	CLERICAL & GENERAL WAGES		Legacy Healthcare Financial Services	100.00%	106,457	106,457	22
23	V	21	CLERICAL & GENERAL OTHER COSTS		Legacy Healthcare Financial Services	100.00%	10,812	10,812	23
24	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	951	951	24
25	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	720	720	25
26	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	29,363	29,363	26
27	V	30	DEPRECIATION		Legacy Healthcare Financial Services	100.00%	1,612	1,612	27
28	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	12	12	28
29	V	33	REAL ESTATE TAXES		Legacy Healthcare Financial Services	100.00%	2,036	2,036	29
30	V	34	RENT		Legacy Healthcare Financial Services	100.00%	7,575	7,575	30
31	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services	100.00%	1,470	1,470	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V	19	BOOKKEEPING FEES	240,000	Legacy Healthcare Financial Services	100.00%		(240,000)	36
37	V								37
38	V								38
39	Total			$ 240,000			$ 189,038	$ * (50,962)	39

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

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	30	DEPRECIATION		Legacy Real Properties	100.00%	2,117	$ 2,117	15
16	V	32	INTEREST EXPENSE		Legacy Real Properties	100.00%	1,145	1,145	16
17	V								17
18	V								18
19	V	34	RENT	7,575	Legacy Real Properties	100.00%		(7,575)	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			$ 7,575			$ 3,262	$ * (4,313)	39

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

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	$ 1,509	$ 1,509	15
16	V	6	MAINTENANCE SALARY		Progressive Healthcare Consulting	100.00%	3	3	16
17	V	6	BUILDING MAINTENANCE AND R&M		Progressive Healthcare Consulting	100.00%	833	833	17
18	V	10	MEDICAL AND NURSING SUPPLIES		Progressive Healthcare Consulting	100.00%	2	2	18
19	V	10	NURSING SALARIES		Progressive Healthcare Consulting	100.00%	57,698	57,698	19
20	V	12	ACTIVITIES PROGRAM		Progressive Healthcare Consulting	100.00%	9	9	20
21	V	12	CLERGY SALARY		Progressive Healthcare Consulting	100.00%	1,460	1,460	21
22	V	12	ADMISSIONS SALARY		Progressive Healthcare Consulting	100.00%	67,117	67,117	22
23	V	15	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	10,719	10,719	23
24	V	17	ADMIN SALARY- NON OWNER		Progressive Healthcare Consulting	100.00%	70,856	70,856	24
25	V	19	PROFESSIONAL FEES		Progressive Healthcare Consulting	100.00%	504	504	25
26	V	20	FEES, SUBSCRIPTIONS		Progressive Healthcare Consulting	100.00%	78	78	26
27	V	21	CLERICAL & GENERAL		Progressive Healthcare Consulting	100.00%	1,000	1,000	27
28	V	24	SEMINARS		Progressive Healthcare Consulting	100.00%	76	76	28
29	V	27	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	13,434	13,434	29
30	V	26	INSURANCE		Progressive Healthcare Consulting	100.00%	3,015	3,015	30
31	V	35	AUTO RENTAL		Progressive Healthcare Consulting	100.00%	618	618	31
32	V	17	ADMINISTRATOR	62,736	Progressive Healthcare Consulting	100.00%		(62,736)	32
33	V	10	NURSING	45,318	Progressive Healthcare Consulting	100.00%		(45,318)	33
34	V	12	SOCIAL SERVICE	56,672	Progressive Healthcare Consulting	100.00%		(56,672)	34
35	V	06	MAINTENANCE	849	Progressive Healthcare Consulting	100.00%		(849)	35
36	V	21	CLERICAL	10,853	Progressive Healthcare Consulting	100.00%		(10,853)	36
37	V	15	PAYROLL TAXES- NURSING	5,438	Progressive Healthcare Consulting	100.00%		(5,438)	37
38	V	27	PAYROLL TAXES	15,733	Progressive Healthcare Consulting	100.00%		(15,733)	38
39	Total			$ 197,599			$ 228,931	$ * 31,332	39

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

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	YAIR ZUCKERMAN	99.00%	ASTORIA PLACE SKILLED NURSING FACILITY LLC	CHICAGO	PRAIRIE PROPERTY HOLDINGS LLC		BUILDING COMPANY	1
2	DINA ZUCKERMAN	1.00%	BETHANY TERRACE	MORTON GROVE	LEGACY REAL PROPERTIES	LINCOLNWOOD	BUILDING CO	2
3			CARLTON SKILLED NURSING FACILITY LLC	CHICAGO	LEGACY HC & FINANCIAL SER	LINCOLNWOOD	HOME OFFICE/BOOKKEEPI	3
4			CHALET SKILLED NURSING FACILITY LLC	CHICAGO	PROGRESSIVE HC	LINCOLNWOOD	NURSE CONSULTANT	4
5			ELMBROOK SKILLED NURSING FACILITY LLC	ELMHURST	ML GROUP DESIGN & DEV	SKOKIE	ASSET MANAGEMENT	5
6			EVANSTON SKILLED NURSING FACILITY LLC	EVANSTON	REMED SERVICES LLC	LINCOLNWOOD	NURSING EQUIPMENT	6
7			LAGRANGE SKILLED NURSING FACILITY LLC	LAGRANGE PARK	AURORA SUPPORTIVE LIVING	AURORA	SUPPORTIVE LIVING	7
8			GROVE AT THE LAKE SKILLED NURSING FACILITY LLC	ZION	TERRACE GARDENS	MORTON GROVE	ASSISTED LIVING	8
9			LAKEFRONT SKILLED NURSING FACILITY LLC	CHICAGO	LINCOLNSHIRE ASSISTED LIVI	LINCOLNSHIRE	ASSISTED LIVING	9
10			LINCOLN PARK SKILLED NURSING FACILITY LLC	CHICAGO				10
11			LINCOLNSHIRE LIVING & REHAB CENTER LLC	LINCOLNSHIRE				11
12			AVANTARA LONG GROVE	LONG GROVE				12
13			SKOKIE SKILLED NURSING FACILITY LLC	SKOKIE				13
14			NORTHBROOK SKILLED NURSING FACILITY LLC	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 LIVING AND REHAB	CHICAGO				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 Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Yair Zuckerman	Owner	Administrative	99.00%	See Attached	1.98	4.95%	Alloc Sal/Fee	$ 9,878	17-3/17-7	1
2											2
3											3
4											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	$ 9,878		13

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

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

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	3	HOUSEKEEPING SUPPLIES	AVAIL. BED DAYS	1,253,624	23	$ 2,296	$	57,670	$ 106	1
2	5	UTILITIES	AVAIL. BED DAYS	1,253,624	23	24,766		57,670	1,139	2
3	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	1,253,624	23	56,504		57,670	2,599	3
4	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,253,624	23	4,642		57,670	214	4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,253,624	23	465,391		57,670	21,409	5
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,253,624	23	20,516		57,670	944	6
7	21	CLERICAL & GENERAL WAG	AVAIL. BED DAYS	1,253,624	23	2,314,153	2,314,153	57,670	106,457	7
8	21	CLERICAL & GENERAL OTH	AVAIL. BED DAYS	1,253,624	23	235,020		57,670	10,812	8
9	24	SEMINARS	AVAIL. BED DAYS	1,253,624	23	20,662		57,670	951	9
10	26	INSURANCE	AVAIL. BED DAYS	1,253,624	23	15,655		57,670	720	10
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	1,253,624	23	638,286		57,670	29,363	11
12	30	DEPRECIATION	AVAIL. BED DAYS	1,253,624	23	35,040		57,670	1,612	12
13	32	INTEREST	AVAIL. BED DAYS	1,253,624	23	267		57,670	12	13
14	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,253,624	23	44,250		57,670	2,036	14
15	34	RENT	AVAIL. BED DAYS	1,253,624	23	164,669		57,670	7,575	15
16	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,253,624	23	31,945		57,670	1,470	16
17										17
18	17	MGMT FEES- Y. ZUCKERMAN	AVG HOURS WKD	50	20	32,807		2.47	1,620	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,106,869	$ 2,314,153		$ 189,038	25

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	30	DEPRECIATION	AVAIL. BED DAYS	1,253,624	23	46,013		57,670	2,117	1
2	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,253,624	23	24,899		57,670	1,145	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					$ 70,912	$		$ 3,262	25

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1,167,679	20	$ 30,560	$	57,670	$ 1,509	1
2	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,167,679	20	65	65	57,670	3	2
3	6	BUILDING MAINTENANCE AI	AVAIL. BED DAYS	1,167,679	20	16,865		57,670	833	3
4	10	MEDICAL AND NURSING SUP	AVAIL. BED DAYS	1,167,679	20	47		57,670	2	4
5	10	NURSING SALARIES	AVAIL. BED DAYS	1,167,679	20	1,168,252	1,168,252	57,670	57,698	5
6	12	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,167,679	20	187		57,670	9	6
7	12	CLERGY SALARY	AVAIL. BED DAYS	1,167,679	20	29,559	29,559	57,670	1,460	7
8	12	ADMISSIONS SALARY	AVAIL. BED DAYS	1,167,679	20	1,358,960	1,358,960	57,670	67,117	8
9	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,167,679	20	217,026		57,670	10,719	9
10	17	ADMIN SALARY- NON OWNE	AVAIL. BED DAYS	1,167,679	20	1,434,659	1,434,659	57,670	70,856	10
11	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,167,679	20	10,207		57,670	504	11
12	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,167,679	20	1,577		57,670	78	12
13	21	CLERICAL & GENERAL	AVAIL. BED DAYS	1,167,679	20	20,243		57,670	1,000	13
14	24	SEMINARS	AVAIL. BED DAYS	1,167,679	20	1,535		57,670	76	14
15	27	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,167,679	20	272,007		57,670	13,434	15
16	26	INSURANCE	AVAIL. BED DAYS	1,167,679	20	61,041		57,670	3,015	16
17	35	AUTO RENTAL	AVAIL. BED DAYS	1,167,679	20	12,512		57,670	618	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,635,301	$ 3,991,495		$ 228,931	25

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	The Private Bank		X	Line of Credit				5,179,296			87,597	6
7	The Private Bank		X	Line of Credit				949,077			40,982	7
8	See Supplemental Schedule										1,157	8
9	TOTAL Facility Related						$	$ 6,128,373			$ 129,736	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,289)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,289)	14
15	TOTALS (line 9+line14)						$	$ 6,128,373			$ 128,447	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 Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Alloc from Legacy Healthcare	X					$	$			$ 12	8
9	Alloc from Legacy Real Prop	X									1,145	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										1,157	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 Grove Of Fox Valley # 0052621 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	27,929	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.)	$	181,073	2
3. Under or (over) accrual (line 2 minus line 1).	$	153,144	3
4. Real Estate Tax accrual used for 2015 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.**	$	100	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** $ 301 **For** 2010-12 **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.	$	153,244	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	113,272	8
	2011	115,226	9
	2012	137,371	10
	2013	159,306	11
	2014	179,037	12

Beginning Accrual Adjusted
Allocated from Legacy Real Properties: $2,036

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2014 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 2014.

	(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	$ 179,036.96	$ 179,036.96
2.	10-35-104-076-0000	Home Office Allocation	$ 39,271.59	$ 1,806.60
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 218,308.55	$ 180,843.56

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 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 Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Allocated from Legacy Real Properties			$ 3,764	1
2					2
3	TOTALS			$ 3,764	3

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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)		64,393	1,842		2,684	842	14,937	68
69	Financial Statement Depreciation			202,684			(202,684)		69
70	TOTAL (lines 4 thru 69)		$ 64,393	$ 204,526		$ 2,684	$ (201,842)	$ 14,937	70

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

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 64,393	$ 204,526		$ 2,684	$ (201,842)	$ 14,937	1
2	Security Systems	2014	15,340		20	805	805	1,610	2
3	Ball Bearing Hinges	2014	5,386		20	90	90	180	3
4	Concrete Work	2014	2,900		20	24	24	48	4
5	Fluorescent Wall Fixture	2014	6,218		20	26	26	52	5
6	Landscaping - Tree Work	2014	22,914		20	1,146	1,146	2,291	6
7	Wings 100,200,300,400 - Handrails,Cornerguards, Flooring	2014	59,130		20	2,957	2,957	5,913	7
8	Kitchen And Room 412-Electrical Wiring And Receptacles	2014	4,653		20	233	233	465	8
9	Elevator Repair	2014	2,556		20	128	128	256	9
10	Exterior Signage	2014	9,505		20	475	475	951	10
11	Laundry Rm - Electrical Wiring	2015	2,850		20	143	143	143	11
12	Installed 2 Beams, Floor Reinforcement	2015	3,750		20	188	188	188	12
13	Basement - Concrete/Electrical And Pumps	2015	5,850		20	293	293	293	13
14	Repaired Boilers	2015	8,148		20	407	407	407	14
15	Installed Steel Pump	2015	2,870		20	144	144	144	15
16	4 Grab Bars For Shower Room	2015	2,600		20	130	130	130	16
17	300 Wing Rm 310,410 - Tiling/Valves/Light Fixtures	2015	5,875		20	294	294	294	17
18	Painted Corridors 401-417	2015	28,240		20	1,412	1,412	1,412	18
19	Tv Wiring	2015	9,663		20	483	483	483	19
20	500 Wing Wallcovering	2015	7,358		20	368	368	368	20
21	1St Floor - Asbestos Removal	2015	114,500		20	5,725	5,725	5,725	21
22	Paint Rms 208-215/201/308//316/401/407/409/411-416/206	2015	80,118		20	4,006	4,006	4,006	22
23	Fire Alarm System	2015	11,959		20	598	598	598	23
24	Installed Bricks	2015	21,872		20	1,094	1,094	1,094	24
25	Entrance Canopy	2015	35,350		20	1,768	1,768	1,768	25
26	Installed A/C System For New Office	2015	4,988		20	249	249	249	26
27	Fire Alarm System	2015	19,279		20	964	964	964	27
28	100-500 Wings - Demo/Electrical/Flooring/Handrails/Frames	2015	147,795		20	7,390	7,390	7,390	28
29	Related Architect Fees - 100-500 Wing Project	2015			20				29
30	Roof Repairs	2015	59,375		20	2,969	2,969	2,969	30
31	Fire Alarm System	2015	11,512		20	576	576	576	31
32	Hallway Window Shades	2015	2,671		20	134	134	134	32
33	Repaired/Sealcoat/Restriped Asphalt	2015	11,350		20	568	568	568	33
34	TOTAL (lines 1 thru 33)		$ 790,968	$ 204,526		$ 38,465	$ (166,061)	$ 56,601	34

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

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 790,968	$ 204,526		$ 38,465	$ (166,061)	$ 56,601	1
2	Wiring For Resident Room A/C	2015	6,023		20	301	301	301	2
3	Replaced Ceiling Cables	2015	2,980		20	149	149	149	3
4	Signs For Room/Restroom/Elevator	2015	10,354		20	518	518	518	4
5	Exterior Hallway Corner Guards And Painted Railings/Doors	2015	2,985		20	149	149	149	5
6	500 Wing Nurse Call System	2015	12,085		20	604	604	604	6
7	Wiring For Phone System	2015	6,115		20	306	306	306	7
8	Installed Low Ambient System	2015	4,988		20	249	249	249	8
9	Repaired Wiring For Phone System	2015	2,679		20	134	134	134	9
10	Repaired Boiler Pumps And Valves	2015	2,640		20	132	132	132	10
11	100-400 Wing Curtains	2015	28,552		20	1,428	1,428	1,428	11
12	40 Bathroom Mirrors	2015	2,705		20	135	135	135	12
13	Lobby/Dining/Library Drapery	2015	18,424		20	921	921	921	13
14	Corridor Pendant Light Fixture	2015	6,994		20	350	350	350	14
15	Corridor Wall And Ceiling Light Fixture	2015	2,566		20	128	128	128	15
16	Nurse Call System	2015	6,825		20	341	341	341	16
17	40 Shades For Resident Rooms	2015	10,125		20	506	506	506	17
18	Corridor Light Fixtures	2015	3,201		20	160	160	160	18
19	100-500 Wing-Demo/Carpentry/Roofing/Walls/Flooring/Electrical	2015	1,759,010		20	87,951	87,951	87,951	19
20	Repaired Pipes For A/C Units	2015	2,982		20	149	149	149	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)		$ 2,683,200	$ 204,526		$ 133,077	$ (71,449)	$ 151,213	34

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

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 2,683,200	$ 204,526		$ 133,077	$ (71,449)	$ 151,213	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)		$ 2,683,200	$ 204,526		$ 133,077	$ (71,449)	$ 151,213	34

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

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 2,683,200	$ 204,526		$ 133,077	$ (71,449)	$ 151,213	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,683,200	$ 204,526		$ 133,077	$ (71,449)	$ 151,213	34

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

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2	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 Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Legacy Real Properties	2009	29,159	992	35	972	(20)	6,318	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Legacy HC Financial Services	2012	1,312	86	20	66	(20)	262	9
10	Allocated from Legacy HC Financial Services	2013	4,196	274	20	210	(64)	629	10
11	Allocated from Legacy HC Financial Services	2014	410	27	20	20	(7)	41	11
12	Allocated from Legacy HC Financial Services	2015	565	37	20	28	(9)	28	12
13									13
14	Allocated from Legacy Real Properties	2009	16,559	245	20	828	583	4,761	14
15	Allocated from Legacy Real Properties	2010	5,035	75	20	202	127	1,109	15
16	Allocated from Legacy Real Properties	2011	7,157	106	20	358	252	1,789	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)		$ 64,393	$ 1,842		$ 2,684	$ 842	$ 14,937	34

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

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 64,393	$ 1,842		$ 2,684	$ 842	$ 14,937	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
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 64,393	$ 1,842		$ 2,684	$ 842	$ 14,937	34

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

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 356,840	$ 1,828	$ 35,006	$ 33,178	10	$ 73,162	71
72	Current Year Purchases	217,658	60	21,766	21,706	10	21,766	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 574,498	$ 1,888	$ 56,772	$ 54,884		$ 94,927	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)	$ 3,261,462	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 206,414	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 189,849	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (16,565)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 246,140	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	Lobby/Exterior/500 Wing	$ 333,249	92
93			93
94			94
95		$ 333,249	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 Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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				2,082			5
6	BNF Venture Fund LLC				771,837			6
7	TOTAL				$ 773,919 **			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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 7,336 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		$	$ 618	17
18					18
19					19
20					20
21	TOTAL		$	$ 618	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 Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 310,910	$		$ 310,910	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			88,969			88,969	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			386,908			386,908	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				220,376		220,376	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					71,294	31,577		102,871	13
14	TOTAL			$		$ 858,081	$ 251,953		$ 1,110,034	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 Grove Of Fox Valley **#** 0052621 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/15 **(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	$ 1,270	$ 9,469	1
2	Cash-Patient Deposits	1,000	1,000	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,389,601	2,389,601	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,285	14,285	6
7	Other Prepaid Expenses	31,764	31,764	7
8	Accounts Receivable (owners or related parties)	2,460,935	2,460,935	8
9	Other(specify):	166,858	166,858	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,065,713	$ 5,073,912	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	2,576,864	2,576,864	15
16	Equipment, at Historical Cost	644,725	644,725	16
17	Accumulated Depreciation (book methods)	(243,080)	(243,080)	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):	409,262	477,070	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,387,771	$ 3,455,579	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,453,484	$ 8,529,491	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,609,085	$ 2,609,085	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	5,179,296	6,128,373	29
30	Accrued Salaries Payable	195,177	195,177	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,717	7,717	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	1,294,671	397,867	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 9,285,946	$ 9,338,219	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				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 9,285,946	$ 9,338,219	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (832,462)	$ (808,728)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,453,484	$ 8,529,491	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (386,286)	1
2	Restatements (describe):		2
3	**PY Management Fees**	(16,235)	3
4	**PY Bad Debt**	(1,037)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (403,558)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(428,904)	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)**	$ (428,904)	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)**	$ (832,462)	24 *

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,983,829	1
2	Discounts and Allowances for all Levels	(5,946,464)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,037,365	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,631,350	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,631,350	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	214,395	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	28,770	19
20	Radiology and X-Ray	7,105	20
21	Other Medical Services	6,339	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 256,609	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,289	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,289	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	3,702	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,702	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,930,315	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,728,117	31
32	Health Care	4,116,251	32
33	General Administration	2,722,415	33
	B. Capital Expense		
34	Ownership	1,127,107	34
	C. Ancillary Expense		
35	Special Cost Centers	1,328,528	35
36	Provider Participation Fee	336,801	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,359,219	40
41	**Income before Income Taxes (line 30 minus line 40)****	(428,904)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (428,904)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,416,346	44
45	Private Pay - Net Inpatient Revenue	472,590	45
46	Medicare - Net Inpatient Revenue	5,979	46
47	Other-(specify) Insurance	142,450	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,037,365	49

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,656	1,696	$ 90,265	$ 53.22	1
2	Assistant Director of Nursing	2,118	2,174	87,805	40.39	2
3	Registered Nurses	34,681	35,507	1,044,599	29.42	3
4	Licensed Practical Nurses	26,296	26,948	687,381	25.51	4
5	CNAs & Orderlies	81,991	84,048	1,138,466	13.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,742	6,948	140,004	20.15	8
9	Activity Director	2,413	2,476	40,809	16.48	9
10	Activity Assistants	9,721	10,025	107,794	10.75	10
11	Social Service Workers	13,036	13,372	352,886	26.39	11
12	Dietician					12
13	Food Service Supervisor	2,104	2,160	69,034	31.96	13
14	Head Cook	5,787	5,939	93,443	15.73	14
15	Cook Helpers/Assistants	19,363	19,899	213,798	10.74	15
16	Dishwashers					16
17	Maintenance Workers	6,379	6,539	138,563	21.19	17
18	Housekeepers	15,765	16,269	173,443	10.66	18
19	Laundry	10,593	10,900	111,953	10.27	19
20	Administrator	4,034	4,132	221,401	53.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,930	11,259	211,378	18.77	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	2,111	2,159	39,074	18.10	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	5,336	5,174	70,977	13.72	33
34	TOTAL (lines 1 - 33)	261,056	267,624	$ 5,033,073 *	$ 18.81	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	$ 40,210	01-03	35
36	Medical Director	Monthly	52,345	09-03	36
37	Medical Records Consultant	Monthly	4,000	10-03	37
38	Nurse Consultant		40,931	10-03	38
39	Pharmacist Consultant	Monthly	5,280	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	3,340	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 146,106		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
Stephanie Sandor	Administrator	0.00%	$ 33,215
Nora O'Goremann	Administrator	0.00%	83,540
Camberly Lanning	Administrator	0.00%	104,647
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 221,401

B. Administrative - Other

Description	Amount
Yair Zuckerman - Management Fees	$ 1,620
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,620
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R/Marcum LLP	Accounting	$ 24,000
Document Solutions	Compliance Audit	935
Achieve Accreditation LLC	Joint Commission Consult	16,451
Personnel Planners	Unemployment Consultant	2,333
Prospect Resources	Energy Procurement	900
Paycor	Payroll Processing	21,709
See Attached	Legal	62,297
PSD Solutions	Compliance	3,470
ALIN	IT Consulting	1,500
Legacy Healthcare	Bookkeeping	240,000
Linda Smith	Long Term Care Consultant	455
See Supplemental Schedule		50,248
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 424,298

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 159,836
Unemployment Compensation Insurance	113,668
FICA Taxes	385,030
Employee Health Insurance	168,422
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	117,318
401K Contribution	4,752
Employee Physical Exam	15,918
Other Employee Benefits	34,295
TOTAL (agree to Schedule V, line 22, col.8)	$ 999,240

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	$ 2,332
Advertising: Employee Recruitment	1,197
Health Care Worker Background Check	7,904
(Indicate # of checks performed 790)	
Patient Background Checks	
Dues and Subscriptions	21,403
License and Permits	7,736
Allocated from Legacy HC Financial Serv	944
Allocated from Progressive HC	78
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 41,594

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	14,387
Allocated from Legacy Financial Serv	951
Allocated from Progressive HC	76
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,414

**See instructions.

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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													
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9													
10													
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12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Grove Of Fox Valley # 0052621 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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 $15,866**

(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. $ **45,026** 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. $ **336,801**
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.