

		FOR BHF USE					

LL1

2025

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

FINANCIAL AND STATISTICAL REPORT (COST REPORT)

FOR LONG-TERM CARE FACILITIES

(FISCAL YEAR 2025)

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: 0056739

Facility Name: Thrive of Fox Valley

Address: 4020 E New York St Aurora 60504
Number City Zip Code

County: DuPage

Telephone Number: (331) 301-5590 Fax # (331) 336-4011

HFS ID Number:

Date of Initial License for Current Owners: 10/9/2020

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Andrew B. Cutler Telephone Number: (847) 940-3269
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2025 to 12/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) (Date)
(Print Name and Title) Andrew B. Cutler Managing Director, Healthcare
(Firm Name & Address) FGMK, LLC 2801 Lakeside Dr., 3rd Floor, Bannockburn, IL 60015
(Telephone) (847) 940-3269 Fax # (847) 964-5469

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number Thrive of Fox Valley # 0056739 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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 <u>N/A</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	74	Skilled (SNF)	74	27,010	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	74	TOTALS	74	27,010	7

B. Census-For the entire report period.										
	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	2			110	156	11,119	12,686	24,073	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	2			110	156	11,119	12,686	24,073	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 89.13%

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 ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 10/9/2020

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 10/9/2020 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter certified beds.
number of certified beds 74

Medicare Intermediary Wellpoint Federal (Formerly NGS)

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☐ NO ☐

Tax Year: 12/31/2025 Fiscal Year: 12/31/2025
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Thrive of Fox Valley # 0056739 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	407,459	33,774	366	441,599		441,599		441,599			1
2	Food Purchase		235,640		235,640		235,640	(2,609)	233,031			2
3	Housekeeping	173,274	36,075		209,349		209,349		209,349			3
4	Laundry		15,733		15,733		15,733		15,733			4
5	Heat and Other Utilities			180,842	180,842		180,842		180,842			5
6	Maintenance	24,626		133,130	157,756		157,756		157,756			6
7	Other (specify):*											7
8	TOTAL General Services	605,359	321,222	314,338	1,240,919		1,240,919	(2,609)	1,238,310			8
	B. Health Care and Programs											
9	Medical Director			13,500	13,500		13,500		13,500			9
10	Nursing and Medical Records	3,891,319	264,249	16,561	4,172,129		4,172,129		4,172,129			10
10a	Therapy											10a
11	Activities	48,978	4,247	26,467	79,692		79,692		79,692			11
12	Social Services	581,178			581,178		581,178		581,178			12
13	CNA Training											13
14	Program Transportation			22,774	22,774		22,774		22,774			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,521,475	268,496	79,302	4,869,273		4,869,273		4,869,273			16
	C. General Administration											
17	Administrative	152,831		958,778	1,111,609		1,111,609		1,111,609			17
18	Directors Fees											18
19	Professional Services			291,457	291,457		291,457	(94,965)	196,492			19
20	Dues, Fees, Subscriptions & Promotions			67,568	67,568		67,568	(3,108)	64,460			20
21	Clerical & General Office Expenses	282,525	3,901	611,137	897,563		897,563	(381,913)	515,650			21
22	Employee Benefits & Payroll Taxes			1,089,171	1,089,171		1,089,171		1,089,171			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,131	2,131		2,131		2,131			24
25	Other Admin. Staff Transportation			18,450	18,450		18,450		18,450			25
26	Insurance-Prop.Liab.Malpractice			253,927	253,927		253,927	139,345	393,272			26
27	Other (specify):*											27
28	TOTAL General Administration	435,356	3,901	3,292,619	3,731,876		3,731,876	(340,641)	3,391,235			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,562,190	593,619	3,686,259	9,842,068		9,842,068	(343,250)	9,498,818			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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			101,265	101,265		101,265	786,055	887,320			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,725	4,725		4,725	527,007	531,732			32
33	Real Estate Taxes			18,406	18,406		18,406	147,414	165,820			33
34	Rent-Facility & Grounds			1,175,483	1,175,483		1,175,483	(1,175,483)				34
35	Rent-Equipment & Vehicles			53,295	53,295		53,295		53,295			35
36	Other (specify):*											36
37	TOTAL Ownership			1,353,174	1,353,174		1,353,174	284,993	1,638,167			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,042,680	621,082	422,785	2,086,547		2,086,547		2,086,547			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			330	330		330		330			41
42	Provider Participation Fee			123,473	123,473		123,473		123,473			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	1,042,680	621,082	546,588	2,210,350		2,210,350		2,210,350			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,604,870	1,214,701	5,586,021	13,405,592		13,405,592	(58,257)	13,347,335			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,609)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(73,853)	30		9
10	Interest and Other Investment Income	(212)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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				18
19	Entertainment				19
20	Contributions	(14,506)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(311,220)	21		24
25	Fund Raising, Advertising and Promotional	(71,747)	21		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	(27,331)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (501,478)		\$	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)	443,221		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 443,221		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (58,257)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities	(3,108)	20	2
3	Bank Fees/Late Charges	(10,289)	21	3
4	Non-Allowable Legal	(13,934)	19	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				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	(27,331)		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

[illegible]

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

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 1,175,483	IH KCB Fox Valley Owner, LLC		\$	(1,175,483)	1
2	V	33	Real Estate Tax		IH KCB Fox Valley Owner, LLC		147,414	147,414	2
3	V	30	Depreciation		IH KCB Fox Valley Owner, LLC		859,908	859,908	3
4	V	32	Interest Expense		IH KCB Fox Valley Owner, LLC		527,219	527,219	4
5	V	26	Insurance		IH KCB Fox Valley Owner, LLC		139,345	139,345	5
6	V	21	Professional Fees		IH KCB Fox Valley Owner, LLC		25,849	25,849	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,175,483			\$ 1,699,735	\$ * 524,252	14

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

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Asset Management Fee	\$ 81,031	IH Asset Management		\$	\$ (81,031)	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			\$ 81,031			\$ 0	\$ * (81,031)	39

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

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Thrive of Lisle	Lisle, IL			IH KCB Fox Valley	Fox Valley, IL	Bldg. Ptrnshp	1
2	Thrive of Lake County	Mundelein, IL			Owner, LLC			2
3								3
4					IH Asset Management	Northbrook, IL	Asset Manager	4
5								5
6								6
7					IH Fox Valley, LLC	Nortnbrrok, IL	Owner	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

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	None								\$		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 Thrive of Fox Valley # 0056739 Report Period Beginning: 1/1/2025 Ending: 2/31/2025

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 Thrive of Fox Valley # 0056739 Report Period Beginning: 1/1/2025 Ending: 2/31/2025

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

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	HUD		X	Mortgage			\$	13,895,847			\$	528,248	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Insurance Financing		X	GL/PL								4,725	6
7													7
8													8
9	TOTAL Facility Related						\$	13,895,847			\$	532,973	9
	B. Non-Facility Related*												
10	Interst Income		X									(212)	10
11	Bldg. Partneship Interst Income	X										(1,029)	11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$	(1,241)	14
15	TOTALS (line 9+line14)						\$	13,895,847			\$	531,732	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 26 Line # 80,645

* 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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2024 report.			\$	196,000	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.)			\$	177,920	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(18,080)	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	183,900	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.					
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	165,820	7
Assessed Value from Real Estate Tax Bill:	2024	2,461,940	8		
Real Estate Tax Bill for Calendar Year:	2020	45,078	9		
	2021	72,667	10		
	2022	146,110	11		
	2023	190,219	12		
	2024	158,714	13		
Real Estate Tax Accrual = \$177,920*103% = \$183,900 (Rounded)				16	16
				17	17

FOR BHF USE ONLY	
14	FROM R. E. TAX STATEMENT FOR 2024 \$ 14
15	PLUS APPEAL COST FROM LINE 5 \$ 15
16	LESS REFUND FROM LINE 6 \$ 16
17	AMOUNT TO USE FOR RATE CALCULATION \$ 17

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Thrive of Fox Valley COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0056739

CONTACT PERSON REGARDING THIS REPORT Andrew B. Cutler

TELEPHONE (847) 940-3269 FAX #: (847) 964-5469

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 07-21-109-006	Long-Term Care Property	\$ 158,713.56	\$ 158,713.56
2. 07-21-109-007	Long-Term Care Property	\$ 19,205.96	\$ 19,205.96
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 177,919.52	\$ 177,919.52

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 copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

X. BUILDING AND GENERAL INFORMATION:

- A. Square Feet:50,582
- B. General Construction Type:ExteriorBrick/SidingFrameSteelNumber of Stories1
- 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

(b) Rent equipment from a Related Organization.

X(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)
- E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

- F. List the bed capacity for the building if it differs from the licensed total.
- G. Have you properly capitalized all major repairs and equipment purchases?
- H. Are you presently operating under a sale and leaseback arrangement?

N/A
- I. Are you presently operating under a sublease agreement?

No
- J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YESNOX

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

- K. Does this cost report reflect any organization or pre-operating costs which are being amortized?

YESXNO
- 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		2		3		4	
	Use		Square Feet		Year Acquired		Cost	
1	Long-Term Care Property		131,925		2016		\$1,070,330	
2								
3	TOTALS		131,925				\$1,070,330	

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	74		2020	2020	\$ 15,407,540	\$	27.5	\$ 560,274	\$ 560,274	\$ 2,825,930	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Franzen Heating and Cooling - HVAC Kitchen			2023	5,210		20	261	261	580	9
10	Dialysis Unit			2025	196,161		20	9,808	9,808	9,838	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	Current Book Depreciation					961,173					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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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
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51									51
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57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$15,608,911	\$961,173		\$570,343	\$570,343	\$2,836,348	70

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

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	\$1,533,268	\$	\$309,435	\$309,435	2-5	\$1,119,540	71
72	Current Year Purchases	37,712		7,542	7,542	5	7,542	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,570,980	\$	\$316,977	\$316,977		\$1,127,082	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)	\$18,250,221	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$961,173	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$887,320	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(73,853)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,963,430	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.

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								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
9. Option to Buy: ☐ YES ☐ NO Terms: *

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: \$ 53,295 Description: BIPAP/CPAP, Patient Monitoring Equipment, RT Monitoring System, Water conditioning, O2 Equip Renta
(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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	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.

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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

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

☒ 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	39-1	hrs	\$ 346,121		\$	\$		\$ 346,121	1
2	Licensed Speech and Language Development Therapist	39-1	hrs	145,727					145,727	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-1	hrs	550,832		758			551,590	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				606,573		606,573	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab/Xray/Dialysis/RT/	39-3				422,027			422,027	12
13	Other (specify): O2/Therapy Supplies	39-2					14,509		14,509	13
14	TOTAL			\$ 1,042,680		\$ 422,785	\$ 621,082		\$ 2,086,547	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.

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	\$ 644,332	\$ 740,902	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (433,599))	1,962,517	1,962,517	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(26,885)	7,839	6
7	Other Prepaid Expenses	18,075	18,075	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	33,518	427,025	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,631,557	\$ 3,156,358	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,070,330	13
14	Buildings, at Historical Cost		12,498,141	14
15	Leasehold Improvements, at Historical Cost	218,111	1,612,869	15
16	Equipment, at Historical Cost	405,326	4,884,716	16
17	Accumulated Depreciation (book methods)	(267,223)	(7,282,956)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		33,560	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(3,986)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached		5,626,580	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 356,214	\$ 18,439,254	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,987,771	\$ 21,595,612	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 206,229	\$ 206,229	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	350,425	350,425	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	20,400	183,900	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	102,536	102,536	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 679,590	\$ 843,090	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,925,422	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	5,626,580	5,626,580	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 5,626,580	\$ 19,552,002	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,306,170	\$ 20,395,092	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,318,399)	\$ 1,200,520	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,987,771	\$ 21,595,612	48

*(See instructions.)

A. Current Assets		Operating	After Consolidation
9	Due from Related Party	30,295	30,295
	Due From ITP Health Insurance	-	-
	Medicaid Exchange	3,223	3,223
	Replacement Reserve Escrow	-	215,329
	Tax Escrow	-	68,776
	MIP Escrow	-	80,645
	Insurance Escrow	-	28,757
		-	-
		-	-
		33,518	427,025
B. Long-Term Assets		Amount	
23	Due From Related Party	-	5,626,580
		-	-
		-	5,626,580
Other Current Liabilities		Amount	
36	Accrued Expense	21,827	21,827
	Due to/from ITP	-	-
	Accrued Bed Tax	11,822	11,822
	Accrued Management Fee	65,201	65,201
	Due Related Party	3,580	3,580
	Unclaimed Property	106	106
		102,536	102,536
Other Long-Term Liabilities		Amount	
43			
	Due to Property Co.	5,626,580.00	5,626,580
		5,626,580.00	5,626,580

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,159,254)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,159,254)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,115,855	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	(2,275,000)	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)	\$ (159,145)	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)	\$ (3,318,399)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Thrive of Fox Valley

0056739

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

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**

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 15,704,494	1
2	Discounts and Allowances for all Levels	(6,861,700)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,842,794	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,659,055	6
7	Oxygen	27	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,659,082	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	1,157	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	643,103	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	194,315	19
20	Radiology and X-Ray	23,150	20
21	Other Medical Services	157,543	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,019,268	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	212	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 212	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income	91	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 91	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,521,447	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,240,919	31
32	Health Care	4,869,273	32
33	General Administration	3,731,876	33
	B. Capital Expense		
34	Ownership	1,353,174	34
	C. Ancillary Expense		
35	Special Cost Centers	2,086,877	35
36	Provider Participation Fee	123,473	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,405,592	40
41	Income before Income Taxes (line 30 minus line 40)**	2,115,855	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,115,855	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 3,131.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer	9,351.00	47
48	Private Pay	112,641.00	48
49	Medicare Part A	5,481,566.00	49
50	Other-(specify) Insurance	3,236,105.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,842,794	56

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,328	2,368	\$ 165,357	\$ 69.83	1
2	Assistant Director of Nursing	2,079	2,249	131,397	58.42	2
3	Registered Nurses	34,190	36,004	1,628,155	45.22	3
4	Licensed Practical Nurses	17,699	18,462	832,166	45.07	4
5	CNAs & Orderlies	44,126	48,021	1,090,606	22.71	5
6	CNA Trainees					6
7	Licensed Therapist	22,616	24,123	1,042,680	43.22	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,560	1,687	48,978	29.03	9
10	Activity Assistants					10
11	Social Service Workers	10,529	13,439	581,178	43.25	11
12	Dietician	2,354	2,473	68,830	27.83	12
13	Food Service Supervisor					13
14	Head Cook	1,713	1,769	69,900	39.51	14
15	Cook Helpers/Assistants	10,652	11,255	240,612	21.38	15
16	Dishwashers	1,512	1,531	28,118	18.37	16
17	Maintenance Workers	610	651	24,626	37.83	17
18	Housekeepers	8,943	9,502	173,274	18.24	18
19	Laundry					19
20	Administrator	1,900	2,060	152,831	74.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,898	9,232	282,525	30.60	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,871	2,007	43,637	21.74	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	173,580	186,833	\$ 6,604,870 *	\$ 35.35	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 366	1-3	35
36	Medical Director	Monthly	13,500	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	16,561	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Montly	26,467	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 56,894		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	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

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberThrive of Fox Valley# 0056739Report Period Beginning:1/1/2025Ending:12/31/2025Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tiana Ng (1/1/2025-2/24/2025)	Admin	0	\$ 27,133
Shonda Burns (2/24/2025-12/31/2025)	Admin	0	125,698
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 152,831

B. Administrative - Other

Description	Amount
IH Asset Management	\$ 81,031
Ignite team Partners	877,747
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Activity Connection, LLC	Software Subscription	\$ 142
Advanced Entry LLC	Software Subscription	1,945
Bamboo Health Inc	Software Subscription	3,500
Brandconnex LLC	Software Subscription	1,529
Clasp Group Inc	Platform Fee	2,539
Clearpol Inc	AI POC Writer	760
Company Nurse, LLC	Linetlio Platform	1,159
Data Service Partners	Cloud Reporting Service	8,600
Direct Supply	Direct Supply	5,114
Heartlegacy SalesMail	Heartlegacy SalesMail	1,164
Square Register Fees	Square Register Fees	86
See Attached	See Attached	264,919
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 291,457

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 103,220
Unemployment Compensation Insurance	61,566
FICA Taxes	456,542
Employee Health Insurance	365,585
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance - Employer Coverage	1,104
401K Employer Contribution	17,817
Employee Retention	48,159
Uniforms	23,066
Other Employee Benefits	12,112
TOTAL (agree to Schedule V, line 22, col.8)	

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	33,378
Health Care Worker Background Check (Indicate # of checks performed 203)	3,403
Patient Background Checks 1282	12,825
Association Dues (total from pg 22, #4)	6,216
Licenses and Permits	8,295
Dues & Subscriptions	3,451
Less: Public Relations Expense	()
PAC and Lobbying payments	(3,108)
All non-allowable advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	2,131
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 2,131

* Attach copy of IMRF notifications

**See instructions.

C Professional Services

Vendor/Payee	Type	Amount
Perk Daily Activities Tool	Theperkdaily.com Activities tool	7.690
Yelp Advertising	Yelp for business advertising pages	30.000
Adobe	Adobe Licenses	1153.150
3CX Phone License Renewal	3CX Phone Licenses	750.000
Jamf Software MDM	Ipad Software management	2628.200
Zoho Service Desk	Cloud software	163.420
Gemini Analytics LLC	Gemini Analytics LLC	2800.000
Health Technologies Inc dba DiningRD	DiningRD	2150.000
Home Care Pulse LLC dba Activated Insights	Activated Insights	2099.610
LICA-MEDMEN	Medication guide	35.180
Kaseya	IT documentation portal	716.680
Avalere Health	Heathcare consulting	3148.150
Clasp Group Inc	Platform Fee	392.860
ITP Repayments	Ignite Team Partners, LLC – Repayments	-2128.150
Inovalon Provider Inc (Ability)	RCM Bundle	6080.560
Juro Online Limited	AI contract solutions	341.340
Managed Care Group LLC	MCG Core applicaion	4800.000
MindWire Inc	Annual Service Fee	343.330
Net Health Systems Inc	License and Support Fee	8851.080
Netsmart Technologies Inc	IT	365.610
Neuromersice Inc: VR Therapy software	Service Fee	3841.770
PAX Holdco Inc dba RADAR APPS LLC	Software Subscription	3289.000
Predictive Index LLC	Predictive Index LLC	1001.110
ProviderTrust Inc	PT Monitor	351.550
Reside Admissions LLC	Admissions software	7960.350
Strategic Healthcare Programs LLC form	Real time analytics	4740.000
Striv Technologies LCC. DBA Striv360	Family engagement and reputation kiosk	2795.400
Third Eye Health Inc	Telemedicine	9270.000
WashSense dba Arsana Health	Infection Control	1800.000
Wellsky Corporation dba Careport Heal	Care Coordination	10568.040
Zunta LLC	Billing	2419.230
Telemedicine Solutions LLC	Telemedicine	3455.250
Ethermed	AI solutions/prior authorization	1041.670
EasyShifts.com LLC	HR	3200.180
Energage	Talent acquisition software	720.000
ExaCare	AI solutions	1200.000
Vigil Health Solutions Inc	Senior living solution	5380.570
Wound Solutions	AI healthcare solutions	685.800
SNFCB COM	SNF Consolidated Billing	475.000
Achieve Compliance Group LLC	Achieve Compliance Group LLC dba Achieve Acc	8031.000
Centaur LLC	Centaur LLC	7500.000
Certisurv LLC	Certisurv LLC	375.000
Collaborative Healthcare Urgency Grou	Collaborative Healthcare Urgency Group (CHUG	579.720
Compliance Institute LLC dba Complia	Compliance Institute LLC dba Compliagent	1008.980
AHCA Registration for Bronze award	Divvy: Shonda Burns Ahca Registration	75.000
Entyre Solutions LLC	Entyre Solutions LLC	1393.450
Olio health	longitudinal care coordination	1125.000
4mybenefits	HR services	1665.520
Luminate HCC	Payroll-Based Journal and Post-Acute Care cons	379.720
Ben Lazare	Government affairs	800.000
Creative planning	Employee retirement plan admin	1255.130
Direct supply	Admin Services	277.780
COSEY SPEAKS	Speaker	2643.630
Naperville Area Chamber of Commerce	Naperville Area Chamber of Commerce	989.000
Onyx Procurement Solutions LLC	Onyx Procurement Solutions LLC	1450.000
The Plaza on New York Community Assi	The Plaza on New York Community Assoc.	23672.870
Zimmet Healthcare Services Group, LLC	Zimmet Healthcare Services Group, LLC	5400.000
Scott & Kraus	legal fees - master line	659.500
PCORI	Self Insured health plans	259.920
ITPC Consulting FEE	ITP Consulting Fee	14308.530
4MyBenefits + adjustment	4MyBenefits Repayment	1356.410
The Joint Commission	The Joint Commission	3230.000
FGMK	Tango Lease software	1922.910
WEX	WEX Admin Fee	34.270
Accounting Fee	Consulting	46710.810
Legal	Legal	38892.000
Total		<u>264919.780</u>

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1/1/2025-12/31/2025

G/L ACCT.			ADJ	Adjusted
DATE	#	PAYEE/VENDOR	Amount	Balance
1/22/2025	662000	Bill - Polsinelli PC	301	301
2/19/2025	662000	Bill - Polsinelli PC	235	235
3/1/2025	662000	Bill - Polsinelli PC	5405	5,405
3/27/2025	662000	Bill - Sher, LLP	133.33	133
4/1/2025	662000	Bill - Much Shelist	1078	-1078
5/1/2025	662000	Bill - CT Corporation System dba CT Lien Solutions	174.86	-174.86
5/1/2025	662000	Bill - CT Corporation System dba CT Lien Solutions	87.43	-87.43
5/1/2025	662000	Bill - CT Corporation System dba CT Lien Solutions	174.86	-174.86
6/1/2025	662000	Bill - CT Corporation System dba CT Lien Solutions	87.43	-87.43
6/1/2025	662000	Bill - Polsinelli PC	141	141
6/1/2025	662000	Bill - Polsinelli PC	2821	2,821
6/1/2025	662000	Bill - Federal Insurance Company: Claim # KY25K2079330 Schueler,	2248	-2248
6/13/2025	662000	Bill - CT Corporation System dba CT Lien Solutions	456	-456
6/16/2025	662000	Bill - Polsinelli PC	846	846
45831	662000	Bill - Ignite Team Partners, LLC	454.95	-454.95
45869	662000	Bill - Polsinelli PC	740	740
45894	662000	Bill - Steven B Pearlman & Associates	2008.7	-2008.7
45901	662000	Bill - Husch Blackwell LLP	882	-882
45916	662000	Bill - CT Corporation System dba CT Lien Solutions	191.69	-161.69
45925	662000	Bill - CT Corporation System dba CT Lien Solutions	53	-53
45930	662000	Bill - Polsinelli PC	1551	-1551
45930	662000	Bill - Federal Insurance Company: Claim # KY25K2079330 S	433	-433
45931	662000	Bill - McCabe Kirshner PC	1735	1,735
45957	662000	Bill - CT Corporation System dba CT Lien Solutions	178	-178
45962	662000	Bill - McCabe Kirshner PC	1735	1,735
45962	662000	Bill - McCabe Kirshner PC	4550	4,550
45962	662000	Bill - McCabe Kirshner PC	4550	4,550
45962	662000	Bill - McCabe Kirshner PC	1735	1,735
45975	662000	Bill - CT Corporation System dba CT Lien Solutions	303	-303
45977	662000	Bill - Allegro Record Solutions	787.5	-787.5
45982	662000	Bill - Polsinelli PC	940	-940
45991	662000	Bill - Allegro Record Solutions	1875	-1875
Total			38891.75	-13934.4 24957.33

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1/1/2025-12/31/2025

DATE	Description	Amount
1/15/2025	Bill - Divvy: Heidi Reich Aguilar FEDEX OFFICE 800000836 Printing for Fox Valley	110.63
2/20/2025	Bill - Elizabeth Graden dba Elizabeth Reinecke	500.00
3/4/2025	Bill - Elizabeth Graden dba Elizabeth Reinecke	166.67
4/15/2025	Bill - Divvy: Marie Rosete Office Max Skills fair supplies Fox Valley	84.37
4/15/2025	Bill - Divvy: Shonda Burns ServSafe Dietary certificate	15.00
4/15/2025	Bill - Divvy: Marie Rosete Office Max Cno supplies	64.50
4/29/2025	Bill - Learning Care Group Inc	46.16
5/7/2025	Bill - Learning Care Group Inc	288.46
5/15/2025	Bill - Divvy: Mathew Thengil The Wigwam NARA (national association of rehab agencies) conference room rental deposit	45.64
7/1/2025	Bill - Elizabeth Graden dba Elizabeth Reinecke	166.67
7/10/2025	Bill - Elizabeth Graden dba Elizabeth Reinecke	100.00
7/15/2025	Bill - Divvy: Mathew Thengil The Wigwam NARA (national association of rehab agencies) conference room rental deposit	43.82
8/26/2025	Bill - Learning Care Group Inc	23.08
9/15/2025	Bill - Divvy: Mathew Thengil Nara Rehab Registration for logan knox for NARA	35.57
9/15/2025	Bill - Divvy: Shonda Burns Meijer Supplies for DCE office and orientation	43.32
9/15/2025	Bill - Divvy: Mathew Thengil The Wigwam Presentation at NARA. Room rental	40.57
10/15/2025	Bill - Divvy: Amy Hammond Illinois Nursing Home Adm Continuing education	81.25
11/15/2025	Bill - Divvy: Marie Rosete BP Gas Drive to Fox valley	36.82
11/15/2025	Bill - Divvy: Marie Rosete License Fee License renewal	102.25
11/24/2025	Bill - Learning Care Group Inc	69.24
12/15/2025	Bill - Divvy: Tiffany Yohn Jimmy John's Alyssa arkeilpane, tiffany yohn and kyla mitchell. Lunch portals and training	43.72
12/29/2025	Bill - Learning Care Group Inc	23.08
Totals		<u>2,130.82</u>

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
HEALTH CARE COUNCIL OF IL (HCCI)	3,108
	3,108 Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

HEALTH CARE COUNCIL OF IL (HCCI)	3,108
	3,108 Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

HEALTH CARE COUNCIL OF IL (HCCI)	6,216
	6,216 Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$ 31,242 Line 10
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 123,473

This amount is to be recorded on line 42 of Schedule V.
- (8)

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.

- (9)

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
- (10)

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? 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.

No
- (11)

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?

Yes Indicate the amount. \$ 1,157
- (12)

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?

LN 14

d. Have vehicle usage logs been maintained?

N/A

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

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
- (13)

Has an audit been performed by an independent certified public accounting firm?

Firm Name: N/A

No
- (14)

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

Yes
- (15)

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.