FOR BHF USE

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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 (Number) North Farnsworth | 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 1/1/18 to 12/31/18 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: 1/1/18 Ending: 12/31/18

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			11,161	11,161	8
9	SNF/PED					9
10	ICF	37,832	4,204		42,036	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,832	4,204	11,161	53,197	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.24%

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 5,410

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: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	382,256	70,374	-	452,630		452,630	1,060	453,690			1
2	Food Purchase		362,132		362,132		362,132	18	362,150			2
3	Housekeeping	279,997	30,044	-	310,041		310,041	1,668	311,709			3
4	Laundry	29,860	20,952	185,624	236,436	0	236,436	(4,742)	231,694			4
5	Heat and Other Utilities			183,270	183,270		183,270	992	184,262			5
6	Maintenance	117,865	85,763	198,393	402,021		402,021	6,350	408,371			6
7	Other (specify):*	-	-	-	0		0	-	0			7
8	**TOTAL General Services**	809,978	569,265	567,287	1,946,530	0	1,946,530	5,346	1,951,876			8
	B. Health Care and Programs											
9	Medical Director	-	-	18,006	18,006		18,006	-	18,006			9
10	Nursing and Medical Records	4,129,175	212,800	207,906	4,549,881		4,549,881	(55,744)	4,494,137			10
10a	Therapy	132,468	-	-	132,468		132,468	-	132,468			10a
11	Activities	142,126	5,189	1,512	148,827		148,827	66	148,893			11
12	Social Services	122,919	-	410	123,329		123,329	4,130	127,459			12
13	CNA Training	-	-	-	0		0	-	0			13
14	Program Transportation	-	-	-	0		0	-	0			14
15	Other (specify):* Mgmt. Co. Alloc.	-	-	518	518		518	7,606	8,124			15
16	**TOTAL Health Care and Programs**	4,526,688	217,989	228,352	4,973,029	0	4,973,029	(43,942)	4,929,087			16
	C. General Administration											
17	Administrative	471,304	-	272,879	744,183		744,183	(566,360)	177,823			17
18	Directors Fees			-	0		0	-	0			18
19	Professional Services			145,505	145,505		145,505	(462)	145,043			19
20	Dues, Fees, Subscriptions & Promotions			66,106	66,106		66,106	(10,076)	56,030			20
21	Clerical & General Office Expenses	183,074	-	297,051	480,125		480,125	361,115	841,240			21
22	Employee Benefits & Payroll Taxes			1,096,751	1,096,751		1,096,751	(75,811)	1,020,940			22
23	Inservice Training & Education			-	0		0	-	0			23
24	Travel and Seminar			649	649		649	2,910	3,559			24
25	Other Admin. Staff Transportation		-	2,249	2,249		2,249	-	2,249			25
26	Insurance-Prop.Liab.Malpractice			194,477	194,477		194,477	5,327	199,804			26
27	Other (specify):* Mgmt. Co. Alloc.	-	-	-	0		0	55,659	55,659			27
28	**TOTAL General Administration**	654,378	0	2,075,667	2,730,045	0	2,730,045	(227,698)	2,502,347			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,991,044	787,254	2,871,306	9,649,604	0	9,649,604	(266,294)	9,383,310			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: 1/1/18 Ending: 12/31/18

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			551,096	551,096		551,096	(258,588)	292,508			30
31	Amortization of Pre-Op. & Org.			-	0		0	-	0			31
32	Interest			52,668	52,668		52,668	21,709	74,377			32
33	Real Estate Taxes			93,912	93,912		93,912	4,499	98,411			33
34	Rent-Facility & Grounds			870,169	870,169		870,169	(154,747)	715,422			34
35	Rent-Equipment & Vehicles			31,363	31,363		31,363	3,971	35,334			35
36	Other (specify):*			-	0		0	-	0			36
37	**TOTAL Ownership**			1,599,208	1,599,208	0	1,599,208	(383,156)	1,216,052			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-	0		0	-	0			38
39	Ancillary Service Centers	-	431,325	1,223,976	1,655,301		1,655,301	-	1,655,301			39
40	Barber and Beauty Shops	-	-	-	0		0	-	0			40
41	Coffee and Gift Shops	-	-	-	0		0	-	0			41
42	Provider Participation Fee			374,564	374,564		374,564	-	374,564			42
43	Other (specify):* Non-Allowable Cos	30,639	-	597,628	628,267		628,267	(628,267)	0			43
44	**TOTAL Special Cost Centers**	30,639	431,325	2,196,168	2,658,132	0	2,658,132	(628,267)	2,029,865			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,021,683	1,218,579	6,666,682	13,906,944	0	13,906,944	(1,277,717)	12,629,227			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: 1/1/18 Ending: 12/31/18

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	(1,346)	43		4
5	Telephone, TV & Radio in Resident Rooms	(7,910)	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	(258,588)	30		9
10	Interest and Other Investment Income	(26,619)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,019)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,391)	43		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(14,694)	43		18
19	Entertainment				19
20	Contributions	(46,000)	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	(330,581)	43		24
25	Fund Raising, Advertising and Promotional	(37,240)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,580)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(210,647)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (937,615)		$ 0	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)	(340,102)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (340,102)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,277,717)		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

Grove Of Fox Valley

ID# 0052621

Report Period Beginning: 1/1/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs - Part A	$ (33,380)	43	1
2	X Rays - Part A	(29,314)	43	2
3	Sequestration	(79,660)	43	3
4	Consolidated Billings	(15,093)	43	4
5	Misc Income	(5,097)	21	5
6	Non Allowable Salaries	(30,639)	43	6
7	Non Allowable Dues	(8,939)	20	7
8	Non allowable dues	(3,545)	20	8
9	Non allowable legal	(4,980)	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**	(210,647)		49

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 964,080	Prairie Property Holdings	100%	$ 768,311	$ (195,769)	1
2	V	19	Accounting		Prairie Property Holdings	100%	1,890	1,890	2
3	V	20	Fees		Prairie Property Holdings	100%	1,975	1,975	3
4	V	20	Tax Return	175	Prairie Property Holdings	100%		(175)	4
5	V	32	Interest		Prairie Property Holdings	100%	43,569	43,569	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 964,255			$ 815,745	$ * (148,510)	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: 1/1/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETICIAN SALARY	$	Legacy Healthcare Financial Services	100%	$ 999	$ 999	15
16	V	01	DIETARY SUPPLIES		Legacy Healthcare Financial Services	100%	61	61	16
17	V	02	FOOD		Legacy Healthcare Financial Services	100%	18	18	17
18	V	03	HOUSEKEEPING		Legacy Healthcare Financial Services	100%	1,668	1,668	18
19	V	04	LINEN REPLACEMENT		Legacy Healthcare Financial Services	100%	10	10	19
20	V	06	MAINTENANCE SALARY		Legacy Healthcare Financial Services	100%	7,093	7,093	20
21	V	06	REPAIRS AND MAINTENANCE		Legacy Healthcare Financial Services	100%	1,237	1,237	21
22	V	10	NURSING SALARY	124,092	Legacy Healthcare Financial Services	100%	65,587	(58,505)	22
23	V	10	NURSE CONSULTANT		Legacy Healthcare Financial Services	100%	2,686	2,686	23
24	V	10	MEDICAL SUPPLIES		Legacy Healthcare Financial Services	100%	75	75	24
25	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services	100%	66	66	25
26	V	12	SOCIAL SERVICE SALARY		Legacy Healthcare Financial Services	100%	4,106	4,106	26
27	V	12	SOCIAL SERVICE CONSULTANT		Legacy Healthcare Financial Services	100%	24	24	27
28	V	15	NURSING PAYROLL TAXES/BENEFITS		Legacy Healthcare Financial Services	100%	7,606	7,606	28
29	V	17	CFO/ADMINISTRATIVE SALARY	381,314	Legacy Healthcare Financial Services	100%	87,833	(293,481)	29
30	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100%	10,678	10,678	30
31	V	20	DUES/LICENSE/PERMITS		Legacy Healthcare Financial Services	100%	607	607	31
32	V	21	CLERICAL AND GENERAL WAGES		Legacy Healthcare Financial Services	100%	357,135	357,135	32
33	V	21	CLERICAL AND OFFICE EXPENSE		Legacy Healthcare Financial Services	100%	10,330	10,330	33
34	V	24	EDUCATION AND SEMINARS		Legacy Healthcare Financial Services	100%	2,910	2,910	34
35	V	26	INSURANCE- GENERAL		Legacy Healthcare Financial Services	100%	4,944	4,944	35
36	V	27	NON-NURSING PAYROLL TAXES/BENI	75,811	Legacy Healthcare Financial Services	100%	55,659	(20,152)	36
37	V	32	INTEREST		Legacy Healthcare Financial Services	100%	32	32	37
38	V	34	RENT		Legacy Healthcare Financial Services	100%	40,870	40,870	38
39	Total			$ 581,217			$ 662,234	$ * 81,017	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: 1/1/18 Ending: 12/31/18

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	34	OFFSITE STORAGE/PARKING	$	Legacy Healthcare Financial Services	100	$ 152	$ 152	15
16	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services	100	213	213	16
17	V	35	AUTO RENTAL		Legacy Healthcare Financial Services	100	3,758	3,758	17
18	V	17	MANAGEMENT FEES	272,879	Legacy Healthcare Financial Services	100		(272,879)	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			$ 272,879			$ 4,123	$ * (268,756)	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: 1/1/18 Ending: 12/31/18

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			$			$ 0	$ *	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: 1/1/18 Ending: 12/31/18

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%	$ 992	$ 993	15
16	V	6	REPAIRS & MAINTENANCE		CF ST. LOUIS, LLC	100%	1,336	1,336	16
17	V	19	PROFESSIONAL FEES		CF ST. LOUIS, LLC	100%	41	41	17
18	V	20	DUES & SUBSCRIPTIONS		CF ST. LOUIS, LLC	100%	1	1	18
19	V	21	OFFICE EXPENSE		CF ST. LOUIS, LLC	100%	327	327	19
20	V	26	INSURANCE		CF ST. LOUIS, LLC	100%	383	383	20
21	V	32	INTEREST EXPENSE		CF ST. LOUIS, LLC	100%	4,727	4,727	21
22	V	33	REAL ESTATE TAXES		CF ST. LOUIS, LLC	100%	4,499	4,499	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			$			$ 12,304	$ * 12,306	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: 1/1/18 Ending: 12/31/18

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	$ 54,909	ReMed Services, LLC	1%	$ 53,328	$ (1,581)	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			$ 54,909			$ 53,328	$ * (1,581)	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: 1/1/18 Ending: 12/31/18

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	$ 30,904	ProPay HR LLC	24%	$ 22,813	$ (8,091)	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			$ 30,904			$ 22,813	$ * (8,091)	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: 1/1/18 Ending: 12/31/18

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	$ 23,315	ML Group Design and Development		$ 21,580	$ (1,735)	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			$ 23,315			$ 21,580	$ * (1,735)	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: 1/1/18 Ending: 12/31/18

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	4	Laundry	$ 203,968	EcoBrite Linen		$ 199,216	$ (4,752)	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			$ 203,968			$ 199,216	$ * (4,752)	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: 1/1/18 Ending: 12/31/18

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	0.99	Astoria Place Living & Rehab	Chicago	Legacy Healthcare	Skokie	Management Co.	1
2	DINA ZUCKERMAN	0.01	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: 1/1/18 Ending: 12/31/18

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: 1/1/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETICIAN SALARY	Bed Days Available	1,918,919	30	$ 33,257	$ 33,257	57,670	$ 999	1
2	01	DIETARY SUPPLIES	Bed Days Available	1,918,919	30	2,031		57,670	61	2
3	02	FOOD	Bed Days Available	1,918,919	30	595		57,670	18	3
4	03	HOUSEKEEPING	Bed Days Available	1,918,919	30	55,512		57,670	1,668	4
5	04	LINEN REPLACEMENT	Bed Days Available	1,918,919	30	343		57,670	10	5
6	06	MAINTENANCE SALARY	Bed Days Available	1,918,919	30	235,999	235,999	57,670	7,093	6
7	06	REPAIRS AND MAINTENANCE	Bed Days Available	1,918,919	30	41,154		57,670	1,237	7
8	10	NURSING SALARY	Bed Days Available	1,918,919	30	2,182,345	2,182,345	57,670	65,587	8
9	10	NURSE CONSULTANT	Bed Days Available	1,918,919	30	89,384		57,670	2,686	9
10	10	MEDICAL SUPPLIES	Bed Days Available	1,918,919	30	2,503		57,670	75	10
11	11	ACTIVITIES PROGRAM	Bed Days Available	1,918,919	30	2,204		57,670	66	11
12	12	SOCIAL SERVICE SALARY	Bed Days Available	1,918,919	30	136,611	136,611	57,670	4,106	12
13	12	SOCIAL SERVICE CONSULTAN	Bed Days Available	1,918,919	30	800		57,670	24	13
14	15	NURSING PAYROLL TAXES/BE	Bed Days Available	1,918,919	30	253,092		57,670	7,606	14
15	17	CFO/ADMINISTRATIVE SALAI	Bed Days Available	1,918,919	30	2,922,553	2,922,553	57,670	87,833	15
16	19	PROFESSIONAL FEES	Bed Days Available	1,918,919	30	355,302		57,670	10,678	16
17	20	DUES/LICENSE/PERMITS	Bed Days Available	1,918,919	30	20,207		57,670	607	17
18	21	CLERICAL AND GENERAL WA	Bed Days Available	1,918,919	30	11,883,371	11,883,371	57,670	357,135	18
19	21	CLERICAL AND OFFICE EXPE	Bed Days Available	1,918,919	30	343,715		57,670	10,330	19
20	24	EDUCATION AND SEMINARS	Bed Days Available	1,918,919	30	96,819		57,670	2,910	20
21	26	INSURANCE- GENERAL	Bed Days Available	1,918,919	30	164,496		57,670	4,944	21
22	27	NON-NURSING PAYROLL TAX	Bed Days Available	1,918,919	30	1,852,008		57,670	55,659	22
23	32	INTEREST	Bed Days Available	1,918,919	30	1,074		57,670	32	23
24	34	RENT	Bed Days Available	1,918,919	30	1,359,900		57,670	40,870	24
25	TOTALS					$ 22,035,273	$ 17,394,136		$ 662,234	25

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	34	OFFSITE STORAGE/PARKING	Bed Days Available	1,918,919	30	$ 5,072	$	57,670	$ 152	1
2	35	EQUIPMENT RENTAL	Bed Days Available	1,918,919	30	7,088		57,670	213	2
3	35	AUTO RENTAL	Bed Days Available	1,918,919	30	125,028		57,670	3,758	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					$ 137,188	$		$ 4,123	25

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/1/18 Ending: 12/31/18

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					$	$		$ 0	25

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	1,916,917	30	$ 32,982	$	57,670	$ 992	1
2	6	REPAIRS & MAINTENANCE	Bed Days Available	1,916,917	30	44,396		57,670	1,336	2
3	19	PROFESSIONAL FEES	Bed Days Available	1,916,917	30	1,378		57,670	41	3
4	20	DUES & SUBSCRIPTIONS	Bed Days Available	1,916,917	30	23		57,670	1	4
5	21	OFFICE EXPENSE	Bed Days Available	1,916,917	30	10,860		57,670	327	5
6	26	INSURANCE	Bed Days Available	1,916,917	30	12,721		57,670	383	6
7	32	INTEREST EXPENSE	Bed Days Available	1,916,917	30	157,106		57,670	4,726	7
8	33	REAL ESTATE TAXES	Bed Days Available	1,916,917	30	149,528		57,670	4,499	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					$ 408,994	$		$ 12,305	25

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/1/18 Ending: 12/31/18

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			$	$		$ 53,328	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					$	$		$ 53,328	25

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/1/18 Ending: 12/31/18

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			$	$		$ 22,813	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					$	$		$ 22,813	25

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 instruct 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				$	$		$ 21,580	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					$	$		$ 21,580	25

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/1/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: EcoBrite Linen
Street Address: 3712 W. Jarvis Avenue
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 582-4000
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	4	Laundry				$	$		$ 199,216	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					$	$		$ 199,216	25

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	Varies	5/1/2014	2,000,000	1,015,000	8/30/2019	0.0685	52,668	6
7	CapEx		X	Line of Credit	Varies	12/31/2017	668500	518,500	12/31/2019	0.0760	43,569	7
8												8
9	TOTAL Facility Related						$ 2,668,500	$ 1,533,500			$ 96,237	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income			(26,619)	12
13								Allocated from Mgmt Co.			4,759	13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ (21,860)	14
15	TOTALS (line 9+line14)						$ 2,668,500	$ 1,533,500			$ 74,377	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: 1/1/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 57715	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.)	2017	$ 151,627	2
3. Under or (over) accrual (line 2 minus line 1).		$ 93,912	3
4. Real Estate Tax accrual used for 2018 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. 4,499	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 98,411	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	159,306	8
	2014	179,037	9
	2015	134,175	10
	2016	139,466	11
	2017	151,627	12

Beginning accrual adjusted

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 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 Moti Ninio

TELEPHONE (847) 676-5315 FAX #: (773) 248-9703

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-12-151-040		$ 151,626.52	$ 151,626.52
2.	10-23-406-034-0000	Home office Allocation	$ 492,481.94	$ 4,498.51
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 644,108.46	$ 156,125.03

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 1/1/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 73911 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	-		$ 5,937	1
2		0		0	2
3	TOTALS			$ 5,937	3

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	Allocation C.F St. Louis, LLC				$ 31,970	$ -	35	$ 913	$ 913	$ 2,740	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: 1/1/18 Ending: 12/31/18

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				-		-			67
68				-		-			68
69				-		-			69
70	TOTAL (lines 4 thru 69)		$ 31,970	$ 0		$ 913	$ 913	$ 2,740	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: 1/1/18 Ending: 12/31/18

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		$ 31,970	$ 0		$ 913	$ 913	$ 2,740	1
2	Security Systems	2014	15,340	-	20	767	767	3,835	2
3	Ball Bearing Hinges	2014	5,386	-	20	269	269	1,347	3
4	Concrete Work	2014	2,900	-	20	145	145	725	4
5	Fluorescent Wall Fixture	2014	6,218	-	20	311	311	1,554	5
6	Landscaping - Tree Work	2014	22,914	-	20	1,146	1,146	5,728	6
7	Wings 100,200,300,400 - Handrails,Cornerguards, Flooring	2014	59,130	-	20	2,957	2,957	14,783	7
8	Kitchen And Room 412-Electrical Wiring And Receptacles	2014	4,653	-	20	233	233	1,163	8
9	Elevator Repair	2014	2,556	-	20	128	128	639	9
10	Exterior Signage	2014	9,505	-	20	475	475	2,376	10
11	Laundry Rm - Electrical Wiring	2015	2,850	-	20	143	143	570	11
12	Installed 2 Beams, Floor Reinforcement	2015	3,750	-	20	188	188	750	12
13	Basement - Concrete/Electrical And Pumps	2015	5,850	-	20	293	293	1,170	13
14	Repaired Boilers	2015	8,148	-	20	407	407	1,630	14
15	Installed Steel Pump	2015	2,870	-	20	144	144	574	15
16	4 Grab Bars For Shower Room	2015	2,600	-	20	130	130	520	16
17	300 Wing Rm 310,410 - Tiling/Valves/Light Fixtures	2015	5,875	-	20	294	294	1,175	17
18	Painted Corridors 401-417	2015	28,240	-	20	1,412	1,412	5,648	18
19	Tv Wiring	2015	9,663	-	20	483	483	1,933	19
20	500 Wing Wallcovering	2015	7,358	-	20	368	368	1,472	20
21	1St Floor - Asbestos Removal	2015	114,500	-	20	5,725	5,725	22,900	21
22	Paint Rms 208-215/201/308//316/401/407/409/411-416/206	2015	80,118	-	20	4,006	4,006	16,024	22
23	Fire Alarm System	2015	11,959	-	20	598	598	2,392	23
24	Installed Bricks	2015	21,872	-	20	1,094	1,094	4,374	24
25	Entrance Canopy	2015	35,350	-	20	1,768	1,768	7,070	25
26	Installed A/C System For New Office	2015	4,988	-	20	249	249	998	26
27	Fire Alarm System	2015	19,279	-	20	964	964	3,856	27
28	100-500 Wings - Demo/Electrical/Flooring/Handrails/Frames	2015	106,940	-	20	5,347	5,347	21,388	28
29	Related Architect Fees - 100-500 Wing Project	2015	40,855	-	20	2,043	2,043	8,171	29
30	Roof Repairs	2015	59,375	-	20	2,969	2,969	11,875	30
31	Fire Alarm System	2015	11,512	-	20	576	576	2,302	31
32	Hallway Window Shades	2015	2,671	-	20	134	134	534	32
33	Repaired/Sealcoat/Restriped Asphalt	2015	11,350	-	20	568	568	2,270	33
34	TOTAL (lines 1 thru 33)		$ 758,545	$ 0		$ 37,242	$ 37,242	$ 154,485	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: 1/1/18 Ending: 12/31/18

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		$ 758,545	$ 0		$ 37,242	$ 37,242	$ 154,485	1
2	Wiring For Resident Room A/C	2015	6,023	-	20	301	301	1,205	2
3	Replaced Ceiling Cables	2015	2,980	-	20	149	149	596	3
4	Signs For Room/Restroom/Elevator	2015	10,354	-	20	518	518	2,071	4
5	Exterior Hallway Corner Guards And Painted Railings/Doors	2015	2,985	-	20	149	149	597	5
6	500 Wing Nurse Call System	2015	12,085	-	20	604	604	2,417	6
7	Wiring For Phone System	2015	6,115	-	20	306	306	1,223	7
8	Installed Low Ambient System	2015	4,988	-	20	249	249	998	8
9	Repaired Wiring For Phone System	2015	2,679	-	20	134	134	536	9
10	Repaired Boiler Pumps And Valves	2015	2,640	-	20	132	132	528	10
11	100-400 Wing Curtains	2015	28,552	-	20	1,428	1,428	5,710	11
12	40 Bathroom Mirrors	2015	2,705	-	20	135	135	541	12
13	Lobby/Dining/Library Drapery	2015	18,424	-	20	921	921	3,685	13
14	Corridor Pendant Light Fixture	2015	6,994	-	20	350	350	1,399	14
15	Corridor Wall And Ceiling Light Fixture	2015	2,566	-	20	128	128	513	15
16	Nurse Call System	2015	6,825	-	20	341	341	1,365	16
17	40 Shades For Resident Rooms	2015	10,125	-	20	506	506	2,025	17
18	Corridor Light Fixtures	2015	3,201	-	20	160	160	640	18
19	Lobby/100-500 Wing-Demo/Carpentry/Roofing/Walls/Flooring/El	2015	1,998,554	-	20	99,928	99,928	399,711	19
20	Repaired Pipes For A/C Units	2015	2,982	-	20	149	149	596	20
21	Architect Fees- Eliminate Interior Improvements 2Nd Floor	2016	8,160	-	20	408	408	1,224	21
22	Installed Outlets And Wires For Tv	2016	5,355	-	20	268	268	803	22
23	Front Entrance - Plants, Trees, Shrubs, Mulch	2016	16,285	-	20	1,629	1,629	4,886	23
24	Repaired & Installed New Valves	2016	2,613	-	20	240	240	719	24
25	Install P-Tac Units	2016	3,443	-	20	631	631	1,894	25
26	Remove & Replaced Concrete-Sidewalk/Back Door; New Ramp	2016	2,500	-	20	458	458	1,375	26
27	Install 4 Amana Ptac Units	2016	5,996	-	20	1,199	1,199	3,598	27
28	Fire Alarm System And Pipes	2016	2,664	-	20	155	155	466	28
29	Hot Water Heater Replacement	2016	16,250	-	20	948	948	2,844	29
30	Kitchen Range/Gas Hose/Plate Casters	2016	4,999	-	20	667	667	2,000	30
31	Firewall/Router Installation	2016	11,789	-	20	393	393	1,179	31
32	Project Management Fee To Ml Group Design - Interior Renovati	2016	46,568	-	20	776	776	2,328	32
33	Installation Of Outlets And Wire For Lounge	2016	5,640	-	20	282	282	846	33
34	TOTAL (lines 1 thru 33)		$ 3,022,582	$ 0		$ 151,884	$ 151,884	$ 605,001	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: 1/1/18 Ending: 12/31/18

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		$ 3,022,582	$ 0		$ 151,884	$ 151,884	$ 605,001	1
2	2Nd Floor Dialysis Room - Demo/Pipe/Electrical/Hvac	2016	279,802	-	20	13,990	13,990	41,970	2
3	Tiling - 2Nd Floor	2016	2,691	-	20	135	135	404	3
4	1St/2Nd Floor Rotunda Corridor/Elevator Cab Renovation	2016	10,000	-	20	500	500	1,375	4
5	2Nd Floor Wall Paper	2016	5,207	-	20	260	260	781	5
6	2Nd Floor Rotunda Elevator Repair	2016	54,690	-	20	2,735	2,735	8,204	6
7	2Nd Floor Rotunda - Electrical/Prime/Paint/Railing	2016	12,750	-	20	638	638	1,913	7
8	2Nd Floor - Install Roller Shades	2016	4,400	-	20	220	220	660	8
9	Architect Fees - Field Measuring, 2Nd Floor Dialysis Room	2016	15,750	-	20	788	788	2,363	9
10	2Nd Floor - Demo/Wall Panels/Lights/Flooring	2016	11,950	-	20	598	598	1,793	10
11	Water System Installation/Piping	2016	12,822	-	20	641	641	1,923	11
12				-		-			12
13				-		-			13
14	New fire devices for new elevator	2017	5,808	-	30	194	194	355	14
15	Install 6" piping for drainage kitchen	2017	8,045	-	30	268	268	424	15
16	Install new door security on 200 wing	2017	8,400	-	30	280	280	467	16
17	Replaces PA Amplifier system	2017	2,500	-	30	83	83	118	17
18	TVs installed common areas	2017	3,658	-	30	121	121	151	18
19	Replaced hot water valve wing #5	2017	2,700	-	30	90	90	105	19
20	Install new relays, smoke/heat detectors on 100/200 wing	2017	7,998	-	30	267	267	289	20
21				-		-			21
22	Plumbing-Replace 2" hot water line in ground slab.	2018	80,000	-	30	1,333	1,333	1,333	22
23	Install new line above ground by soffit			-		-			23
24	Plumbing is through out entire building including bathrooms,			-		-			24
25	basement, wing #3 and wing #4.			-		-			25
26	Fix leak in physical therapy room ceiling. Leak in the water			-		-			26
27	line feeding hot water to the 500 wing.					-			27
28	Re-piped with 1 1/2" type L copper pipe.	2018	2,695	-	30	45	45	45	28
29	Mixing valve replacement on boiler basement	2018	2,700	-	30	45	45	45	29
30	Repair drywall holes, patching and painting west side of			-		-			30
31	office/conference room. 310,311,312,314,315,316 repair			-		-			31
32	drywall. Hallway building soffits put up cherry panels on walls.			-		-			32
33	301,302,303,304, utility room fix driwall.	2018	16,500	-	30	275	275	275	33
34	TOTAL (lines 1 thru 33)		$ 3,573,650	$ 0		$ 175,388	$ 175,388	$ 669,994	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: 1/1/18 Ending: 12/31/18

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		$ 3,573,650	$ 0		$ 175,388	$ 175,388	$ 669,994	1
2	Install drainage at the west wing, door frame repaired	2018	3,450	-	30	58	58	58	2
3	Replaced dishwashing machine exhaust fan-kitchen	2018	2,500	-	30	42	42	42	3
4	Kitchen AC unit-install 3 mini-split system	2018	6,380	-	30	106	106	106	4
5	Aluminum directional signs building interior	2018	3,067	-	30	51	51	51	5
6	32 resident rooms AC power, remove breaker panel with new	2018	13,580	-	30	226	226	226	6
7	Broke up floor put in drain to convert two tubs to showers.	2018	4,630	-	30	77	77	77	7
8	Fix float switches to get pumps to work, replace	2018	2,648	-	30	44	44	44	8
9	bad motor starter.			-					9
10				-		-			10
11				-		-			11
12				-		-			12
13				-		-			13
14				-		-			14
15				-		-			15
16				-		-			16
17	Reconcile to book depreciation			551,096		-	(551,096)		17
18				-		-			18
19				-		-			19
20				-		-			20
21				-		-			21
22	Allocated from CF St. Louis LLC	2016	198,491	-	20	9,925	9,925	29,774	22
23	Allocated from CF St. Louis LLC	2017	4,607	-	20	230	230	461	23
24				-		-			24
25	Allocated from Legacy	2018	237	-	20	12	12	12	25
26				-		-			26
27				-		-			27
28				-		-			28
29				-		-			29
30				-		-			30
31				-		-			31
32				-		-			32
33				-		-			33
34	TOTAL (lines 1 thru 33)		$ 3,813,240	$ 551,096		$ 186,159	$ (364,937)	$ 700,845	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: 1/1/18 Ending: 12/31/18

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	$ 824,617	$	$ 102,089	$ 102,089		$ 327,304	71
72	Current Year Purchases	27,303		2,807	2,807		2,807	72
73	Fully Depreciated Assets				-			73
74	MGMT Allocation	14,536		1,453	1,453		3,684	74
75	TOTALS	$ 866,456	$ 0	$ 106,349	$ 106,349		$ 333,795	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			$ 0	$ 0	$ 0	$ 0		$ -	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)	$ 4,685,633	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 551,096	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 292,508	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (258,588)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,034,640	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: 1/1/18 Ending: 12/31/18

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	$ 674,400	10		3
4	Additions							4
5	Allocated from Mgmt co. Storage							5
6	Allocated from Mgmt co. Rent				41,022			6
7	TOTAL				$ 715,422 **			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.	/2019	$ 680810
13.	/2020	$ 694431
14.	/2021	$ 708,052

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: $ 28912 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		$	$ 2,664	17
18					18
19	Allocated from Mgmt. Co.			3,758	19
20					20
21	TOTAL		$	$ 6,422	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: **12/31/18**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Durable Medical Equipment	8,690
Oxygen	893
Therapy	5,200
Dietary	2,268
Housekeeping	8,352
Office	3,296
Allocation MGMT	213
Total - Line 16	**28,912**

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/1/18 Ending: 12/31/18

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		$	$	$	$ 0
2	Books and Supplies					0
3	Classroom Wages	(a)				0
4	Clinical Wages	(b)				0
5	In-House Trainer Wages	(c)				0
6	Transportation					0
7	Contractual Payments					0
8	CNA Competency Tests					0
9	TOTALS		$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2	(e)	$ 0			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	$	6,540	$ 470,882	$	6,540	$ 470,882	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,115	152,262		2,115	152,262	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		7,716	555,573		7,716	555,573	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				411,424		411,424	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	39(2)					19,901		19,901	12
13	Other (specify): Ambulance	39(3)			629	45,259		629	45,259	13
14	TOTAL			$	17,000	$ 1,223,976	$ 431,325	17,000	$ 1,655,301	14

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

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/1/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18 (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	$ 2,270	$ 56,997	1
2	Cash-Patient Deposits	0	0	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 719,566)	2,691,699	2,691,699	3
4	Supply Inventory (priced at)	0	0	4
5	Short-Term Investments	0	0	5
6	Prepaid Insurance	(44,474)	(44,474)	6
7	Other Prepaid Expenses	17,831	184,556	7
8	Accounts Receivable (owners or related parties)	0	0	8
9	Other(specify): See Attached Schedule	1,476,252	1,476,252	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,143,578	$ 4,365,030	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	0	0	11
12	Long-Term Investments	0	0	12
13	Land	0	5,937	13
14	Buildings, at Historical Cost	0	31,970	14
15	Leasehold Improvements, at Historical Cost	3,851,366	3,781,270	15
16	Equipment, at Historical Cost	869,236	866,456	16
17	Accumulated Depreciation (book methods)	(1,710,737)	(1,034,640)	17
18	Deferred Charges	0	0	18
19	Organization & Pre-Operating Costs	0	0	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	0	0	20
21	Restricted Funds	0	0	21
22	Other Long-Term Assets (spe	0	0	22
23	Other(specify): See Attached Schedule	(52,703)	(52,703)	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,957,162	$ 3,598,290	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,100,740	$ 7,963,320	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 876,554	$ 876,554	26
27	Officer's Accounts Payable	0	0	27
28	Accounts Payable-Patient Deposits	0	0	28
29	Short-Term Notes Payable	0	518,500	29
30	Accrued Salaries Payable	367,210	367,210	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,415	11,415	31
32	Accrued Real Estate Taxes(Sch.IX-B)	0	0	32
33	Accrued Interest Payable	0	0	33
34	Deferred Compensation	0	0	34
35	Federal and State Income Taxes	0	0	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	7,407,028	6,685,383	36
37		0	0	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 8,662,207	$ 8,459,062	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,015,000	1,015,000	39
40	Mortgage Payable	0	0	40
41	Bonds Payable	0	0	41
42	Deferred Compensation	0	0	42
	Other Long-Term Liabilities(specify):			
43		0	0	43
44		0	0	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,015,000	$ 1,015,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 9,677,207	$ 9,474,062	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,576,467)	$ (1,510,742)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,100,740	$ 7,963,320	48

*(See instructions.)

Facility Name: **Grove Of Fox Valley**
IDPH License ID Number: **0052621**
Fiscal Year End: **12/31/18**

Schedule 17A

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

Description	Operating	After Consolidation
RESIDENT FUND	6,260	6,260
REFUND	81,170	81,170
INSURANCE REFUND EXCHANGE	(83,661)	(83,661)
PROJECT MGMT RETAINER	105,000	105,000
SECURITY DEPOSIT	(6,600)	(6,600)
DUE TO/FROM - GROVE OF FOX VALLEY & VISTAS	217,944	217,944
DUE TO/FROM PRIOR VISTAS MANAGER	1,125,831	1,125,831
STATE WITHHOLDING TAXES	30,308	30,308
Total - Line 9	**1,476,252**	**1,476,252**

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

Description	Operating	After Consolidation
REFUND - TRANSFER	(131,575)	(131,575)
DUE TO/FROM PRIOR OWNER	54,477	54,477
DUE TO/FROM MEDICARE	(6,243)	(6,243)
BAD DEBT PART A - MMAI	15,851	15,851
DUE TO BCBS - UPP	14,787	14,787
Total - Line 23	**(52,703)**	**(52,703)**

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

Description	Operating	After Consolidation
EXCHANGE	(15,869)	(15,869)
PAYROLL EXCHANGE	15,908	15,908
EMPLOYEE LOANS,ADV,WAGE ASSIGN	1,995	1,995
DUE TO/FROM - GROVE OF FOX VALLEY & MANAGEMENT COM	1,295,600	1,295,600
DUE TO/FROM - GROVE OF FOX VALLEY & AVANTARA LONG	2,248,199	2,248,199
DUE TO/FROM - GROVE OF FOX VALLEY & WELLSHIRE MORT	300,000	300,000
DUE TO/FROM PROPCO	839,223	839,223
DUE TO/FROM OTHERS	2,158,481	2,158,481
DUE TO/FROM 10 PACK LLC	250,000	250,000
CHASE *2090 ALG	25,987	25,987
AMEX *1004 GFV	13,996	13,996
ACCRUED EXPENSE	67,463	67,463
ACCRUED MANAGEMENT FEES ENTITIES	118,858	118,858
DUE TO/FROM MEDICAID	12,838	12,838
BCBS ACCELERATED PAYMENT	74,349	74,349
Total - Line 36	**7,407,028**	**7,407,028**

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/1/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ -2323364	1	
2	Restatements (describe):		2	
3	**Prior Period Adjustment**	(6,354)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,329,718)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(246,749)	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)**	$ (246,749)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,576,467)	24	*

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

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 17,043,874	1
2	Discounts and Allowances for all Levels	(8,918,756)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,125,118	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,988,766	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,988,766	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	386,937	17
18	Sale of Supplies to Non-Patients	50,874	18
19	Laboratory	61,586	19
20	Radiology and X-Ray	(55)	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 499,342	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	26,619	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 26,619	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	20,350	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 20,350	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,660,195	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,946,530	31
32	Health Care	4,973,029	32
33	General Administration	2,730,045	33
	B. Capital Expense		
34	Ownership	1,599,208	34
	C. Ancillary Expense		
35	Special Cost Centers	2,283,568	35
36	Provider Participation Fee	374,564	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,906,944	40
41	**Income before Income Taxes (line 30 minus line 40)****	(246,749)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (246,749)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,878,056	44
45	Private Pay - Net Inpatient Revenue	726,490	45
46	Medicare - Net Inpatient Revenue	522,930	46
47	Other-(specify) Insurance/Veterans	502,881	47
48	Other-(specify) Part B	(505,239)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,125,118	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No^ 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.**

^ **Entity is a cash basis taxpayer**

Facility Name: **Grove Of Fox Valley**
IDPH License ID Number: **0052621**
Fiscal Year End: **12/31/18**

Schedule 19A

XVII. Income Statement
Line 28 Other Revenue (specify):

Description	Amount
RENTALS	7,913
DISCOUNTS EARNED	5,960
MISC INCOME	5,097
LABORATORY - PRIOR PERIOD	(200)
STATE INCOME TAX	1,580
Total - Line 28	**20,350**

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	1,631	2,012	$ 107,308	$ 53.34	1
2	Assistant Director of Nursing	2,027	2,080	94,855	45.60	2
3	Registered Nurses	32,450	35,730	1,226,188	34.32	3
4	Licensed Practical Nurses	29,805	33,154	936,468	28.25	4
5	CNAs & Orderlies	94,478	103,589	1,562,739	15.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,551	6,059	132,468	21.86	8
9	Activity Director	1,929	2,080	47,402	22.79	9
10	Activity Assistants	7,184	7,903	94,724	11.99	10
11	Social Service Workers	3,832	4,160	122,919	29.55	11
12	Dietician					12
13	Food Service Supervisor	1,677	2,080	73,001	35.10	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,624	23,909	309,255	12.93	15
16	Dishwashers					16
17	Maintenance Workers	3,726	4,160	117,865	28.33	17
18	Housekeepers	20,446	22,867	279,997	12.24	18
19	Laundry	1,817	2,043	29,860	14.62	19
20	Administrator	4,605	2,080	304,803	146.54	20
21	Assistant Administrator	3,624	3,756	166,501	44.33	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,097	10,434	183,074	17.55	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	1,879	2,041	41,952	20.55	31
32	Other Health C: MDS	3,907	4,291	159,665	37.21	32
33	Other(specify) Admissions	671	758	30,639	40.42	33
34	TOTAL (lines 1 - 33)	251,958	275,184	$ 6,021,683 *	$ 21.88	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	18,006	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	2,846	10(7)	38
39	Pharmacist Consultant	Monthly	16,299	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	518	15(3)	42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,512	11(3)	44
45	Social Service Consultant	Monthly	434	12(3)	45
46	Other(specify) MDS Consultant	Monthly	37,781	10(3)	46
47	Transitional Care	Monthly	2,000	10(3)	47
48	Dialysis/DME	Monthly	151,666	10(3)	48
49	TOTAL (lines 35 - 48)		$ 231,062		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		N/A		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/1/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Camberly Lanning	Administrator	0	$ 277,435
Ashley L. Condotti	Assistant Admin	0	193,869
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 471,304

B. Administrative - Other

Description	Amount
Management Fees	$ 272,879
TOTAL (agree to Schedule V, line 17, col. 3)	$ 272,879
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Sch 21C		$ 145,505
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 145,505

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 74,012
Unemployment Compensation Insurance	55,731
FICA Taxes	419,003
Employee Health Insurance	236,073
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement	27,167
Payroll Taxes	51,244
PTO Adjustment	(11,998)
Uniforms	12,116
Other Benefits	233,403
Allocation from Mgmt	(75,811)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,020,940

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,114
Advertising: Employee Recruitment	271
Health Care Worker Background Check	
(Indicate # of checks performed 46)	553
Patient Background Checks 496	5,953
Dues and Subscriptions	18,561
HCCI & IHCA Dues	29,000
License and Permits	9,654
Allocated from Mgmt Co.	2,408
Non Allowable Dues	(12,484)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 56,030

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	649
Allocated from Mgmt Co.	2,910
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,559

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **Grove Of Fox Valley**
IDPH License ID Number: **0052621**
Fiscal Year End: **12/31/18**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Achieve Accreditation LLC	Accreditation	10,413
Adam Zollinger Interiors	Interior Design	2,444
Broadcast Music Inc	Media	754
Compliagent	Professional Fees	1,800
Curaspan Health Group	administrative	3,555
Deborah D. Cole Goodwill	Professional Fees	500
Integra Scripts	Pharmacy	15,962
Language Line Services, Inc.	Language Services	4
Legacy Expense Reimbursement	Professional Fees	4,850
Lexisnexis Risk Solutions	Risk Advisory	20
Marcum LLP	Accounting Services	28,580
ML Group Design	Asset Management	18,000
Motion Picture Licensing Corp	Media	190
MTS Consulting	Tax	3,351
Personnel Planners	Unemployment	1,500
Prospect Resources Inc	Staff recruiting	900
PSD Solutions	Professional Fees	104
Corporation Service Company	Legal	258
Kitch Drutchas Wagner Valitutt	Legal	785
Legacy Expense Reimbursement	Legal	1,209
Nelson Hardiman LLP	Legal	31
Purchase Journal Accrual	Legal	2,101
Robbins, Salomon & Patt, LTD	Legal	41
Stone , McGuire & Siegel	Legal	1,154
Stone Pogrund & Korey LLC	Legal	12,984
Comliance Resources Inc	Legal	169
Paycor, Inc	Payroll	30,904
Other Professional Fees	Other Professional Fees	2,942
Total (agree to Schedule V, line 19, column 3)		145,505
Allocated from Management Company	Legal Fees	
Allocated from Management Company	Professional Services	10,678
Allocated from Management Company	Accounting Fees	1,931
Less: Non-Allowable Legal Fees		(4,980)
Lees:Non-allowable Paycor fees		(8,091)
Total (agree to Schedule V, line 19, column 8)		145,043

Facility Name & ID Number Grove Of Fox Valley # 0052621 Report Period Beginning: 1/1/18 Ending: 12/31/18

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. **HCCOI - $17,877 & IHCA-$11,123**

(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?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **56,365** 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. $ **374,564**
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. $ **0**

(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 1**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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