FOR BHF USE

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

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

I. IDPH License ID Number: 0052621

Facility Name: The Grove of Fox Valley

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

County: Kane

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/20 to 12/31/20 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)
** Subject to the attached Accountants' Consulting Report* (Date)
(Print Name and Title) Steven N. Lavenda, CPA — Partner
(Firm Name & Address) Marcum, LLP — 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1 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	57,828	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	57,828	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			9,256	9,256	8
9	SNF/PED					9
10	ICF	36,517	2,388		38,905	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,517	2,388	9,256	48,161	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.28%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 02/01/2014

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/2014 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 158 and days of care provided 4,711

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: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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	435,327	68,917	6,020	510,264		510,264	2,982	513,246			1
2	Food Purchase		381,749		381,749		381,749	5,482	387,231			2
3	Housekeeping	295,088	29,131	862	325,081		325,081	1,934	327,015			3
4	Laundry	59,437	25,419	159,573	244,429		244,429	131	244,560			4
5	Heat and Other Utilities			138,613	138,613		138,613	(2,080)	136,533			5
6	Maintenance	118,351	13,739	171,918	304,008		304,008	10,231	314,239			6
7	Other (specify):*											7
8	TOTAL General Services	908,203	518,955	476,986	1,904,144		1,904,144	18,680	1,922,824			8
	B. Health Care and Programs											
9	Medical Director			15,000	15,000		15,000		15,000			9
10	Nursing and Medical Records	4,288,171	379,494	46,635	4,714,300		4,714,300	88,562	4,802,862			10
10a	Therapy	106,648			106,648		106,648		106,648			10a
11	Activities	118,508	3,687	1,143	123,338		123,338	8	123,346			11
12	Social Services	132,599		1,440	134,039		134,039	5,180	139,219			12
13	CNA Training											13
14	Program Transportation			2,360	2,360		2,360		2,360			14
15	Other (specify):*							5,373	5,373			15
16	TOTAL Health Care and Programs	4,645,926	383,181	66,578	5,095,685		5,095,685	99,124	5,194,809			16
	C. General Administration											
17	Administrative	229,328			229,328		229,328	57,667	286,995			17
18	Directors Fees											18
19	Professional Services			497,921	497,921	(50,346)	447,575	(263,241)	184,335			19
20	Dues, Fees, Subscriptions & Promotions			103,549	103,549		103,549	(67,863)	35,686			20
21	Clerical & General Office Expenses	183,888	3,331	485,776	672,995		672,995	(95,109)	577,886			21
22	Employee Benefits & Payroll Taxes			1,076,880	1,076,880		1,076,880		1,076,880			22
23	Inservice Training & Education											23
24	Travel and Seminar			786	786		786	129	915			24
25	Other Admin. Staff Transportation			857	857		857	4,311	5,168			25
26	Insurance-Prop.Liab.Malpractice			258,597	258,597		258,597	4,763	263,360			26
27	Other (specify):*							23,113	23,113			27
28	TOTAL General Administration	413,216	3,331	2,424,366	2,840,913	(50,346)	2,790,567	(336,230)	2,454,338			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,967,345	905,467	2,967,930	9,840,742	(50,346)	9,790,396	(218,426)	9,571,970			29

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

Facility Name & ID Number The Grove of Fox Valley #0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

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							629,648	629,648			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,215	22,215		22,215	591,763	613,978			32
33	Real Estate Taxes			79,305	79,305	50,346	129,651	3,176	132,827			33
34	Rent-Facility & Grounds			895,991	895,991		895,991	(893,182)	2,809			34
35	Rent-Equipment & Vehicles			10,863	10,863		10,863	4,095	14,958			35
36	Other (specify):*							9,350	9,350			36
37	**TOTAL Ownership**			1,008,374	1,008,374	50,346	1,058,720	344,850	1,403,569			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		499,477	1,125,802	1,625,279		1,625,279	(14,756)	1,610,523			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			365,493	365,493		365,493		365,493			42
43	Other (specify):*			509,925	509,925		509,925	(509,925)	0			43
44	**TOTAL Special Cost Centers**		499,477	2,001,220	2,500,697		2,500,697	(524,681)	1,976,016			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,967,345	1,404,944	5,977,524	13,349,813		13,349,813	(398,257)	12,951,556			45

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(3,089)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	623,427	30		9
10	Interest and Other Investment Income	(16,115)	32		10
11	Discounts, Allowances, Rebates & Refunds	(7,181)	10		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(192)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(12,713)	21		18
19	Entertainment	(549)	21		19
20	Contributions	(50,203)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(278,339)	21		24
25	Fund Raising, Advertising and Promotional	(3,658)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(726,718)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (475,330)		$	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)	77,072		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 77,072		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (398,258)		37

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

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

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

The Grove of Fox Valley

ID# 0052621

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable Expense	$ (508,938)	43	1
2	Patient Personal Items	(711)	10	2
3	Bank Charges	(20,159)	21	3
4	Sequestration Expense	(33,227)	21	4
5	Pharmacy Discounts	(2)	10	5
6	Non-Allowable Expense	(987)	43	6
7	PAC Dues	(17,235)	20	7
8	Non-Allowable Legal	(35,365)	19	8
9	Prior Year Equipment Rental	(93)	35	9
10	Building Co. - Accounting Fees	(10,710)	19	10
11	Building Co. - Legal	(60,310)	19	11
12	Building Co. - Professional Fees - Loan	(37,864)	19	12
13	Building Co. - Amortization	(1,117)	36	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(726,718)		49

Detail lines 29 and 35 of Page 5 starting in C12. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 5B**

The Grove of Fox Valley

IDF 0052621

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		b		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

Reference 1 Reference 2 Reference 3 Reference 4 Reference 5 Reference 6 Reference 7 Reference 9 Reference 10 Reference 10a Reference 11 Reference 12 Reference 13 Reference 14 Reference 15 Reference 17 Reference 18 Reference 19 Reference 20 Reference 21 Reference 22 Reference 23 Reference 24 Reference 25 Reference 26 Reference 27 Reference 30 Reference 31 Reference 32 Reference 33 Reference 34 Reference 35 Reference 36 Reference 38 Reference 39 Reference 40 Reference 41 Reference 42 Reference 43

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			2,982									2,982	1
2	Food Purchase	(192)		5,674									5,482	2
3	Housekeeping			1,934									1,934	3
4	Laundry			131									131	4
5	Heat and Other Utilities	(3,089)				1,009							(2,080)	5
6	Maintenance			9,695		977	(441)						10,231	6
7	Other (specify):*													7
8	**TOTAL General Services**	(3,281)		20,416		1,986	(441)						18,680	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(7,894)		99,169				(2,713)					88,562	10
10a	Therapy													10a
11	Activities			8									8	11
12	Social Services			5,180									5,180	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				5,373								5,373	15
16	**TOTAL Health Care and Programs**	(7,894)		104,358	5,373			(2,713)					99,124	16
	C. General Administration													
17	Administrative			57,667									57,667	17
18	Directors Fees													18
19	Professional Services	(144,249)	108,884	(221,068)		425			(7,232)				(263,241)	19
20	Fees, Subscriptions & Promotions	(71,096)		3,232		1							(67,863)	20
21	Clerical & General Office Expenses	(344,987)		249,643		234							(95,109)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			129									129	24
25	Other Admin. Staff Transportation			4,311									4,311	25
26	Insurance-Prop.Liab.Malpractice		4,396	114		253							4,763	26
27	Other (specify):*			23,113									23,113	27
28	**TOTAL General Administration**	(560,332)	113,279	117,142		913			(7,232)				(336,230)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(571,507)	113,279	241,915	5,373	2,899	(441)	(2,713)	(7,232)				(218,426)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	623,427				6,221							629,648	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(16,115)	604,382			3,496							591,763	32
33	Real Estate Taxes					3,176							3,176	33
34	Rent-Facility & Grounds		(893,272)	29,274		(29,184)							(893,182)	34
35	Rent-Equipment & Vehicles	(93)			4,188								4,095	35
36	Other (specify):*	(1,117)	10,467										9,350	36
37	TOTAL Ownership	606,102	(278,423)	29,274	4,188	(16,291)							344,850	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers										(14,756)		(14,756)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(509,925)											(509,925)	43
44	TOTAL Special Cost Centers	(509,925)									(14,756)		(524,681)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(475,330)	(165,144)	271,189	9,561	(13,392)	(441)	(2,713)	(7,232)		(14,756)		(398,257)	45

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 893,272	Prairie Property Holdings		$	$ (893,272)	1
2	V	32	Interest	72	Prairie Property Holdings		604,454	604,382	2
3	V	26	Property Insurance		Prairie Property Holdings		4,396	4,396	3
4	V	36	Mortgage Insurance Premium		Prairie Property Holdings		9,350	9,350	4
5	V	19	Professional Fees - Accounting		Prairie Property Holdings		10,710	10,710	5
6	V	19	Professional Fees - Legal		Prairie Property Holdings		60,310	60,310	6
7	V	19	Professional Fees - Loan		Prairie Property Holdings		37,864	37,864	7
8	V	36	Amortization		Prairie Property Holdings		1,117	1,117	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 893,344			$ 728,200	$ * (165,144)	14

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Yair Zuckerman	99.00%	Astoria Place Skilled Nursing Facility LLC	Chicago	Prairie Property Holdings		Building Company	1
2	Dina Zuckerman	1.00%	Avantara Arlington	Arlington, SD	Legacy HC & Financial Services	Lincolnwood	Home Office/Bookkeeping	2
3			Avantara Armour	Armour, SD	CF St. Louis LLC	Skokie	Building Company	3
4			Avantara Arrowhead	Rapid City, SD	ML Group Design & Development	Skokie	Asset Management	4
5			Avantara Aurora	Aurora	ReMED Services LLC	Lincolnwood	Nursing Equipment	5
6			Avantara Billings	Billings, MT	Propay HR	Evanston	Payroll Processing	6
7			Avantara Clark	Clark, SD	Ecobrite Linen	Skokie	Laundry Supplies	7
8			Avantara Elgin	Elgin	Aurora Supportive Living	Aurora	Supportive Living	8
9			Avantara Evergreen Park	Evergreen Park	Terrace Gardens	Morton Grove	Assisted Living	9
10			Avantara Groton	Groton, SD	Lincolnshire Assisted Living Center	Lincolnshire	Assisted Living	10
11			Avantara Huron	Huron, SD	Wellshire Park Place	Milbank, SD	Assisted Living	11
12			Avantara Ipswich	Ipswich, SD	Wellshire Huron	Huron, SD	Assisted Living	12
13			Avantara Lake Norden	Lake Norden, SD	Lifescan Labs of Illinois	Skokie	Laboratory	13
14			Avantara Long Grove	Long Grove				14
15			Avantara Milbank	Milbank, SD				15
16			Avantara Mountainview	Rapid City, SD				16
17			Avantara North	Rapid City, SD				17
18			Avantara Norton	Sioux Falls, SD				18
19			Avantara Park Ridge	Park Ridge				19
20			Avantara Pierre	Pierre, SD				20
21			Avantara Redfield	Redfield, SD				21
22			Avantara Salem	Salem, SD				22
23			Avantara St. Cloud	Rapid City, SD				23
24			Avantara Watertown	Watertown, SD				24
25			Bella Terra Streamwood	Streamwood				25
26			Bella Terra Wheeling	Wheeling				26
27			Bethany Terrace	Morton Grove				27
28			Carlton Skilled Nursing Facility LLC	Chicago				28
29			Chalet Skilled Nursing Facility LLC	Chicago				29
30			Clark Skilled Nursing Facility	Chicago				30

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Elmbrook Skilled Nursing Facility LLC	Elmhurst				1
2			Evanston Skilled Nursing Facility LLC	Evanston				2
3			Grove at the Lake Skilled Nursing Facility LLC	Zion				3
4			Grove of Berwyn	Berwyn				4
5			Grove of St. Charles	St. Charles				5
6			Lagrange Skilled Nursing Facility LLC	Lagrange Park				6
7			Lakefront Skilled Nursing Facility LLC	Chicago				7
8			Lincoln Park Skilled Nursing Facility LLC	Chicago				8
9			Lincolnshire Living & Rehab Center LLC	Lincolnshire				9
10			Northbrook Skilled Nursing Facility LLC	Northbrook				10
11			Peterson Park Associates Limited Partnership	Chicago				11
12			Skokie Skilled Nursing Facility LLC	Skokie				12
13			Valley Skilled Nursing Facility	Billings, MT				13
14			Warren Barr Living And Rehab	Chicago				14
15			Warren Barr North Shore	Highland Park				15
16			Warren Barr South Loop	Chicago				16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 2,966	$ 2,966	15
16	V	01	Dietary Supplies		Legacy Healthcare Financial Services		16	16	16
17	V	02	Food		Legacy Healthcare Financial Services		5,674	5,674	17
18	V	03	Housekeeping		Legacy Healthcare Financial Services		1,934	1,934	18
19	V	04	Linen Replacement		Legacy Healthcare Financial Services		131	131	19
20	V	06	Maintenance Salary		Legacy Healthcare Financial Services		9,152	9,152	20
21	V	06	Repairs & Maintenance		Legacy Healthcare Financial Services		543	543	21
22	V	10	Nursing Salary		Legacy Healthcare Financial Services		75,747	75,747	22
23	V	10	Nurse/Medical Director Consultant		Legacy Healthcare Financial Services		7,149	7,149	23
24	V	10	Medical Supplies		Legacy Healthcare Financial Services		16,274	16,274	24
25	V	12	Social Service Salary		Legacy Healthcare Financial Services		5,160	5,160	25
26	V	11	Activities Program		Legacy Healthcare Financial Services		8	8	26
27	V	12	Social Service Consultant		Legacy Healthcare Financial Services		20	20	27
28	V	17	COO / Administrative Salary		Legacy Healthcare Financial Services		57,667	57,667	28
29	V	19	Professional Fees	240,000	Legacy Healthcare Financial Services		18,932	(221,068)	29
30	V	20	Dues / Licenses / Permits		Legacy Healthcare Financial Services		3,232	3,232	30
31	V	21	Clerical & General Wages		Legacy Healthcare Financial Services		232,676	232,676	31
32	V	21	Clerical & Office Expense		Legacy Healthcare Financial Services		16,967	16,967	32
33	V	24	Education & Seminars		Legacy Healthcare Financial Services		129	129	33
34	V	25	Travel		Legacy Healthcare Financial Services		4,311	4,311	34
35	V	26	Insurance - General		Legacy Healthcare Financial Services		114	114	35
36	V	27	Non-Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		23,113	23,113	36
37	V	34	Rent		Legacy Healthcare Financial Services		29,184	29,184	37
38	V	34	Offsite Storage / Parking		Legacy Healthcare Financial Services		90	90	38
39	Total			$ 240,000			$ 511,189	$ * 271,189	39

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	35	Equipment Rental		Legacy Healthcare Financial Services		389	$ 389	15
16	V	35	Auto Rental		Legacy Healthcare Financial Services		3,798	3,798	16
17	V	15	Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		5,373	5,373	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			$			$ 9,561	$ * 9,561	39

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 1,009	$ 1,009	15
16	V	6	Repairs & Maintenance		CF St. Louis LLC		977	977	16
17	V	19	Property Valuation Fee		CF St. Louis LLC		346	346	17
18	V	19	Accounting Fees		CF St. Louis LLC		79	79	18
19	V	20	Dues & Subscriptions		CF St. Louis LLC		1	1	19
20	V	21	Office Expense		CF St. Louis LLC		234	234	20
21	V	26	Insurance		CF St. Louis LLC		253	253	21
22	V	30	Depreciation		CF St. Louis LLC		6,221	6,221	22
23	V	32	Interest Expense		CF St. Louis LLC		3,496	3,496	23
24	V	33	Real Estate Taxes		CF St. Louis LLC		3,176	3,176	24
25	V								25
26	V	34	Rent	29,184	CF St. Louis LLC			(29,184)	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			$ 29,184			$ 15,792	$ * (13,392)	39

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance	$ 18,000	ML Group Design & Development		$ 17,559	$ (441)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 18,000			$ 17,559	$ * (441)	39

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	10	Medical Supplies	$ 9,000	ReMED Services		$ 6,287	$ (2,713)	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			$ 9,000			$ 6,287	$ * (2,713)	39

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 31,568	ProPay HR LLC		$ 24,336	$ (7,232)	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			$ 31,568			$ 24,336	$ * (7,232)	39

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	04	Laundry Services	$ 203,968	EcoBrite Linen		$ 203,968	$	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			$ 203,968	$ *	39

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	39	Laboratory	$ 36,255	Lifescan Labs of Illinois		$ 21,499	$ (14,756)	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			$ 36,255			$ 21,499	$ * (14,756)	39

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1	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	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	Available Bed Days	2,540,133	53	$ 130,303	$ 130,303	57,828	$ 2,966	1
2	01	Dietary Supplies	Available Bed Days	2,540,133	53	697		57,828	16	2
3	02	Food	Available Bed Days	2,540,133	53	249,220		57,828	5,674	3
4	03	Housekeeping	Available Bed Days	2,540,133	53	84,952		57,828	1,934	4
5	04	Linen Replacement	Available Bed Days	2,540,133	53	5,771		57,828	131	5
6	06	Maintenance Salary	Available Bed Days	2,540,133	53	401,986	401,986	57,828	9,152	6
7	06	Repairs & Maintenance	Available Bed Days	2,540,133	53	23,857		57,828	543	7
8	10	Nursing Salary	Available Bed Days	2,540,133	53	3,327,223	3,327,223	57,828	75,747	8
9	10	Nurse/Medical Director Consultan	Available Bed Days	2,540,133	53	314,035		57,828	7,149	9
10	10	Medical Supplies	Available Bed Days	2,540,133	53	714,824		57,828	16,274	10
11	12	Social Service Salary	Available Bed Days	2,540,133	53	226,662	226,662	57,828	5,160	11
12	11	Activities Program	Available Bed Days	2,540,133	53	335		57,828	8	12
13	12	Social Service Consultant	Available Bed Days	2,540,133	53	893		57,828	20	13
14	17	COO / Administrative Salary	Available Bed Days	2,540,133	53	2,533,078	2,533,078	57,828	57,667	14
15	19	Professional Fees	Available Bed Days	2,540,133	53	831,592		57,828	18,932	15
16	20	Dues / Licenses / Permits	Available Bed Days	2,540,133	53	141,983		57,828	3,232	16
17	21	Clerical & General Wages	Available Bed Days	2,540,133	53	10,220,453	10,220,453	57,828	232,676	17
18	21	Clerical & Office Expense	Available Bed Days	2,540,133	53	745,293		57,828	16,967	18
19	24	Education & Seminars	Available Bed Days	2,540,133	53	5,655		57,828	129	19
20	25	Travel	Available Bed Days	2,540,133	53	189,364		57,828	4,311	20
21	26	Insurance - General	Available Bed Days	2,540,133	53	4,997		57,828	114	21
22	27	Non-Nursing Payroll Taxes / Bene	Available Bed Days	2,540,133	53	1,015,274		57,828	23,113	22
23	34	Rent	Available Bed Days	2,540,133	53	1,281,940		57,828	29,184	23
24	34	Offsite Storage / Parking	Available Bed Days	2,540,133	53	3,949		57,828	90	24
25	TOTALS					$ 22,454,338	$ 16,839,706		$ 511,189	25

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	35	Equipment Rental	Available Bed Days	2,540,133	53	17,109		57,828	389	1
2	35	Auto Rental	Available Bed Days	2,540,133	53	166,843		57,828	3,798	2
3	15	Nursing Payroll Taxes / Benefits	Available Bed Days	2,540,133	53	236,021		57,828	5,373	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 419,973	$		$ 9,561	25

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	Available Bed Days	2,540,133	53	$ 44,301	$	57,828	$ 1,009	1
2	6	Repairs & Maintenance	Available Bed Days	2,540,133	53	42,932		57,828	977	2
3	19	Property Valuation Fee	Available Bed Days	2,540,133	53	15,181		57,828	346	3
4	19	Accounting Fees	Available Bed Days	2,540,133	53	3,453		57,828	79	4
5	20	Dues & Subscriptions	Available Bed Days	2,540,133	53	23		57,828	1	5
6	21	Office Expense	Available Bed Days	2,540,133	53	10,298		57,828	234	6
7	26	Insurance	Available Bed Days	2,540,133	53	11,124		57,828	253	7
8	30	Depreciation	Available Bed Days	2,540,133	53	273,261		57,828	6,221	8
9	32	Interest Expense	Available Bed Days	2,540,133	53	153,558		57,828	3,496	9
10	33	Real Estate Taxes	Available Bed Days	2,540,133	53	139,524		57,828	3,176	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 693,655	$		$ 15,792	25

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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: 3424 Oakton St
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 676-5300
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Direct			$	$		$ 17,559	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					$	$		$ 17,559	25

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: ReMED Services LLC
Street Address: 3424 Oakton Street, Suite 102
City / State / Zip Code: Skokie, IL
Phone Number: (847) 440-2600
Fax Number: ( )

	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	10	Medical Supplies	Direct			$	$		$ 6,287	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 6,287	25

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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 St.
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: ((847) 905 3268
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct			$	$		$ 24,336	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					$	$		$ 24,336	25

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: EcoBrite Linen
Street Address: 3712 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	04	Laundry Services	Direct			$	$		$ 203,968	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					$	$		$ 203,968	25

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	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	39	Laboratory	Direct			$	$		$ 21,499	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					$	$		$ 21,499	25

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	CIBC		X	Mortgage Payable			$	$ 14,779,260			$ 604,454	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CIBC		X	Interest Only							22,215	6
7	Allocated from CF St. Louis		X								3,496	7
8												8
9	TOTAL Facility Related						$	$ 14,779,260			$ 630,165	9
	B. Non-Facility Related*											
10	Interest Income		X								(16,115)	10
11	Interest Income - Bldg Co.		X								(72)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (16,187)	14
15	TOTALS (line 9+line14)						$	$ 14,779,260			$ 613,978	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 9,350 Line # 36

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

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		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.)	$	82,481	2
3. Under or (over) accrual (line 2 minus line 1).	$	82,481	3
4. Real Estate Tax accrual used for 2020 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.)**	$	50,346	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	132,827	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2015	134,175	8
2016	139,466	9
2017	151,627	10
2018	152,798	11
2019	79,305	12

2020 Accrual = 79,305 x 4.31 = $341,933
Allocated from CF St. Louis LLC: $3,176

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Grove of Fox Valley COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0052621

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-12-151-040	Long Term Care Facility	$ 79,305.02	$ 79,305.02
2.	10-23-406-034-0000	Home Office Allocation	$ 459,532.44	$ 3,176.36
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 538,837.46	$ 82,481.38

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Grove of Fox Valley COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0052621

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

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

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

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

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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	Facility			$ 700,000	1
2	Allocated from CF St. Louis, LLC			4,493	2
3	TOTALS			$ 704,493	3

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 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	158		2019	1962	$ 8,965,842	$	35	$ 256,167	$ 256,167	$ 512,334	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2014	128,602		20	6,430	6,430	45,011	9
10	Various			2015	2,688,895		20	134,445	134,445	806,669	10
11	Various			2016	542,324		20	27,116	27,116	135,581	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		211,456	5,735		10,054	4,319	44,980	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 12,537,119	$ 5,735		$ 434,212	$ 428,477	$ 1,544,574	70

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 12,537,119	$ 5,735		$ 434,212	$ 428,477	$ 1,544,574	1
2	New Fire Devices For New Elevator	2017	5,808		20	290	290	1,162	2
3	Install 6" Piping For Drainage Kitchen	2017	8,045		20	402	402	1,609	3
4	Install New Door Security On 200 Wing	2017	8,400		20	420	420	1,680	4
5	Replaces Pa Amplifier System	2017	2,500		20	125	125	500	5
6	Tvs Installed Common Areas	2017	3,658		20	183	183	732	6
7	Replaced Hot Water Valve Wing #5	2017	2,700		20	135	135	540	7
8	Install New Relays, Smoke/Heat Detectors On 100/200 Wing	2017	7,998		20	400	400	1,600	8
9	Plumbing-Replace 2" Hot Water Line In Ground Slab.	2018	80,000		20	4,000	4,000	12,000	9
10	Re-Piped With 1 1/2" Type L Copper Pipe.	2018	2,695		20	135	135	404	10
11	Mixing Valve Replacement On Boiler Basement	2018	2,700		20	135	135	405	11
12	301,302,303,304, Utility Room Fix Driwall.	2018	16,500		20	825	825	2,475	12
13	Install Drainage At The West Wing, Door Frame Repaired	2018	3,450		20	173	173	518	13
14	Replaced Dishwashing Machine Exhaust Fan-Kitchen	2018	2,500		20	125	125	375	14
15	Kitchen Ac Unit-Install 3 Mini-Split System	2018	6,380		20	319	319	957	15
16	Aluminum Directional Signs Building Interior	2018	3,067		20	153	153	460	16
17	32 Resident Rooms Ac Power, Remove Breaker Panel With New	2018	13,580		20	679	679	2,037	17
18	Broke Up Floor Put In Drain To Convert Two Tubs To Showers.	2018	4,630		20	232	232	695	18
19	Fix Float Switches To Get Pumps To Work, Replace	2018	2,648		20	132	132	397	19
20	Double Doors, Panic Devices. 500 Conference Room Install	2019	4,007		20	200	200	401	20
21	Repair And Replace Courtyard Gate. Posts, Link Door	2019	2,790		20	140	140	279	21
22	Add 6" Pvc Drainage Pipes From Existing Retention Pond	2019	2,900		20	145	145	290	22
23	Boilder Room:Pipe Fittings Removal, Reinsulate	2019	6,800		20	340	340	680	23
24	Asphalt Repairs: 2,375 Sq. Ft. Tack Coat, Level Areas	2019	12,265		20	613	613	1,227	24
25	Repair Masonry Cracks, Sidewalk, Chain Ling Fence ($2,950)	2019	2,878		20	144	144	144	25
26	Sprinkler System Modifications ($50,169)	2020	48,940		20	2,447	2,447	2,447	26
27	Voice Wiring - Voltage Box,Wall Mount Rack,Patch Penal ($5,683	2020	5,544		20				27
28	Install New Panel Radiator In Ceiling ($2,585)	2020	2,522		20	126	126	126	28
29	Parking Lot Sealing & Striping ($3,150)	2020	3,073		20	154	154	154	29
30	Water Heater Replacement ($7,555)	2020	7,370		20	368	368	368	30
31	Water Leak - Dug Up And Repaired 4" Water Main Pipe ($18,700	2020	18,242		20	912	912	935	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,831,707	$ 5,735		$ 448,665	$ 442,929	$ 1,580,169	34

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 12,831,707	$ 5,735		$ 448,665	$ 442,929	$ 1,580,169	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,831,707	$ 5,735		$ 448,665	$ 442,929	$ 1,580,169	34

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 12,831,707	$ 5,735		$ 448,665	$ 442,929	$ 1,580,169	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,831,707	$ 5,735		$ 448,665	$ 442,929	$ 1,580,169	34

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 12,831,707	$ 5,735		$ 448,665	$ 442,929	$ 1,580,169	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,831,707	$ 5,735		$ 448,665	$ 442,929	$ 1,580,169	34

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party								1
2	Buildings:								2
3	Allocated from CF St. Louis, LLC	2016	24,193	1,123	35	691	(432)	3,456	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	150,202	3,705	20	7,510	3,805	37,550	9
10	Allocated from CF St. Louis, LLC	2017	3,486	86	20	174	88	697	10
11	Allocated from CF St. Louis, LLC	2019	31,598	780	20	1,580	800	3,160	11
12	Allocated from CF St. Louis, LLC	2019	1,662	41	20	83	42	83	12
13									13
14	Allocated from Legacy HC	2018	179		20	9	9	27	14
15	Allocated from Legacy HC	2020	135		20	7	7	7	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 211,456	$ 5,735		$ 10,054	$ 4,319	$ 44,980	34

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 211,456	$ 5,735		$ 10,054	$ 4,319	$ 44,980	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 211,456	$ 5,735		$ 10,054	$ 4,319	$ 44,980	34

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,801,637	$ 484	$ 180,164	$ 179,680	10	$ 622,492	71
72	Current Year Purchases	8,197	2	820	818	10	897	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,809,835	$ 486	$ 180,983	$ 180,498		$ 623,389	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)	$ 15,346,035	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 6,221	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 629,648	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 623,427	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,203,558	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 The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Offsite Storage				2,719			5
6	Allocated from Legacy Financial				90			6
7	TOTAL				$ 2,809 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 11,160 Description: See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Legacy Financial		$	$ 3,798	17
18					18
19					19
20					20
21	TOTAL		$	$ 3,798	21

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

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 345,743	$		$ 345,743	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			133,891			133,891	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			536,403			536,403	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				371,013		371,013	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					109,765	128,464		238,229	13
14	TOTAL			$		$ 1,125,802	$ 499,477		$ 1,625,279	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 The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/20 (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	$ 515,531	$ 769,157	1
2	Cash-Patient Deposits	5,703	5,703	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	260,671	260,671	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,050	9,841	6
7	Other Prepaid Expenses	367,125	376,475	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	383,587	383,645	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,533,667	$ 1,805,492	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	22,914	780,861	13
14	Buildings, at Historical Cost		5,847,023	14
15	Leasehold Improvements, at Historical Cost	4,026,751	4,026,751	15
16	Equipment, at Historical Cost	943,921	1,918,425	16
17	Accumulated Depreciation (book methods)	(2,232,295)	(2,363,795)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	2,855,280	3,836,333	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,616,571	$ 14,045,598	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,150,238	$ 15,851,090	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 585,936	$ 585,935	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	384,686	384,686	30
31	Accrued Taxes Payable (excluding real estate taxes)	231,542	231,542	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		37,873	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,112,720	1,112,720	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,314,884	$ 2,352,756	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		14,779,260	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	7,023,439	5,327,861	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 7,023,439	$ 20,107,121	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 9,338,323	$ 22,459,877	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,188,085)	$ (6,608,787)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,150,238	$ 15,851,090	48

***(See instructions.)**

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,303,776)	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(181,444)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,485,220)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	297,135	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)**	$ 297,135	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)**	$ (2,188,085)	24 *

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 15,852,252	1
2	Discounts and Allowances for all Levels	(6,486,704)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,365,548	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,628,425	6
7	Oxygen	81	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,628,506	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	320,940	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	87,789	19
20	Radiology and X-Ray	270	20
21	Other Medical Services	30,032	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 439,031	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16,115	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16,115	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	1,197,748	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,197,748	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,646,948	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,904,144	31
32	Health Care	5,095,685	32
33	General Administration	2,840,913	33
	B. Capital Expense		
34	Ownership	1,008,374	34
	C. Ancillary Expense		
35	Special Cost Centers	2,135,204	35
36	Provider Participation Fee	365,493	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,349,813	40
41	**Income before Income Taxes (line 30 minus line 40)****	297,135	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 297,135	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,830,149	44
45	Private Pay - Net Inpatient Revenue	403,761	45
46	Medicare - Net Inpatient Revenue	1,266,049	46
47	Other-(specify) Insurance	480,860	47
48	Other-(specify) Veterans	384,729	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,365,548	49

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

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

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

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,001	2,141	$ 126,517	$ 59.09	1
2	Assistant Director of Nursing	1,903	2,128	95,433	44.85	2
3	Registered Nurses	34,069	40,825	1,524,849	37.35	3
4	Licensed Practical Nurses	25,930	31,612	1,000,915	31.66	4
5	CNAs & Orderlies	70,931	87,482	1,500,902	17.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,424	5,388	106,648	19.79	8
9	Activity Director	1,876	1,980	38,468	19.43	9
10	Activity Assistants	5,585	6,194	80,040	12.92	10
11	Social Service Workers	3,696	3,978	121,109	30.44	11
12	Dietician					12
13	Food Service Supervisor	1,045	1,240	47,483	38.29	13
14	Head Cook	6,180	7,206	121,962	16.93	14
15	Cook Helpers/Assistants	16,785	19,513	265,882	13.63	15
16	Dishwashers					16
17	Maintenance Workers	3,752	4,160	118,351	28.45	17
18	Housekeepers	18,255	21,175	295,088	13.94	18
19	Laundry	3,585	4,138	59,437	14.36	19
20	Administrator	1,968	2,080	141,141	67.86	20
21	Assistant Administrator	1,936	2,080	88,187	42.40	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,074	8,991	183,888	20.45	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	317	353	6,290	17.82	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	2,279	2,649	44,755	16.90	33
34	TOTAL (lines 1 - 33)	214,591	255,313	$ 5,967,345 *	$ 23.37	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		$ 6,020	01-03	35
36	Medical Director	Monthly	15,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	41,224	10-03	38
39	Pharmacist Consultant	Monthly	5,411	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,143	11-03	44
45	Social Service Consultant	Monthly	1,440	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 70,238		49

C. CONTRACT NURSES

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

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Camberly Lanning	Administrator	0	$ 141,141
Ashley Condotti	Assistant Admin.	0	88,187
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 229,328

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 24,000
ProPay HR	Payroll Processing	31,568
Onyx Procurement Solutions	Procurement Services	11,270
Legacy HC Financial Services	Clerical Services	240,000
Achieve Accreditation	Accreditation	8,428
Compliagent	Compliance	3,843
PatientPing, Inc.	Care Collaboration Software	18,000
Personnel Planners	Unemployment Tax Consultant	1,500
Cortex Health Care	Data Processing	9,390
Telemedicine Solutions	Risk Prevention Software	6,008
See Attached	Legal	135,138
See Supplemental Schedule		8,776
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 497,921

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 88,047
Unemployment Compensation Insurance	31,985
FICA Taxes	456,502
Employee Health Insurance	253,201
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	178,189
Employee Benefits	17,605
401K Expense	27,917
Voluntary Benefit Contributions	19,725
Employee Physical Exams	3,710
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,076,880

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	468
Health Care Worker Background Check	529
(Indicate # of checks performed 53)	
Patient Background Checks 10	950
Dues & Subscriptions	28,749
Licenses & Fees	1,758
See Supplemental Schedule	3,233
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 35,687

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	786
See Supplemental Schedule	129
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 915

**See instructions.

Facility Name & ID Number The Grove of Fox Valley # 0052621 Report Period Beginning: 01/01/20 Ending: 12/31/20

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI - $26,933, IHCA - $13,714**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **38,655** 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. $ **365,493**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **Yes**
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.