FOR BHF USE

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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

I. IDPH License ID Number: 0052621

Facility Name: 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: Amanda Springborn **Telephone Number:** (314) 925-3838
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 1/01/17 to 12/31/17 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) RSM US LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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: 1/01/17 Ending: 12/31/17

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			9,246	9,246	8
9	SNF/PED					9
10	ICF	40,782	3,671		44,453	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,782	3,671	9,246	53,699	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.11%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
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] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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 6,139

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Grove Of Fox Valley # 0052621 **Report Period Beginning:** 1/01/17 **Ending:** 12/31/17

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	406,790	62,816	-	469,606		469,606	-	469,606			1
2	Food Purchase		335,032		335,032		335,032	65	335,097			2
3	Housekeeping	259,366	28,608	-	287,974		287,974	210	288,184			3
4	Laundry	29,921	18,562	184,900	233,383	-	233,383	6	233,389			4
5	Heat and Other Utilities			166,702	166,702		166,702	1,237	167,939			5
6	Maintenance	117,131	76,244	171,986	365,361		365,361	47,373	412,734			6
7	Other (specify):*	-	-	-	-		-	-	-			7
8	**TOTAL General Services**	813,208	521,262	523,588	1,858,058	-	1,858,058	48,891	1,906,949			8
	B. Health Care and Programs											
9	Medical Director	-	-	19,610	19,610		19,610	645	20,255			9
10	Nursing and Medical Records	4,044,768	198,210	178,417	4,421,395		4,421,395	(3,601)	4,417,794			10
10a	Therapy	107,916	-	-	107,916		107,916	-	107,916			10a
11	Activities	184,530	5,464	1,985	191,979		191,979	4,899	196,878			11
12	Social Services	123,418	-	851	124,269		124,269	1,759	126,028			12
13	CNA Training	-	-	-	-		-	-	-			13
14	Program Transportation	-	-	-	-		-	-	-			14
15	Other (specify):* Mgmt. Co. Alloc.	-	-	-	-		-	16,811	16,811			15
16	**TOTAL Health Care and Programs**	4,460,632	203,674	200,863	4,865,169	-	4,865,169	20,513	4,885,682			16
	C. General Administration											
17	Administrative	290,556	-	257,686	548,242		548,242	(423,976)	124,266			17
18	Directors Fees			-	-		-	-	-			18
19	Professional Services			104,053	104,053		104,053	14,401	118,454			19
20	Dues, Fees, Subscriptions & Promotions			68,724	68,724		68,724	(3,179)	65,545			20
21	Clerical & General Office Expenses	207,826	-	307,567	515,393		515,393	207,052	722,445			21
22	Employee Benefits & Payroll Taxes			1,104,802	1,104,802		1,104,802	-	1,104,802			22
23	Inservice Training & Education			-	-		-	-	-			23
24	Travel and Seminar			1,500	1,500		1,500	1,943	3,443			24
25	Other Admin. Staff Transportation		-	140	140		140	-	140			25
26	Insurance-Prop.Liab.Malpractice			109,702	109,702		109,702	3,582	113,284			26
27	Other (specify):* Mgmt. Co. Alloc.	-	-	-	-		-	3,519	3,519			27
28	**TOTAL General Administration**	498,382	-	1,954,174	2,452,556	-	2,452,556	(196,658)	2,255,898			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,772,222	724,936	2,678,625	9,175,783	-	9,175,783	(127,254)	9,048,529			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:** 1/01/17 **Ending:** 12/31/17

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			492,607	492,607		492,607	(250,530)	242,077			30
31	Amortization of Pre-Op. & Org.			-	-		-	-	-			31
32	Interest			94,243	94,243		94,243	46,089	140,332			32
33	Real Estate Taxes			188,212	188,212		188,212	4,760	192,972			33
34	Rent-Facility & Grounds			864,367	864,367		864,367	(165,244)	699,123			34
35	Rent-Equipment & Vehicles			59,809	59,809		59,809	4,460	64,269			35
36	Other (specify):*			-	-		-	-	-			36
37	**TOTAL Ownership**			1,699,238	1,699,238	-	1,699,238	(360,465)	1,338,773			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-	-		-	-	-			38
39	Ancillary Service Centers	-	554,607	894,839	1,449,446		1,449,446	-	1,449,446			39
40	Barber and Beauty Shops	-	-	-	-		-	-	-			40
41	Coffee and Gift Shops	-	-	-	-		-	-	-			41
42	Provider Participation Fee			375,571	375,571		375,571	-	375,571			42
43	Other (specify):* **Non-Allowable Cos**	86,971	-	534,781	621,752		621,752	(621,752)	-			43
44	**TOTAL Special Cost Centers**	86,971	554,607	1,805,191	2,446,769	-	2,446,769	(621,752)	1,825,017			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,859,193	1,279,543	6,183,054	13,321,790	-	13,321,790	(1,109,471)	12,212,319			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: 1/01/17 Ending: 12/31/17

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(428)	43		4
5	Telephone, TV & Radio in Resident Rooms	(22,788)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(251,343)	30		9
10	Interest and Other Investment Income	(7,040)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,630)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,023)	43		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,783)	43		18
19	Entertainment				19
20	Contributions	(51,239)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(314,118)	43		24
25	Fund Raising, Advertising and Promotional	(25,864)	43		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 See Page 5A	(208,297)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (890,553)		$	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)	(218,918)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (218,918)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,109,471)		37

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

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

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

STATE OF ILLINOIS **Page 5A**

Grove Of Fox Valley

ID# **0052621**

Report Period Beginning: **1/01/17**

Ending: **12/31/17**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs - Part A	$ (16,965)	43	1
2	X Rays - Part A	(11,611)	43	2
3	Sequestration	(80,840)	43	3
4	Consolidated Billings	(1,492)	43	4
5	Misc Income	(271)	21	5
6	Non Allowable Salaries	(86,971)	43	6
7	Non Allowable Dues	(5,849)	20	7
8	Non allowable dues	(560)	20	8
9	Non allowable legal	(3,738)	19	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
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**	(208,297)		49

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/01/17 Ending: 12/31/17

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	Rent	$ 1,052,579	Prairie Property Holdings	100.00%	$ 843,359	$ (209,220)	1
2	V	32	Interest		Prairie Property Holdings	100.00%	47,577	47,577	2
3	V	19	Legal Fees		Prairie Property Holdings	100.00%	4,500	4,500	3
4	V	19	Professional Fees		Prairie Property Holdings	100.00%	1,750	1,750	4
5	V	20	Licenses and Permits		Prairie Property Holdings	100.00%	250	250	5
6	V	20	Fees		Prairie Property Holdings	100.00%	2,000	2,000	6
7	V	20	Tax Return	59				(59)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,052,638			$ 899,436	$ * (153,202)	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: 1/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	FOOD	$	Legacy Healthcare Financial Services	100.00%	$ 47	$ 47	15
16	V	3	HOUSEKEEPING SUPPLIES		Legacy Healthcare Financial Services	100.00%	210	210	16
17	V	4	LINEN REPLACEMENT		Legacy Healthcare Financial Services	100.00%	6	6	17
18	V	5	UTILITIES		Legacy Healthcare Financial Services	100.00%	12	12	18
19	V	6	GROUNDS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	2,823	2,823	19
20	V	9	MEDICAL DIRECTOR CONSULTANT		Legacy Healthcare Financial Services	100.00%	645	645	20
21	V	10	MEDICAL SUPPLIES		Legacy Healthcare Financial Services	100.00%	40	40	21
22	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services	100.00%	4,880	4,880	22
23	V	12	SOCIAL SERVICE CONSULTANT		Legacy Healthcare Financial Services	100.00%	77	77	23
24	V	17	CFO SALARY		Legacy Healthcare Financial Services	100.00%	22,183	22,183	24
25	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	15,072	15,072	25
26	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	857	857	26
27	V	21	CLERICAL & GENERAL WAGES		Legacy Healthcare Financial Services	100.00%	171,258	171,258	27
28	V	21	CLERICAL & GENERAL OTHER COSTS		Legacy Healthcare Financial Services	100.00%	4,733	4,733	28
29	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	1,133	1,133	29
30	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	950	950	30
31	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	36,112	36,112	31
32	V	30	DEPRECIATION		Legacy Healthcare Financial Services	100.00%			32
33	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	18	18	33
34	V	33	REAL ESTATE TAXES		Legacy Healthcare Financial Services	100.00%			34
35	V	34	RENT		Legacy Healthcare Financial Services	100.00%	43,821	43,821	35
36	V	34	STORAGE		Legacy Healthcare Financial Services	100.00%	92	92	36
37	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services	100.00%	22	22	37
38	V	35	AUTO RENTAL		Legacy Healthcare Financial Services	100.00%	3,193	3,193	38
39	Total			$			$ 308,184	$ * 308,184	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: 1/01/17 Ending: 12/31/17

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	17	MANAGEMENT FEE	$ 257,686	Legacy Healthcare Financial Services, LLC	100.00%	$	$ (257,686)	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			$ 257,686			$ 0	$ * (257,686)	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: 1/01/17 Ending: 12/31/17

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

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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%	$ 18	$ 18	15
16	V	6	MAINTENANCE SALARY		Progressive Healthcare Consulting	100.00%	44,032	44,032	16
17	V	6	BUILDING MAINTENANCE AND R&M		Progressive Healthcare Consulting	100.00%	131	131	17
18	V	10	NURSING SALARIES	111,819	Progressive Healthcare Consulting	100.00%	108,178	(3,641)	18
19	V	12	ACTIVITIES PROGRAM		Progressive Healthcare Consulting	100.00%	19	19	19
20	V	12	CLERGY CONSULANT		Progressive Healthcare Consulting	100.00%	1,678	1,678	20
21	V	12	SOCIAL SERVICES		Progressive Healthcare Consulting	100.00%	4	4	21
22	V	15	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	16,811	16,811	22
23	V	17	AMINISTRATIVE SALARY	334,736	Progressive Healthcare Consulting	100.00%	146,263	(188,473)	23
24	V	19	PAYROLL PROCESSING		Progressive Healthcare Consulting	100.00%	341	341	24
25	V	19	PROFESSIONAL LEGAL FEES		Progressive Healthcare Consulting	100.00%	4	4	25
26	V	19	OTHER PROFESSIONAL		Progressive Healthcare Consulting	100.00%	23	23	26
27	V	20	DUES AND SUBSCRIPTIONS		Progressive Healthcare Consulting	100.00%	180	180	27
28	V	21	OFFICE SALARY		Progressive Healthcare Consulting	100.00%	31,000	31,000	28
29	V	21	OFFICE EXPENSE		Progressive Healthcare Consulting	100.00%	331	331	29
30	V	24	EDUCATION AND SEMINARS		Progressive Healthcare Consulting	100.00%	810	810	30
31	V	26	INSURANCE		Progressive Healthcare Consulting	100.00%	2,315	2,315	31
32	V	27	EMP. BEN.-NURSING	66,983	Progressive Healthcare Consulting	100.00%	34,390	(32,593)	32
33	V	30	DEPRECIATON		Progressive Healthcare Consulting	100.00%	813	813	33
34	V	34	STORAGE RENTAL		Progressive Healthcare Consulting	100.00%	63	63	34
35	V	35	AUTO		Progressive Healthcare Consulting	100.00%	1,245	1,245	35
36	V								36
37	V								37
38	V								38
39	Total			$ 513,538			$ 388,649	$ * (124,889)	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: 1/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	CF ST. LOUIS, LLC	100.00%	$ 1,225	$ 1,225	15
16	V	6	REPAIRS & MAINTENANCE		CF ST. LOUIS, LLC	100.00%	1,548	1,548	16
17	V	19	ACCOUNTING		CF ST. LOUIS, LLC	100.00%	32	32	17
18	V	19	LEGAL		CF ST. LOUIS, LLC	100.00%			18
19	V	19	PROFESSIONAL FEES		CF ST. LOUIS, LLC	100.00%	50	50	19
20	V	20	DUES AND SUBSCRIPTIONS		CF ST. LOUIS, LLC	100.00%	2	2	20
21	V	21	OFFICE EXPENSE		CF ST. LOUIS, LLC	100.00%	1	1	21
22	V	26	INSURANCE		CF ST. LOUIS, LLC	100.00%	317	317	22
23	V	32	INTEREST EXPENSE		CF ST. LOUIS, LLC	100.00%	5,534	5,534	23
24	V	33	REAL ESTATE TAXES		CF ST. LOUIS, LLC	100.00%	4,535	4,535	24
25	V	33	REAL ESTATE LEGAL		CF ST. LOUIS, LLC	100.00%	225	225	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			$			$ 13,469	$ * 13,469	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: 1/01/17 Ending: 12/31/17

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	6	Repairs & Maintenance	$ 28,512	ReMed Services, LLC	1.00%	$ 27,351	$ (1,161)	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			$ 28,512			$ 27,351	$ * (1,161)	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: 1/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	$ 15,183	ProPay HR LLC	24.00%	$ 11,550	$ (3,633)	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			$ 15,183			$ 11,550	$ * (3,633)	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: 1/01/17 Ending: 12/31/17

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	6	Repairs & Maintenance	$ 362,157	ML Group Design and Development		$ 362,157	$	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			$ 362,157			$ 362,157	$ *	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: 1/01/17 Ending: 12/31/17

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 Living & Rehab	Chicago	Legacy Healthcare	Skokie	Management Co.	1
2	DINA ZUCKERMAN	1.00%	Bella Terra Morton Grove	Morton Grove	Financial Srvcs, LLC			2
3			Chalet Living & Rehab Center	Chicago				3
4			Elmbrook Nursing	Elmhurst	Legacy Real	Skokie	Real Estate	4
5			The Grove of Evanston, LLC	Evanston	Properties, LLC			5
6			The Villa at Evergreen	Evergreen Park				6
7			Warren Barr Lincolnshire	Lincolnshire	Grove Healthcare	Skokie	Real Estate	7
8			The Grove of LaGrange Park LLC	LaGrange Park	Properties, LLC			8
9			The Grove at the Lake	Zion				9
10			Lakefront Nursing & Rehab Center, LLC	Chicago	ReMED Services,	Skokie	Medical	10
11			The Grove at Lincoln Park Living & Rehab	Chicago	LLC		Equipment Sales	11
12			Avantara Long-Grove	Long Grove				12
13			The Grove North Living & Rehab Center	Skokie	Progressive	Skokie	Consulting	13
14			The Grove of Northbrook	Northbrook	Healthcare			14
15			Warren Barr North Shore	Highland Park	Consulting			15
16			Avantara Park Ridge	Park Ridge				16
17			Peterson Park Associates Ltd. Partnetship	Chicago	MG Property	Morton Grove	Real Estate	17
18			Warren Barr South Loop	Chicago	Holdings, LLC			18
19			Warren Barr	Chicago				19
20			Aurora Supportive Living	Aurora	Lifeline Ambulance	Chicago	Ambulance Svcs.	20
21								21
22					ProPay	Evanston	Payroll Services	22
23								23
24					ML Group Design	Skokie	Asset Mgmt Fees	24
25								25
26					ML Enterprise	Skokie	Asset Mgmt Fees	26
27								27
28					CF St.Louis Inc	Skokie	Management Co.	28
29								29
30								30

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/01/17 Ending: 12/31/17

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									$		1
2											2
3											3
4											4
5											5
6	No Owners from this facility										6
7	received any compensation.										7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	FOOD	Bed Days Available	1,789,215	30	$ 1,460	$	57,670	$ 47	1
2	3	HOUSEKEEPING SUPPLIES	Bed Days Available	1,789,215	30	6,519		57,670	210	2
3	4	LINEN REPLACEMENT	Bed Days Available	1,789,215	30	171		57,670	6	3
4	5	UTILITIES	Bed Days Available	1,789,215	30	372		57,670	12	4
5	6	GROUNDS & MAINTENANCE	Bed Days Available	1,789,215	30	87,596		57,670	2,824	5
6	9	MEDICAL DIRECTOR CONSU	Bed Days Available	1,789,215	30	20,000		57,670	645	6
7	10	MEDICAL SUPPLIES	Bed Days Available	1,789,215	30	1,237		57,670	40	7
8	11	ACTIVITIES PROGRAM	Bed Days Available	1,789,215	30	151,405		57,670	4,880	8
9	12	SOCIAL SERVICE CONSULTA	Bed Days Available	1,789,215	30	2,392		57,670	77	9
10	17	CFO SALARY	Bed Days Available	1,789,215	30	688,242	688,242	57,670	22,183	10
11	19	PROFESSIONAL FEES	Bed Days Available	1,789,215	30	467,580		57,670	15,071	11
12	20	FEES, SUBSCRIPTIONS	Bed Days Available	1,789,215	30	26,590		57,670	857	12
13	21	CLERICAL & GENERAL WAG	Bed Days Available	1,789,215	30	5,313,296	5,313,296	57,670	171,258	13
14	21	CLERICAL & GENERAL OTH	Bed Days Available	1,789,215	30	146,833		57,670	4,733	14
15	24	SEMINARS	Bed Days Available	1,789,215	30	35,138		57,670	1,133	15
16	26	INSURANCE	Bed Days Available	1,789,215	30	29,475		57,670	950	16
17	27	EMP. BEN.-GEN. ADMIN.	Bed Days Available	1,789,215	30	1,120,380		57,670	36,112	17
18	30	DEPRECIATION	Bed Days Available	1,789,215	30			57,670	0	18
19	32	INTEREST	Bed Days Available	1,789,215	30	561		57,670	18	19
20	33	REAL ESTATE TAXES	Bed Days Available	1,789,215	30			57,670	0	20
21	34	RENT	Bed Days Available	1,789,215	30	1,359,562		57,670	43,821	21
22	34	STORAGE	Bed Days Available	1,789,215	30	2,843		57,670	92	22
23	35	EQUIPMENT RENTAL	Bed Days Available	1,789,215	30	694		57,670	22	23
24	35	AUTO RENTAL	Bed Days Available	1,789,215	30	99,070		57,670	3,193	24
25	TOTALS					$ 9,561,416	$ 6,001,538		$ 308,184	25

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	MANAGEMENT FEES	Bed Days Available			$ (257,686)	$		$ (257,686)	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					$	$		$ (257,686)	25

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/01/17 Ending: 12/31/17

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: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 679-9797
Fax Number: (847) 683-2900

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	FOOD	Bed Days Available	1,374,590	30	$ 432	$	57,670	$ 18	1
2	6	MAINTENANCE SALARY	Bed Days Available	1,374,590	30	1,049,531	1,049,531	57,670	44,032	2
3	6	BUILDING MAINTENANCE AI	Bed Days Available	1,374,590	30	3,133		57,670	131	3
4	10	NURSING SALARIES	Bed Days Available	1,374,590	30	2,578,462	2,578,462	57,670	108,178	4
5	12	ACTIVITIES PROGRAM	Bed Days Available	1,374,590	30	443		57,670	19	5
6	12	CLERGY CONSULANT	Bed Days Available	1,374,590	30	39,998		57,670	1,678	6
7	12	SOCIAL SERVICES	Bed Days Available	1,374,590	30	95		57,670	4	7
8	15	EMP. BEN.-NURSING	Bed Days Available	1,374,590	30	400,703		57,670	16,811	8
9	17	AMINISTRATIVE SALARY	Bed Days Available	1,374,590	30	3,486,246	3,486,246	57,670	146,263	9
10	19	PAYROLL PROCESSING	Bed Days Available	1,374,590	30	8,134		57,670	341	10
11	19	PROFESSIONAL LEGAL FEES	Bed Days Available	1,374,590	30	107		57,670	4	11
12	19	OTHER PROFESSIONAL	Bed Days Available	1,374,590	30	560		57,670	23	12
13	20	DUES AND SUBSCRIPTIONS	Bed Days Available	1,374,590	30	4,293		57,670	180	13
14	21	OFFICE SALARY	Bed Days Available	1,374,590	30	738,904	738,904	57,670	31,000	14
15	21	OFFICE EXPENSE	Bed Days Available	1,374,590	30	7,880		57,670	331	15
16	24	EDUCATION AND SEMINARS	Bed Days Available	1,374,590	30	19,314		57,670	810	16
17	26	INSURANCE	Bed Days Available	1,374,590	30	55,168		57,670	2,315	17
18	27	EMP. BEN.-MGMT	Bed Days Available	1,374,590	30	819,705		57,670	34,390	18
19	30	DEPRECIATON	Bed Days Available	1,374,590	30	19,384		57,670	813	19
20	34	STORAGE RENTAL	Bed Days Available	1,374,590	30	1,500		57,670	63	20
21	35	AUTO RENTAL	Bed Days Available	1,374,590	30	29,674		57,670	1,245	21
22										22
23										23
24										24
25	TOTALS					$ 9,263,666	$ 7,853,143		$ 388,649	25

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	Bed Days Available	1,789,215	30	$ 37,998	$	57,670	$ 1,225	1
2	6	REPAIRS & MAINTENANCE	Bed Days Available	1,789,215	30	48,042		57,670	1,548	2
3	19	ACCOUNTING	Bed Days Available	1,789,215	30	1,001		57,670	32	3
4	19	LEGAL	Bed Days Available	1,789,215	30	6,986		57,670	225	4
5	19	PROFESSIONAL FEES	Bed Days Available	1,789,215	30	1,564		57,670	50	5
6	20	DUES AND SUBSCRIPTIONS	Bed Days Available	1,789,215	30	76		57,670	2	6
7	21	OFFICE EXPENSE	Bed Days Available	1,789,215	30	32		57,670	1	7
8	26	INSURANCE	Bed Days Available	1,789,215	30	9,839		57,670	317	8
9	32	INTEREST EXPENSE	Bed Days Available	1,789,215	30	171,679		57,670	5,534	9
10	33	REAL ESTATE TAXES	Bed Days Available	1,789,215	30	140,710		57,670	4,535	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					$ 417,927	$		$ 13,469	25

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	REPAIRS & MAINTENANCE	Direct Allocation			$	$		$ 27,351	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					$	$		$ 27,351	25

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: ProPay HR LLC
Street Address: 2201 W. Main Street
City / State / Zip Code: Evanston, IL 60202
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	19	PAYROLL SERVICES	Direct Allocation			$	$		$ 11,550	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					$	$		$ 11,550	25

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: ML Group Design and Development
Street Address: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 679-9797
Fax Number: (847) 683-2900

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	REPAIRS & MAINTENANCE				$	$		$ 362,157	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					$	$		$ 362,157	25

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/01/17 Ending: 12/31/17

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	The Private Bank		X	Line of Credit			$ 2,000,000	$ 483,696	11/17/2018	Libor + 5%	$ 94,243	1
2												2
3												3
4												4
5												5
	Working Capital											
6	The Private Bank		X	Line of Credit				668,500	11/17/2018	0.0661	47,576	6
7												7
8												8
9	TOTAL Facility Related						$ 2,000,000	$ 1,152,196			$ 141,819	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income			(7,040)	12
13								Allocated from Mgmt Co.			5,553	13
14	TOTAL Non-Facility Related						$	$			$ (1,487)	14
15	TOTALS (line 9+line14)						$ 2,000,000	$ 1,152,196			$ 140,332	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A 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:** 1/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ (48,746)	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.)	2016	$ 139,466	2
3. Under or (over) accrual (line 2 minus line 1).		$ 188,212	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	**Alloc Fr. Mgmt Co.** 4,535 **Alloc Fr. Mgmt Co. Appea** 225	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 192,972	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	137,371	8
	2013	159,306	9
	2014	179,037	10
	2015	134,175	11
	2016	139,466	12

Beginning accrual adjusted

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 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) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-12-151-040	Skilled Nursing Facility	$ 139,466.32	$ 139,466.32
2.	10-23-406-034-0000	Home office Allocation	$ 463,439.00	$ 4,535.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 602,905.32	$ 144,001.32

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/01/17 Ending: 12/31/17

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 [ ] (b) Rent from a Related Organization. [X] (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 [ ] (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).

N/A

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 CF St. Louis			$ 20,951	1
2					2
3	TOTALS			$ 20,951	3

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/01/17 Ending: 12/31/17

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	Allocation C.F St. Louis, LLC				34,252					1,957	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: 1/01/17 Ending: 12/31/17

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		$ 34,252	$		$	$	$ 1,957	1
2	Security Systems	2014	15340		20	767	767	3,068	2
3	Ball Bearing Hinges	2014	5386.25		20	269	269	1,077	3
4	Concrete Work	2014	2900		20	145	145	580	4
5	Fluorescent Wall Fixture	2014	6217.56		20	311	311	1,244	5
6	Landscaping - Tree Work	2014	22913.75		20	1,146	1,146	4,583	6
7	Wings 100,200,300,400 - Handrails,Cornerguards, Flooring	2014	59130.17		20	2,957	2,957	11,826	7
8	Kitchen And Room 412-Electrical Wiring And Receptacles	2014	4653		20	233	233	931	8
9	Elevator Repair	2014	2556		20	128	128	511	9
10	Exterior Signage	2014	9505		20	475	475	1,901	10
11	Laundry Rm - Electrical Wiring	2015	2850		20	143	143	428	11
12	Installed 2 Beams, Floor Reinforcement	2015	3750		20	188	188	563	12
13	Basement - Concrete/Electrical And Pumps	2015	5850		20	293	293	878	13
14	Repaired Boilers	2015	8148		20	407	407	1,222	14
15	Installed Steel Pump	2015	2870		20	144	144	431	15
16	4 Grab Bars For Shower Room	2015	2599.5		20	130	130	390	16
17	300 Wing Rm 310,410 - Tiling/Valves/Light Fixtures	2015	5875		20	294	294	881	17
18	Painted Corridors 401-417	2015	28240		20	1,412	1,412	4,236	18
19	Tv Wiring	2015	9663.13		20	483	483	1,449	19
20	500 Wing Wallcovering	2015	7358.32		20	368	368	1,104	20
21	1St Floor - Asbestos Removal	2015	114500		20	5,725	5,725	17,175	21
22	Paint Rms 208-215/201/308//316/401/407/409/411-416/206	2015	80118		20	4,006	4,006	12,018	22
23	Fire Alarm System	2015	11958.74		20	598	598	1,794	23
24	Installed Bricks	2015	21872		20	1,094	1,094	3,281	24
25	Entrance Canopy	2015	35350		20	1,768	1,768	5,303	25
26	Installed A/C System For New Office	2015	4988		20	249	249	748	26
27	Fire Alarm System	2015	19278.76		20	964	964	2,892	27
28	100-500 Wings - Demo/Electrical/Flooring/Handrails/Frames	2015	106940.37		20	5,347	5,347	16,041	28
29	Related Architect Fees - 100-500 Wing Project	2015	40855		20	2,043	2,043	6,128	29
30	Roof Repairs	2015	59375		20	2,969	2,969	8,906	30
31	Fire Alarm System	2015	11512.45		20	576	576	1,727	31
32	Hallway Window Shades	2015	2670.55		20	134	134	401	32
33	Repaired/Sealcoat/Restriped Asphalt	2015	11350		20	568	568	1,703	33
34	TOTAL (lines 1 thru 33)		$ 760,827	$		$ 36,329	$ 36,329	$ 117,373	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: 1/01/17 Ending: 12/31/17

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		$ 760,827	$		$ 36,329	$ 36,329	$ 117,373	1
2	Wiring For Resident Room A/C	2015	6,023		20	301	301	903	2
3	Replaced Ceiling Cables	2015	2,980		20	149	149	447	3
4	Signs For Room/Restroom/Elevator	2015	10,354		20	518	518	1,553	4
5	Exterior Hallway Corner Guards And Painted Railings/Doors	2015	2,985		20	149	149	448	5
6	500 Wing Nurse Call System	2015	12,085		20	604	604	1,813	6
7	Wiring For Phone System	2015	6,115		20	306	306	917	7
8	Installed Low Ambient System	2015	4,988		20	249	249	748	8
9	Repaired Wiring For Phone System	2015	2,679		20	134	134	402	9
10	Repaired Boiler Pumps And Valves	2015	2,640		20	132	132	396	10
11	100-400 Wing Curtains	2015	28,552		20	1,428	1,428	4,283	11
12	40 Bathroom Mirrors	2015	2,705		20	135	135	406	12
13	Lobby/Dining/Library Drapery	2015	18,424		20	921	921	2,764	13
14	Corridor Pendant Light Fixture	2015	6,994		20	350	350	1,049	14
15	Corridor Wall And Ceiling Light Fixture	2015	2,566		20	128	128	385	15
16	Nurse Call System	2015	6,825		20	341	341	1,024	16
17	40 Shades For Resident Rooms	2015	10,125		20	506	506	1,519	17
18	Corridor Light Fixtures	2015	3,201		20	160	160	480	18
19	Lobby/100-500 Wing-Demo/Carpentry/Roofing/Walls/Flooring/El	2015	1,998,554		20	99,928	99,928	299,783	19
20	Repaired Pipes For A/C Units	2015	2,982		20	149	149	447	20
21	Architect Fees- Eliminate Interior Improvements 2Nd Floor	2016	8,160		20	408	408	816	21
22	Installed Outlets And Wires For Tv	2016	5,355		20	268	268	536	22
23	Front Entrance - Plants, Trees, Shrubs, Mulch	2016	16,285		20	1,629	1,629	3,257	23
24	Repaired & Installed New Valves	2016	2,613		20	240	240	479	24
25	Install P-Tac Units	2016	3,443		20	631	631	1,262	25
26	Remove & Replaced Concrete-Sidewalk/Back Door; New Ramp	2016	2,500		20	458	458	917	26
27	Install 4 Amana Ptac Units	2016	5,996		20	1,199	1,199	2,398	27
28	Fire Alarm System And Pipes	2016	2,664		20	155	155	311	28
29	Hot Water Heater Replacement	2016	16,250		20	948	948	1,896	29
30	Kitchen Range/Gas Hose/Plate Casters	2016	4,999		20	667	667	1,333	30
31	Firewall/Router Installation	2016	11,789		20	393	393	786	31
32	Project Management Fee To Ml Group Design - Interior Renovati	2016	46,568		20	776	776	1,552	32
33	Installation Of Outlets And Wire For Lounge	2016	5,640		20	282	282	564	33
34	TOTAL (lines 1 thru 33)		$ 3,024,864	$		$ 150,971	$ 150,971	$ 453,247	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: 1/01/17 Ending: 12/31/17

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		$ 3,024,864	$		$ 150,971	$ 150,971	$ 453,247	1
2	2Nd Floor Dialysis Room - Demo/Pipe/Electrical/Hvac	2016	279,802		20	13,990	13,990	27,980	2
3	Tiling - 2Nd Floor	2016	2,691		20	135	135	270	3
4	1St/2Nd Floor Rotunda Corridor/Elevator Cab Renovation	2016	10,000		20	500	500	875	4
5	2Nd Floor Wall Paper	2016	5,207		20	260	260	520	5
6	2Nd Floor Rotunda Elevator Repair	2016	54,690		20	2,735	2,735	5,470	6
7	2Nd Floor Rotunda - Electrical/Prime/Paint/Railing	2016	12,750		20	638	638	1,276	7
8	2Nd Floor - Install Roller Shades	2016	4,400		20	220	220	440	8
9	Architect Fees - Field Measuring, 2Nd Floor Dialysis Room	2016	15,750		20	788	788	1,576	9
10	2Nd Floor - Demo/Wall Panels/Lights/Flooring	2016	11,950		20	598	598	1,196	10
11	Water System Installation/Piping	2016	12,822		20	641	641	1,282	11
12									12
13									13
14	New fire devices for new elevator	2017	5,808		30	161	161	161	14
15	Install 6" piping for drainage kitchen	2017	8,045		30	156	156	156	15
16	Install new door security on 200 wing	2017	8,400		30	187	187	187	16
17	Replaces PA Amplifier system	2017	2,500		30	35	35	35	17
18	TVs installed common areas	2017	3,658		30	30	30	30	18
19	Replaced hot water valve wing #5	2017	2,700		30	15	15	15	19
20	Install new relays, smoke/heat detectors on 100/200 wing	2017	7,998		30	22	22	22	20
21									21
22	Allocated from CF St. Louis LLC	2016	212,658		20			21,266	22
23	Allocated from CF St. Louis LLC	2017	4,936		20			247	23
24									24
25									25
26									26
27	Reconcile to book depreciation			492,607			(492,607)		27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,691,631	$ 492,607		$ 172,080	$ (320,527)	$ 516,249	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: 1/01/17 Ending: 12/31/17

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	$ 645,141	$	$ 66,194	$ 66,194	5	$ 222,225	71
72	Current Year Purchases	179,476		2,990	2,990	5	2,990	72
73	Fully Depreciated Assets							73
74	Allocated from MGMT Co.	24,296		813	813		5,457	74
75	TOTALS	$ 848,913	$	$ 69,997	$ 69,997		$ 230,672	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)	$ 4,561,495	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 492,607	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 242,077	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (250,530)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 746,921	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/01/17 Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Aurora Account, LLC
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. [X] 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:			2/1/2014	$ 655,147	10		3
4	Additions							4
5	Allocated from Mgmt co. Storage				155			5
6	Allocated from Mgmt co. Rent				43,821			6
7	TOTAL				$ 699,123 **			7

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

9. Option to Buy: [ ] YES [ ] NO Terms: _____ *

10. Effective dates of current rental agreement:
    Beginning 2/1/2016
    Ending 1/31/2024

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

	Fiscal Year Ending	Annual Rent
12.	12/2018	$ 667,464
13.	12/2019	$ 680,810
14.	12/2020	$ 694,431

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 52,724 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	Facility		$	$ 7,107	17
18					18
19	Allocated from Mgmt. Co.			4,438	19
20					20
21	TOTAL		$	$ 11,545	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: **Grove Of Fox Valley**
IDPH License ID Number: **0052621**
Fiscal Year End: **12/31/17**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Oxgyen	173
Office Equipment	4,216
Housekeeping	6,960
Dietary	1,701
Medical equipment	22,652
Therapy	15,600
Maintenance	1,400
Allocated from Mgmt Co.	22
Total - Line 16	**52,724**

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/01/17 Ending: 12/31/17

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

It is the policy of this facility to only hire certified nurses aides.

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 | STATE OF ILLINOIS # 0052621 | Report Period Beginning: 1/01/17 Ending: 12/31/17

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	$	5,222	$ 375,980	$	5,222	$ 375,980	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,320	95,055		1,320	95,055	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		5,792	417,013		5,792	417,013	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				543,170		543,170	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	39(2)					11,437		11,437	12
13	Other (specify): Ambulance	39(3)			94	6,791		94	6,791	13
14	TOTAL			$	12,428	$ 894,839	$ 554,607	12,428	$ 1,449,446	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:** 1/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(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	$ 2,770	$ 55,123	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (681,881))	1,864,795	1,864,795	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(51,717)	(51,717)	6
7	Other Prepaid Expenses	15,859	15,917	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	2,003,574	2,170,241	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,835,281	$ 4,054,359	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		20,951	13
14	Buildings, at Historical Cost		34,252	14
15	Leasehold Improvements, at Historical Cost	3,713,215	3,657,379	15
16	Equipment, at Historical Cost	839,440	848,913	16
17	Accumulated Depreciation (book methods)	(1,159,641)	(746,921)	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 (spe			22
23	Other(specify): See Attached Schedule	148,928	148,928	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,541,942	$ 3,963,502	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,377,223	$ 8,017,861	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,380,372	$ 1,380,372	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		668,500	29
30	Accrued Salaries Payable	338,226	338,226	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,359	10,359	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	7,487,934	6,762,424	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 9,216,891	$ 9,159,881	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	483,696	483,696	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)**	$ 483,696	$ 483,696	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 9,700,587	$ 9,643,577	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,323,364)	$ (1,625,716)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,377,223	$ 8,017,861	48

***(See instructions.)**

Facility Name: **Grove Of Fox Valley**
IDPH License ID Number: **0052621**
Fiscal Year End: **12/31/17**

Schedule 17A

XV. Balance Sheet
Line 9 Current Assets Other (specify):

Description	Operating	After Consolidation
AUR Resident Fund	6,260	6,260
AUR Refund	105,004	105,004
AUR Insurance refund exchange	(975)	(975)
AUR Project MGMT retainer	105,000	271,667
AUR Due To/from Grove of Fox Valley	632,146	632,146
AUR Due To/from prior Vistas	1,125,831	1,125,831
AUR State withholding taxes	30,308	30,308
Total - Line 9	**2,003,574**	**2,170,241**

XV. Balance Sheet
Line 23 Long-Term Assets Other (specify):

Description	Operating	After Consolidation
AUR Refund - Transfer	(119,833)	(119,833)
AUR Due to/from prior owner	54,650	54,650
AUR due to/from Medicare	201,490	201,490
AUR Bad Debt Part A	12,621	12,621
Total - Line 23	**148,928**	**148,928**

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
AUR Exchange	(204,629)	(204,629)
AUR Payroll Exchange	(5,734)	(5,734)
AUR Employee Loans, ADV, Wages	(1,995)	(1,995)
AUR Due to/from - Grove of Fox Valley & MGMT	(1,017,533)	(1,199,200)
AUR Due to/from Grove of Fox Valley & Avantara	(2,498,199)	(2,498,199)
AUR Due to/from - Avantara Park Ridge	(30,000)	(30,000)
AUR Due to/from - Grove at Fox Valley & Wellshire	(150,000)	(150,000)
AUR Due to/from Propco	(843,088)	(843,088)
AUR Due to/from Others	(2,253,481)	(1,410,393)
AUR Due to/from 10 Pack LLC	(250,000)	(185,911)
AUR Accrued Expense	(31,057)	(31,057)
AUR Accrued Manamgement Fees	(130,810)	(130,810)
AUR Loan from BCBS	(74,349)	(74,349)
AUR HCCI Loan	2,941	2,941
Total - Line 36	**(7,487,934)**	**(6,762,424)**

Facility Name & ID Number Grove Of Fox Valley # 0052621 **Report Period Beginning:** 1/01/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,915,086)	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	4	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,915,082)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(408,282)	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)**	$ (408,282)	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)**	$ (2,323,364)	24 *

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

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/01/17 Ending: 12/31/17

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	$ 16,940,905	1
2	Discounts and Allowances for all Levels	(8,740,850)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,200,055	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,057,819	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,057,819	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	536,715	17
18	Sale of Supplies to Non-Patients	29,875	18
19	Laboratory	37,417	19
20	Radiology and X-Ray	55	20
21	Other Medical Services	2,466	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 606,528	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,040	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,040	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	42,066	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 42,066	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,913,508	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,858,058	31
32	Health Care	4,865,169	32
33	General Administration	2,452,556	33
	B. Capital Expense		
34	Ownership	1,699,238	34
	C. Ancillary Expense		
35	Special Cost Centers	2,071,198	35
36	Provider Participation Fee	375,571	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,321,790	40
41	**Income before Income Taxes (line 30 minus line 40)****	(408,282)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (408,282)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,608,967	44
45	Private Pay - Net Inpatient Revenue	383,610	45
46	Medicare - Net Inpatient Revenue	2,316,147	46
47	Other-(specify) Insurance/Veterans	891,331	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,200,055	49

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

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

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

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

Facility Name: **Grove Of Fox Valley**
IDPH License ID Number: **0052621**
Fiscal Year End: **12/31/17**

Schedule 19A

XVII. Income Statement
Line 28 Other Revenue :

Description	Amount
AUR RENTALS	(26,454)
AUR DISCOUNTS EARNED	(15,337)
AUR MISC INCOME	(271)
AUR LAB - PRIOR PERIOD	46
RENTALS - PRIOR PERIOD	(50)
Total - Line 28	**(42,066)**

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/01/17 Ending: 12/31/17

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,038	2,163	$ 110,885	$ 51.26	1
2	Assistant Director of Nursing	1,921	2,080	91,118	43.81	2
3	Registered Nurses	36,226	40,043	1,351,342	33.75	3
4	Licensed Practical Nurses	24,774	26,581	759,507	28.57	4
5	CNAs & Orderlies	94,708	103,052	1,559,788	15.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,231	4,580	107,916	23.56	8
9	Activity Director	2,684	3,038	63,432	20.88	9
10	Activity Assistants	9,135	10,336	121,098	11.72	10
11	Social Service Workers	3,577	3,809	123,418	32.40	11
12	Dietician					12
13	Food Service Supervisor	1,899	2,080	79,727	38.33	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,896	24,853	327,063	13.16	15
16	Dishwashers					16
17	Maintenance Workers	3,718	4,160	117,131	28.16	17
18	Housekeepers	20,255	22,168	259,366	11.70	18
19	Laundry	1,841	2,113	29,921	14.16	19
20	Administrator	3,196	3,351	182,895	54.58	20
21	Assistant Administrator	2,423	2,945	107,661	36.56	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,903	11,425	207,826	18.19	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,896	2,095	42,096	20.09	31
32	Other Health C See Sch 20A	6,109	6,532	217,003	33.22	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	253,430	277,404	$ 5,859,193 *	$ 21.12	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	20,255	9(7)	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	80	10(3)	38
39	Pharmacist Consultant	Monthly	16,178	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,985	11(3)	44
45	Social Service Consultant	Monthly	932	12(7)	45
46	Other(specify) MDS Consultant	Monthly	38,681	10(3)	46
47	Clergy Consultant	Monthly	1,678	12(3)	47
48	Dialysis/DME	Monthly	123,078	10(3)	48
49	TOTAL (lines 35 - 48)		$ 202,867		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	16	400	10(3)	52
53	TOTAL (lines 50 - 52)	16	$ 400		53

Facility Name: **Grove Of Fox Valley**
IDPH License ID Number: **0052621**
Fiscal Year End: **12/31/17**

Schedule 20A

XVIII. Staffing and Salary Costs
Line 32 Other Health Care (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
MDS/Care Plan Coordinator LPN	1,276	1,293	41,909	32.41
MDS/Care Plan Coordinator RN	2,004	2,080	88,124	42.37
Admissions Coord(Asst/Clerk)	0	0	0	
Admissions Director	1,196	1,342	41,899	31.22
Guest Services Aide	155	158	3,546	22.44
Guest Services Director	1,478	1,659	41,525	25.03
Total - Line 32 Other Health Care (specify):	**6,109**	**6,532**	**217,003**	

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Camberly Lanning	Administrator	0	$ 137,181
Jessica Avelino	Assistant Admin	0	49,927
Ashley L. Condotti	Assistant Admin	0	103,448
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 290,556

B. Administrative - Other

Description	Amount
Management Fees	$ 257,686
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 257,686

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ (2,153)
Accrued 2016 YE Entries	Legal	(2,325)
Purchase Journal 12.16	Legal	(1,261)
Stone, Mcguire & Siegel	Legal	16,207
Much Shelist	Legal	257
Stone Pogrund & Korey LLC	Legal	13,357
Meyer Magence	Legal	14
Corporation Service Company	Legal	236
Legacy Expense Reimbursement	Legal	3,517
Gutnicki Llp	Legal	458
Kitch Drutchas Wagner Valitutt	Legal	1,274
See Sch 21C		74,472
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 104,053

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 116,015
Unemployment Compensation Insurance	70,328
FICA Taxes	423,753
Employee Health Insurance	212,603
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement	23,790
Payroll Taxes	24,472
PTO Adjustment	26,999
Uniforms	9,092
Other Benefits	197,750
Allocated from MGMT	
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,104,802

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	1,507
Health Care Worker Background Check	
(Indicate # of checks performed 331)	3,977
Patient Background Checks 480	5,756
Dues and Subscriptions	16,029
License and Permits	37,475
Allocated from Mgmt Co.	3,230
Non Allowable Dues	(6,409)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 65,545

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,500
Allocated from Mgmt Co.	1,943
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,443

**See instructions.

Facility Name: **Grove Of Fox Valley**
IDPH License ID Number: **0052621**
Fiscal Year End: **12/31/17**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Scott & Kraus	Legal	2,164
Documentation Solutions	Legal	3,888
Compliance Resources, Inc.	Legal	1,384
Legacy Expense Reimbursement	Legal	41
Achieve Accreditation LLC	Other Professional Fees	5,516
BlueOrange Compliance	Other Professional Fees	1,301
Deborah D. Cole Goodwill	Other Professional Fees	500
Legacy Expense Reimbursement 04.17	Other Professional Fees	5,496
Legacy Healthcare Financial Services	Other Professional Fees	76
Lexisnexis Risk Solutions	Other Professional Fees	49
McCabe Kirshner & Ballester PC	Other Professional Fees	864
Medical Consultant 05.17	Other Professional Fees	245
MTS Consulting	Other Professional Fees	3,790
Paycor Fee	Other Professional Fees	13,766
Personnel Planners	Other Professional Fees	1,200
Prospect Resources Inc	Other Professional Fees	900
PSD Solutions	Other Professional Fees	740
Reversed -- Accrued 2016 YE Entries	Other Professional Fees	(651)
Strauss' Data Consulting	Other Professional Fees	20
Paycor Fee	Paycor	15,183
Ml Group Design	Asset Management Fee	18,000
	Total (agree to Schedule V, line 19, column 3)	74,472
Allocated from Real Estate Entity	Legal Fees	6,250
Allocated from Management Company	Professional Services	11,889
Less: Non-Allowable Legal Fees		(3,738)
	Total (agree to Schedule V, line 19, column 8)	118,454

Facility Name & ID Number Grove Of Fox Valley # 0052621 **Report Period Beginning:** 1/01/17 **Ending:** 12/31/17

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. **ICLTC - $17,723 & IHCA-$1,864**

(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? **5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **55,642** 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. $ **375,571**
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. $ **0** 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**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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