FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0052639

Facility Name: Avantara Long Grove

Address: 1666 Rfd (Checker Road) (Number) | Long Grove (City) | 60047 (Zip Code)

County: Lake

Telephone Number: (847) 419-1111 **Fax #** (847) 419-1119

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/15 to 12/31/15 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

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

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	190	Skilled (SNF)	190	69,350	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	190	TOTALS	190	69,350	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	47,940	3,533	9,958	61,431	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,940	3,533	9,958	61,431	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.58%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
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 2/1/2014

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/2014 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 190 and days of care provided 8,762

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

Facility Name & ID Number Avantara Long Grove # 0052639 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	454,670	74,026	21,539	550,235		550,235		550,235			1
2	Food Purchase		404,993		404,993		404,993	(5,778)	399,215			2
3	Housekeeping	290,557	48,500	2,577	341,634		341,634	127	341,761			3
4	Laundry	43,655	10,493		54,148		54,148		54,148			4
5	Heat and Other Utilities			240,846	240,846		240,846	(41,410)	199,436			5
6	Maintenance	67,154		364,710	431,864		431,864	94,310	526,174			6
7	Other (specify):*											7
8	**TOTAL General Services**	856,036	538,012	629,672	2,023,720		2,023,720	47,249	2,070,969			8
	B. Health Care and Programs											
9	Medical Director			161,655	161,655		161,655		161,655			9
10	Nursing and Medical Records	3,892,023	246,141	56,213	4,194,377		4,194,377	8,185	4,202,562			10
10a	Therapy	221,305	547	15,753	237,605		237,605		237,605			10a
11	Activities	175,728	10,483		186,211		186,211	257	186,468			11
12	Social Services	273,896		3,842	277,738		277,738	43,051	320,789			12
13	CNA Training											13
14	Program Transportation			10,504	10,504		10,504		10,504			14
15	Other (specify):*							5,984	5,984			15
16	**TOTAL Health Care and Programs**	4,562,952	257,171	247,967	5,068,090		5,068,090	57,477	5,125,567			16
	C. General Administration											
17	Administrative	262,995		1,948	264,943		264,943	32,997	297,940			17
18	Directors Fees											18
19	Professional Services			465,831	465,831	(121)	465,710	(239,509)	226,201			19
20	Dues, Fees, Subscriptions & Promotions			258,838	258,838		258,838	(203,128)	55,710			20
21	Clerical & General Office Expenses	292,748	4,808	600,610	898,166		898,166	(397,584)	500,582			21
22	Employee Benefits & Payroll Taxes			991,197	991,197		991,197		991,197			22
23	Inservice Training & Education											23
24	Travel and Seminar			17,369	17,369		17,369	1,234	18,603			24
25	Other Admin. Staff Transportation			6,732	6,732		6,732		6,732			25
26	Insurance-Prop.Liab.Malpractice			128,591	128,591		128,591	4,491	133,082			26
27	Other (specify):*							38,451	38,451			27
28	**TOTAL General Administration**	555,743	4,808	2,471,116	3,031,667	(121)	3,031,546	(763,049)	2,268,497			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,974,731	799,991	3,348,755	10,123,477	(121)	10,123,356	(658,322)	9,465,034			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 Avantara Long Grove #0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			173,745	173,745		173,745	(69,221)	104,524			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			105,936	105,936		105,936	43,400	149,336			32
33	Real Estate Taxes			120,391	120,391	121	120,512	2,448	122,960			33
34	Rent-Facility & Grounds			1,382,813	1,382,813		1,382,813	58,746	1,441,559			34
35	Rent-Equipment & Vehicles			24,098	24,098		24,098	2,510	26,608			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,806,983	1,806,983	121	1,807,104	37,884	1,844,988			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		476,285	1,594,706	2,070,991		2,070,991		2,070,991			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			403,979	403,979		403,979		403,979			42
43	Other (specify):*			311,442	311,442		311,442	(311,442)	0			43
44	**TOTAL Special Cost Centers**		476,285	2,310,127	2,786,412		2,786,412	(311,442)	2,474,970			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,974,731	1,276,276	7,465,865	14,716,872		14,716,872	(931,880)	13,784,992			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 Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 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				4
5	Telephone, TV & Radio in Resident Rooms	(42,780)	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	(73,704)	30		9
10	Interest and Other Investment Income	(1,326)	32		10
11	Discounts, Allowances, Rebates & Refunds	(7,360)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(233)	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	(57,908)	21		18
19	Entertainment				19
20	Contributions	(100,875)	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	(345,777)	21		24
25	Fund Raising, Advertising and Promotional	(98,188)	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	(379,542)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,107,693)		$	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)	175,813		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 175,813		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (931,880)		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

Avantara Long Grove

ID# 0052639

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Additional R&M	$ 91,247	06	1
2	Sequestration	(100,587)	21	2
3	Miscellaneous Income	(130)	21	3
4	Patient Personal Items	(3,663)	10	4
5	Meals	(11,436)	21	5
6	Bank Charges	(10,172)	21	6
7	PAC Dues	(5,294)	20	7
8	Non-Allowable Legal	(25,860)	19	8
9	Building Co - Legal	(100)	19	9
10	Building Co - Professional Fees	(2,000)	19	10
11	Building Co - Penalties	(106)	21	11
12	Non-Allowable Expense	(311,442)	43	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**	(379,542)		49

Avantara Long Grove

ID# 0052639

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total	0		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Avantara Long Grove **#** 0052639 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(7,593)				1,815							(5,778)	2
3	Housekeeping			127									127	3
4	Laundry													4
5	Heat and Other Utilities	(42,780)		1,370									(41,410)	5
6	Maintenance	91,247		3,126		(62)							94,310	6
7	Other (specify):*													7
8	**TOTAL General Services**	40,874		4,623		1,753							47,249	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(3,663)				11,848							8,185	10
10a	Therapy													10a
11	Activities			257									257	11
12	Social Services					43,051							43,051	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					5,984							5,984	15
16	**TOTAL Health Care and Programs**	(3,663)		257		60,883							57,477	16
	C. General Administration													
17	Administrative			1,948		31,048							32,997	17
18	Directors Fees													18
19	Professional Services	(27,960)	2,100	(214,255)		606							(239,509)	19
20	Fees, Subscriptions & Promotions	(204,357)		1,135		94							(203,128)	20
21	Clerical & General Office Expenses	(526,115)	106	141,019		(12,595)							(397,584)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,143		91							1,234	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			866		3,625							4,491	26
27	Other (specify):*			35,310		3,141							38,451	27
28	**TOTAL General Administration**	(758,432)	2,206	(32,833)		26,011							(763,049)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(721,221)	2,206	(27,954)		88,647							(658,322)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Avantara Long Grove # 0052639 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(73,704)		1,938	2,545								(69,221)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,326)	43,334	15	1,377								43,400	32
33	Real Estate Taxes			2,448									2,448	33
34	Rent-Facility & Grounds		58,746	9,109	(9,109)								58,746	34
35	Rent-Equipment & Vehicles			1,767		743							2,510	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(75,030)	102,080	15,277	(5,186)	743							37,884	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(311,442)											(311,442)	43
44	**TOTAL Special Cost Centers**	(311,442)											(311,442)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,107,693)	104,286	(12,676)	(5,186)	89,390							(931,880)	45

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,381,652	Buffalo Property Holdings LLC	100.00%	$ 1,440,398	$ 58,746	1
2	V	19	Legal Fees		Buffalo Property Holdings LLC	100.00%	100	100	2
3	V	19	Professional Fees		Buffalo Property Holdings LLC	100.00%	2,000	2,000	3
4	V	32	Interest		Buffalo Property Holdings LLC	100.00%	43,334	43,334	4
5	V	21	Penalties		Buffalo Property Holdings LLC	100.00%	106	106	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,381,652			$ 1,485,938	$ * 104,286	14

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING SUPPLIES	$	Legacy Healthcare Financial Services	100.00%	$ 127	$ 127	15
16	V	5	UTILITIES		Legacy Healthcare Financial Services	100.00%	1,370	1,370	16
17	V	6	GROUNDS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	3,126	3,126	17
18	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services	100.00%	257	257	18
19	V	17	MANAGEMENT FEES - Y. ZUCKERMAN		Legacy Healthcare Financial Services	100.00%	1,948	1,948	19
20	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	25,745	25,745	20
21	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	1,135	1,135	21
22	V	21	CLERICAL & GENERAL WAGES		Legacy Healthcare Financial Services	100.00%	128,018	128,018	22
23	V	21	CLERICAL & GENERAL OTHER COSTS		Legacy Healthcare Financial Services	100.00%	13,001	13,001	23
24	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	1,143	1,143	24
25	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	866	866	25
26	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	35,310	35,310	26
27	V	30	DEPRECIATION		Legacy Healthcare Financial Services	100.00%	1,938	1,938	27
28	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	15	15	28
29	V	33	REAL ESTATE TAXES		Legacy Healthcare Financial Services	100.00%	2,448	2,448	29
30	V	34	RENT		Legacy Healthcare Financial Services	100.00%	9,109	9,109	30
31	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services	100.00%	1,767	1,767	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V	19	BOOKKEEPING FEES	240,000	Legacy Healthcare Financial Services	100.00%		(240,000)	36
37	V								37
38	V								38
39	Total			$ 240,000			$ 227,324	$ * (12,676)	39

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	DEPRECIATION		Legacy Real Properties	100.00%	2,545	$ 2,545	15
16	V	32	INTEREST EXPENSE		Legacy Real Properties	100.00%	1,377	1,377	16
17	V								17
18	V								18
19	V	34	RENT	9,109	Legacy Real Properties	100.00%		(9,109)	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			$ 9,109			$ 3,923	$ * (5,186)	39

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	FOOD	$	Progressive Healthcare Consulting	100.00%	$ 1,815	$ 1,815	15
16	V	6	MAINTENANCE SALARY		Progressive Healthcare Consulting	100.00%	4	4	16
17	V	6	BUILDING MAINTENANCE AND R&M		Progressive Healthcare Consulting	100.00%	1,002	1,002	17
18	V	10	MEDICAL AND NURSING SUPPLIES		Progressive Healthcare Consulting	100.00%	3	3	18
19	V	10	NURSING SALARIES		Progressive Healthcare Consulting	100.00%	69,384	69,384	19
20	V	12	ACTIVITIES PROGRAM		Progressive Healthcare Consulting	100.00%	11	11	20
21	V	12	CLERGY SALARY		Progressive Healthcare Consulting	100.00%	1,756	1,756	21
22	V	12	ADMISSIONS SALARY		Progressive Healthcare Consulting	100.00%	80,710	80,710	22
23	V	15	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	12,889	12,889	23
24	V	17	ADMIN SALARY- NON OWNER		Progressive Healthcare Consulting	100.00%	85,206	85,206	24
25	V	19	PROFESSIONAL FEES		Progressive Healthcare Consulting	100.00%	606	606	25
26	V	20	FEES, SUBSCRIPTIONS		Progressive Healthcare Consulting	100.00%	94	94	26
27	V	21	CLERICAL & GENERAL		Progressive Healthcare Consulting	100.00%	1,202	1,202	27
28	V	24	SEMINARS		Progressive Healthcare Consulting	100.00%	91	91	28
29	V	27	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	16,155	16,155	29
30	V	26	INSURANCE		Progressive Healthcare Consulting	100.00%	3,625	3,625	30
31	V	35	AUTO RENTAL		Progressive Healthcare Consulting	100.00%	743	743	31
32	V	17	ADMINISTRATOR	54,158	Progressive Healthcare Consulting	100.00%		(54,158)	32
33	V	10	NURSING	57,539	Progressive Healthcare Consulting	100.00%		(57,539)	33
34	V	12	SOCIAL SERVICE	39,426	Progressive Healthcare Consulting	100.00%		(39,426)	34
35	V	06	MAINTENANCE	1,068	Progressive Healthcare Consulting	100.00%		(1,068)	35
36	V	21	CLERICAL	13,797	Progressive Healthcare Consulting	100.00%		(13,797)	36
37	V	15	PAYROLL TAXES - NURSING	6,905	Progressive Healthcare Consulting	100.00%		(6,905)	37
38	V	27	PAYROLL TAXES	13,014	Progressive Healthcare Consulting	100.00%		(13,014)	38
39	Total			$ 185,907			$ 275,297	$ * 89,390	39

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$ 0	15
16	V							0	16
17	V							0	17
18	V							0	18
19	V							0	19
20	V							0	20
21	V							0	21
22	V							0	22
23	V							0	23
24	V							0	24
25	V							0	25
26	V							0	26
27	V							0	27
28	V							0	28
29	V							0	29
30	V							0	30
31	V							0	31
32	V							0	32
33	V							0	33
34	V							0	34
35	V							0	35
36	V							0	36
37	V							0	37
38	V							0	38
39	Total			$ 0			$ 0	$ * 0	39

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$ 0	15
16	V							0	16
17	V							0	17
18	V							0	18
19	V							0	19
20	V							0	20
21	V							0	21
22	V							0	22
23	V							0	23
24	V							0	24
25	V							0	25
26	V							0	26
27	V							0	27
28	V							0	28
29	V							0	29
30	V							0	30
31	V							0	31
32	V							0	32
33	V							0	33
34	V							0	34
35	V							0	35
36	V							0	36
37	V							0	37
38	V							0	38
39	Total			$ 0			$ 0	$ * 0	39

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$ 0	15
16	V							0	16
17	V							0	17
18	V							0	18
19	V							0	19
20	V							0	20
21	V							0	21
22	V							0	22
23	V							0	23
24	V							0	24
25	V							0	25
26	V							0	26
27	V							0	27
28	V							0	28
29	V							0	29
30	V							0	30
31	V							0	31
32	V							0	32
33	V							0	33
34	V							0	34
35	V							0	35
36	V							0	36
37	V							0	37
38	V							0	38
39	Total			$ 0			$ 0	$ * 0	39

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$ 0	15
16	V							0	16
17	V							0	17
18	V							0	18
19	V							0	19
20	V							0	20
21	V							0	21
22	V							0	22
23	V							0	23
24	V							0	24
25	V							0	25
26	V							0	26
27	V							0	27
28	V							0	28
29	V							0	29
30	V							0	30
31	V							0	31
32	V							0	32
33	V							0	33
34	V							0	34
35	V							0	35
36	V							0	36
37	V							0	37
38	V							0	38
39	Total			$ 0			$ 0	$ * 0	39

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	YAIR ZUCKERMAN	99.00%	ASTORIA PLACE SKILLED NURSING FACILITY LLC	CHICAGO	BUFFALO PROPERTY HOLDINGS LLC		BUILDING COMPANY	1
2	DINA ZUCKERMAN	1.00%	BETHANY TERRACE	MORTON GROVE	LEGACY REAL PROPERTIES	LINCOLNWOOD	BUILDING CO	2
3			CARLTON SKILLED NURSING FACILITY LLC	CHICAGO	LEGACY HC & FINANCIAL SER	LINCOLNWOOD	HOME OFFICE/BOOKKEEPI	3
4			CHALET SKILLED NURSING FACILITY LLC	CHICAGO	PROGRESSIVE HC	LINCOLNWOOD	NURSE CONSULTANT	4
5			ELMBROOK SKILLED NURSING FACILITY LLC	ELMHURST	ML GROUP DESIGN & DEV	SKOKIE	ASSET MANAGEMENT	5
6			EVANSTON SKILLED NURSING FACILITY LLC	EVANSTON	REMED SERVICES LLC	LINCOLNWOOD	NURSING EQUIPMENT	6
7			GROVE OF FOX VALLEY	AURORA	AURORA SUPPORTIVE LIVING	AURORA	SUPPORTIVE LIVING	7
8			LAGRANGE SKILLED NURSING FACILITY LLC	LAGRANGE PARK	TERRACE GARDENS	MORTON GROVE	ASSISTED LIVING	8
9			GROVE AT THE LAKE SKILLED NURSING FACILITY LLC	ZION	LINCOLNSHIRE ASSISTED LIVI	LINCOLNSHIRE	ASSISTED LIVING	9
10			LAKEFRONT SKILLED NURSING FACILITY LLC	CHICAGO				10
11			LINCOLN PARK SKILLED NURSING FACILITY LLC	CHICAGO				11
12			LINCOLNSHIRE LIVING & REHAB CENTER LLC	LINCOLNSHIRE				12
13			SKOKIE SKILLED NURSING FACILITY LLC	SKOKIE				13
14			NORTHBROOK SKILLED NURSING FACILITY LLC	NORTHBROOK				14
15			WARREN BARR NORTH SHORE	HIGHLAND PARK				15
16			AVANTARA PARK RIDGE	PARK RIDGE				16
17			PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO				17
18			WARREN BARR SOUTH LOOP	CHICAGO				18
19			WARREN BARR LIVING AND REHAB	CHICAGO				19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yair Zuckerman	Owner	Administrative	99.00%	See Attached	2.38	5.95%	Alloc Sal/Fee	$ 11,878	17-3/17-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 11,878		13

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

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Legacy Healthcare Financial Services
Street Address: 7040 N. Ridgeway
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: (847) 679-9797
Fax Number: (847) 679-1126

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING SUPPLIES	AVAIL. BED DAYS	1,253,624	23	$ 2,296	$	69,350	$ 127	1
2	5	UTILITIES	AVAIL. BED DAYS	1,253,624	23	24,766		69,350	1,370	2
3	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	1,253,624	23	56,504		69,350	3,126	3
4	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,253,624	23	4,642		69,350	257	4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,253,624	23	465,391		69,350	25,745	5
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,253,624	23	20,516		69,350	1,135	6
7	21	CLERICAL & GENERAL WAG	AVAIL. BED DAYS	1,253,624	23	2,314,153	2,314,153	69,350	128,018	7
8	21	CLERICAL & GENERAL OTH	AVAIL. BED DAYS	1,253,624	23	235,020		69,350	13,001	8
9	24	SEMINARS	AVAIL. BED DAYS	1,253,624	23	20,662		69,350	1,143	9
10	26	INSURANCE	AVAIL. BED DAYS	1,253,624	23	15,655		69,350	866	10
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	1,253,624	23	638,286		69,350	35,310	11
12	30	DEPRECIATION	AVAIL. BED DAYS	1,253,624	23	35,040		69,350	1,938	12
13	32	INTEREST	AVAIL. BED DAYS	1,253,624	23	267		69,350	15	13
14	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,253,624	23	44,250		69,350	2,448	14
15	34	RENT	AVAIL. BED DAYS	1,253,624	23	164,669		69,350	9,109	15
16	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,253,624	23	31,945		69,350	1,767	16
17										17
18	17	MGMT FEES- Y. ZUCKERMAN	AVG HOURS WKD	50	20	32,807		2.97	1,948	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,106,869	$ 2,314,153		$ 227,324	25

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Legacy Real Properties
Street Address: 7040 N. Ridgeway
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: (847) 679-9797
Fax Number: (847) 679-1126

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	AVAIL. BED DAYS	1,253,624	23	46,013		69,350	2,545	1
2	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,253,624	23	24,899		69,350	1,377	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 70,912	$		$ 3,923	25

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Progressive Healthcare Consulting
Street Address: 7040 N. Ridgeway
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: (847) 679-9797
Fax Number: (847) 679-1126

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	FOOD	AVAIL. BED DAYS	1,167,679	20	$ 30,560	$	69,350	$ 1,815	1
2	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,167,679	20	65	65	69,350	4	2
3	6	BUILDING MAINTENANCE AI	AVAIL. BED DAYS	1,167,679	20	16,865		69,350	1,002	3
4	10	MEDICAL AND NURSING SUP	AVAIL. BED DAYS	1,167,679	20	47		69,350	3	4
5	10	NURSING SALARIES	AVAIL. BED DAYS	1,167,679	20	1,168,252	1,168,252	69,350	69,384	5
6	12	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,167,679	20	187		69,350	11	6
7	12	CLERGY SALARY	AVAIL. BED DAYS	1,167,679	20	29,559	29,559	69,350	1,756	7
8	12	ADMISSIONS SALARY	AVAIL. BED DAYS	1,167,679	20	1,358,960	1,358,960	69,350	80,710	8
9	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,167,679	20	217,026		69,350	12,889	9
10	17	ADMIN SALARY- NON OWNE	AVAIL. BED DAYS	1,167,679	20	1,434,659	1,434,659	69,350	85,206	10
11	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,167,679	20	10,207		69,350	606	11
12	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,167,679	20	1,577		69,350	94	12
13	21	CLERICAL & GENERAL	AVAIL. BED DAYS	1,167,679	20	20,243		69,350	1,202	13
14	24	SEMINARS	AVAIL. BED DAYS	1,167,679	20	1,535		69,350	91	14
15	27	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,167,679	20	272,007		69,350	16,155	15
16	26	INSURANCE	AVAIL. BED DAYS	1,167,679	20	61,041		69,350	3,625	16
17	35	AUTO RENTAL	AVAIL. BED DAYS	1,167,679	20	12,512		69,350	743	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,635,301	$ 3,991,495		$ 275,297	25

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$ 0	1
2									0	2
3									0	3
4									0	4
5									0	5
6									0	6
7									0	7
8									0	8
9									0	9
10									0	10
11									0	11
12									0	12
13									0	13
14									0	14
15									0	15
16									0	16
17									0	17
18									0	18
19									0	19
20									0	20
21									0	21
22									0	22
23									0	23
24									0	24
25	TOTALS					$ 0	$ 0		$ 0	25

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$ 0	1
2									0	2
3									0	3
4									0	4
5									0	5
6									0	6
7									0	7
8									0	8
9									0	9
10									0	10
11									0	11
12									0	12
13									0	13
14									0	14
15									0	15
16									0	16
17									0	17
18									0	18
19									0	19
20									0	20
21									0	21
22									0	22
23									0	23
24									0	24
25	TOTALS					$ 0	$ 0		$ 0	25

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$ 0	1
2									0	2
3									0	3
4									0	4
5									0	5
6									0	6
7									0	7
8									0	8
9									0	9
10									0	10
11									0	11
12									0	12
13									0	13
14									0	14
15									0	15
16									0	16
17									0	17
18									0	18
19									0	19
20									0	20
21									0	21
22									0	22
23									0	23
24									0	24
25	TOTALS					$ 0	$ 0		$ 0	25

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$ 0	1
2									0	2
3									0	3
4									0	4
5									0	5
6									0	6
7									0	7
8									0	8
9									0	9
10									0	10
11									0	11
12									0	12
13									0	13
14									0	14
15									0	15
16									0	16
17									0	17
18									0	18
19									0	19
20									0	20
21									0	21
22									0	22
23									0	23
24									0	24
25	TOTALS					$ 0	$ 0		$ 0	25

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$ 0	1
2									0	2
3									0	3
4									0	4
5									0	5
6									0	6
7									0	7
8									0	8
9									0	9
10									0	10
11									0	11
12									0	12
13									0	13
14									0	14
15									0	15
16									0	16
17									0	17
18									0	18
19									0	19
20									0	20
21									0	21
22									0	22
23									0	23
24									0	24
25	TOTALS					$ 0	$ 0		$ 0	25

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	CapEx		X	Line of Credit			$	$ 1,003,304			$ 43,334	1
2												2
3												3
4												4
5												5
	Working Capital											
6	The Private Bank		X	Line of Credit				3,969,201			105,936	6
7	Allocated from Legacy HC	X									15	7
8	See Supplemental Schedule										1,377	8
9	TOTAL Facility Related						$	$ 4,972,505			$ 150,662	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,326)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,326)	14
15	TOTALS (line 9+line14)						$	$ 4,972,505			$ 149,336	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Alloc from Legacy Real Prop	X					$	$			$ 1,377	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										1,377	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Avantara Long Grove # 0052639 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		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.)	$	122,839	2
3. Under or (over) accrual (line 2 minus line 1).	$	122,839	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**	$	121	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** $ 362 **For** 2010-12 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	122,959	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2010		8
2011		9
2012		10
2013	118,391	11
2014	120,391	12

Allocated from Legacy Real Properties: $2,448

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Avantara Long Grove COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0052639

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2014 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-31-201-082	Long Term Care Property	$ 112,974.42	$ 112,974.42
2.	15-31-201-083	Long Term Care Property	$ 7,416.23	$ 7,416.23
3.	10-35-104-076-0000	Home Office Allocation	$ 39,271.59	$ 2,172.49
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 159,662.24	$ 122,563.14

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Avantara Long Grove COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0052639

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 0.00	$ 0.00

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,302 B. General Construction Type: Exterior Drivit/Face Brick Frame Cinder Block Number of Stories 1

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

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

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

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Allocated from Legacy Real Properties			$ 4,526	1
2					2
3	TOTALS			$ 4,526	3

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		77,434	2,213		3,227	1,014	17,963	68
69	Financial Statement Depreciation			173,745			(173,745)		69
70	TOTAL (lines 4 thru 69)		$ 77,434	$ 175,958		$ 3,227	$ (172,731)	$ 17,963	70

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 77,434	$ 175,958		$ 3,227	$ (172,731)	$ 17,963	1
2	Roof Repairs	2014	6,375		20	27	27	53	2
3	Water Softening System	2014	10,800		20	360	360	720	3
4	Landscaping/Water Softening System	2014	10,180		20	509	509	1,018	4
5	Bathroom, Dining Room, Play Room - Plaster And Painting	2014	9,850		20	493	493	985	5
6	Security System Cameras And Cable Wiring	2014	20,590		20	1,030	1,030	2,059	6
7	Resid Rms Electric Cabling, Drywall/Paint, Replaced Stair	2014	77,950		20	3,897	3,897	7,795	7
8	Repair Generator Circuit Breaker	2014	2,874		20	144	144	287	8
9	West Wing - Doors, Receptacles, Light Fixtures, Plywood	2014	36,248		20	1,812	1,812	3,625	9
10	Front Entrance - Plant And Flower Installation	2014	9,465		20	473	473	947	10
11	Signage	2014	8,510		20	426	426	851	11
12	Sprinkler System	2015	6,237		20	312	312	312	12
13	Resid Rms - 36 Receptacles And Wiring	2015	7,810		20	391	391	391	13
14	Resid Rms - Painting/Priming	2015	9,500		20	475	475	475	14
15	41 Patient Rooms - Drapery	2015	21,401		20	1,070	1,070	1,070	15
16	Roof Repairs	2015	45,110		20	2,256	2,256	2,256	16
17	Exterior Concrete And Gravel Base	2015	12,780		20	639	639	639	17
18	Open Cell On Roof	2015	13,500		20	675	675	675	18
19	Repaired Chiller	2015	2,921		20	146	146	146	19
20	Repaired Pumps	2015	23,873		20	1,194	1,194	1,194	20
21	Repaired Pavement, Sewer/Sealcoating/Restriping	2015	11,430		20	572	572	572	21
22	Installed Fire Alarm System	2015	13,665		20	683	683	683	22
23	Installed Two Elevator Pit Ladders	2015	2,500		20	125	125	125	23
24	Repaired 3 Pump Bodies And Pipes	2015	5,389		20	269	269	269	24
25	Signage For Library/Office/Pt/Ot/Conference Rms	2015	5,910		20	295	295	295	25
26	Wanderguard System - Lower/Upper Levels For 100-400 Wings	2015	40,744		20	2,037	2,037	2,037	26
27	Repaired Fence	2015	3,200		20	160	160	160	27
28	Installed Storage Tank For Plumbing	2015	3,900		20	195	195	195	28
29	Repaired Plumbing In Kitchen	2015	3,268		20	163	163	163	29
30	Wiring For Phone Systems	2015	3,597		20	180	180	180	30
31	New Unit Interior Signage	2015	4,334		20	217	217	217	31
32	Installed Fire Alarm System	2015	38,639		20	1,932	1,932	1,932	32
33	Corridor Light Fixtures	2015	4,557		20	228	228	228	33
34	TOTAL (lines 1 thru 33)		$ 554,539	$ 175,958		$ 26,610	$ (149,348)	$ 50,516	34

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 554,539	$ 175,958		$ 26,610	$ (149,348)	$ 50,516	1
2	30 Corridor Wall Sconces And 36 Flush Mount	2015	17,372		20	869	869	869	2
3	Canopy Light Fixtures	2015	2,925		20	146	146	146	3
4	Faucets	2015	7,439		20	372	372	372	4
5	Chandelier	2015	5,654		20	283	283	283	5
6	Bathroom Mirrors	2015	3,733		20	187	187	187	6
7	Corridor Light Fixtures	2015	4,331		20	217	217	217	7
8	Lobby Drapery	2015	2,584		20	129	129	129	8
9	Patient Room Shades	2015	10,785		20	539	539	539	9
10	62 Handrails And 46 Casings For Doors In Corridor	2015	20,448		20	1,022	1,022	1,022	10
11	Installed Pt Workstation	2015	11,412		20	571	571	571	11
12	Bathroom Shower Curtains	2015	3,582		20	179	179	179	12
13	Resident Room Bedside Sconces	2015	10,052		20	503	503	503	13
14	Installed A/C Units In Lower Level Office Area	2015	8,182		20	409	409	409	14
15	Nurse Call System Upgrade - Panels/Call Stations	2015	17,100		20	855	855	855	15
16	Nurse Stations - Panels/Lights/Single Room Call Stations	2015	16,850		20	843	843	843	16
17	Hr Office/Storage Rooms/Elevator/Lobby - Prep/Prime/Paint Wal	2015	14,665		20	733	733	733	17
18	Exterior - Carpentry/Steel/Concrete	2015	96,440		20	4,822	4,822	4,822	18
19	Demolition/Concrete/Excavation/Masonry For Exterior Signs	2015	34,850		20	1,743	1,743	1,743	19
20	Outside Sprinkler System Repair/Installed Entrance Tree	2015	31,724		20	1,586	1,586	1,586	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)		$ 874,667	$ 175,958		$ 42,616	$ (133,342)	$ 66,522	34

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 874,667	$ 175,958		$ 42,616	$ (133,342)	$ 66,522	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)		$ 874,667	$ 175,958		$ 42,616	$ (133,342)	$ 66,522	34

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 874,667	$ 175,958		$ 42,616	$ (133,342)	$ 66,522	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)		$ 874,667	$ 175,958		$ 42,616	$ (133,342)	$ 66,522	34

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Legacy Real Properties	2009	35,065	1,193	20	1,169	(24)	7,597	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Legacy HC Financial Services	2012	1,577	103	20	79	(24)	316	9
10	Allocated from Legacy HC Financial Services	2013	5,046	329	20	252	(77)	757	10
11	Allocated from Legacy HC Financial Services	2014	493	32	20	25	(7)	49	11
12	Allocated from Legacy HC Financial Services	2015	679	44	20	34	(10)	34	12
13									13
14	Allocated from Legacy Real Properties	2009	19,913	295	20	996	701	5,725	14
15	Allocated from Legacy Real Properties	2010	6,055	90	20	242	152	1,333	15
16	Allocated from Legacy Real Properties	2011	8,606	127	20	430	303	2,152	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)		$ 77,434	$ 2,213		$ 3,227	$ 1,014	$ 17,963	34

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 77,434	$ 2,213		$ 3,227	$ 1,014	$ 17,963	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 77,434	$ 2,213		$ 3,227	$ 1,014	$ 17,963	34

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 332,181	$ 2,198	$ 26,801	$ 24,603	10	$ 57,389	71
72	Current Year Purchases	351,069	72	35,107	35,035	10	35,107	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 683,250	$ 2,270	$ 61,908	$ 59,638		$ 92,495	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)	$ 1,562,443	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 178,228	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 104,524	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (73,704)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 159,018	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92	Lobby/Corridor/PT Room	$ 1,640,789	92
93	Architect Fees	31,790	93
94			94
95		$ 1,672,579	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 Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Kedzie Home LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		190		$ 1,440,398			3
4	Additions							4
5	Storage				1,161			5
6								6
7	TOTAL		190		$ 1,441,559 **			7

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

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

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2016	$
13.	/2017	$
14.	/2018	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 16,115 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2015 GMC Yukon	$ 750.00	$ 9,750	17
18	Allocated from Progressive HC			743	18
19					19
20					20
21	TOTAL		$ 750.00	$ 10,493	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 Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		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	$		$ 541,952	$		$ 541,952	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			175,887			175,887	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			811,434			811,434	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				400,208		400,208	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					65,433	76,077		141,510	13
14	TOTAL			$		$ 1,594,706	$ 476,285		$ 2,070,991	14

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

STATE OF ILLINOIS

Facility Name & ID Number Avantara Long Grove **#** 0052639 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 834	$ 33,972	1
2	Cash-Patient Deposits	1,000	1,000	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,837,376	3,837,376	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(12,811)	(12,811)	6
7	Other Prepaid Expenses	7,912	7,912	7
8	Accounts Receivable (owners or related parties)	812,975	1,855,594	8
9	Other(specify):	197,722	197,722	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,845,008	$ 5,920,765	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	954,083	954,083	15
16	Equipment, at Historical Cost	750,411	750,411	16
17	Accumulated Depreciation (book methods)	(211,470)	(211,470)	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):	2,103,710	2,103,710	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,596,734	$ 3,596,734	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,441,742	$ 9,517,499	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,241,120	$ 1,241,120	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,969,201	4,972,505	29
30	Accrued Salaries Payable	394,390	394,390	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,775	16,775	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,578,440	1,589,127	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,199,926	$ 8,213,917	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	599,729	599,729	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 599,729	$ 599,729	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,799,655	$ 8,813,646	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 642,087	$ 703,853	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,441,742	$ 9,517,499	48

***(See instructions.)**

Facility Name & ID Number Avantara Long Grove # 0052639 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (286,126)	1
2	Restatements (describe):		2
3	**PY Bad Debt**	75,810	3
4	**PY Bed Tax**	25,935	4
5	**PY Bank Charges/Promotions**	13,213	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (171,168)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	813,255	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)**	$ 813,255	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)**	$ 642,087	24 *

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 16,529,308	1
2	Discounts and Allowances for all Levels	(7,597,267)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,932,041	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,119,884	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 6,119,884	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	394,887	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	54,894	19
20	Radiology and X-Ray	16,270	20
21	Other Medical Services	3,335	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 469,386	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,326	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,326	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	7,490	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,490	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,530,127	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,023,720	31
32	Health Care	5,068,090	32
33	General Administration	3,031,667	33
	B. Capital Expense		
34	Ownership	1,806,983	34
	C. Ancillary Expense		
35	Special Cost Centers	2,382,433	35
36	Provider Participation Fee	403,979	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,716,872	40
41	**Income before Income Taxes (line 30 minus line 40)****	813,255	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 813,255	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,275,185	44
45	Private Pay - Net Inpatient Revenue	774,177	45
46	Medicare - Net Inpatient Revenue	(249,326)	46
47	Other-(specify) Insurance	132,005	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,932,041	49

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,792	1,832	$ 105,336	$ 57.50	1
2	Assistant Director of Nursing	1,822	1,846	71,889	38.95	2
3	Registered Nurses	24,045	24,547	800,949	32.63	3
4	Licensed Practical Nurses	43,504	44,383	1,273,776	28.70	4
5	CNAs & Orderlies	105,539	107,390	1,498,234	13.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,087	11,308	221,305	19.57	8
9	Activity Director	2,032	2,080	40,898	19.66	9
10	Activity Assistants	10,426	10,655	134,830	12.65	10
11	Social Service Workers	8,240	8,403	189,817	22.59	11
12	Dietician					12
13	Food Service Supervisor	2,764	2,820	65,784	23.33	13
14	Head Cook	11,012	11,203	189,776	16.94	14
15	Cook Helpers/Assistants	17,465	17,715	199,110	11.24	15
16	Dishwashers					16
17	Maintenance Workers	3,278	3,357	67,154	20.00	17
18	Housekeepers	25,489	25,980	290,557	11.18	18
19	Laundry	4,145	4,235	43,655	10.31	19
20	Administrator	2,925	2,999	205,667	68.58	20
21	Assistant Administrator	2,112	2,160	57,328	26.54	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,162	16,463	292,748	17.78	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,176	2,224	52,972	23.82	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	10,708	10,940	172,947	15.81	33
34	TOTAL (lines 1 - 33)	306,724	312,539	$ 5,974,732 *	$ 19.12	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	458	$ 21,539	01-03	35
36	Medical Director	Monthly	161,655	09-03	36
37	Medical Records Consultant	Monthly	3,216	10-03	37
38	Nurse Consultant	Monthly	47,053	10-03	38
39	Pharmacist Consultant	Monthly	5,464	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	15,753	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	70	3,842	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	528	$ 258,522		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	10	$ 480	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	10	$ 480		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Scott Sklar	Administrator	0.00%	$ 52,606
Jim Farlee	Administrator	0.00%	153,062
Kevin O'Hare	Assistant Admin	0.00%	13,685
Lily Osel	Assistant Admin	0.00%	43,644
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 262,996

B. Administrative - Other

Description	Amount
Yair Zuckerman - Management Fees	$ 1,948
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,948
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R/Marcum LLP	Accounting	$ 24,000
Legacy Healthcare	Bookkeeping	240,000
Achieve Accreditation	Joint Commission Consult	11,924
See Attached	Legal	83,233
Wescom Solutions	Data Processing	29,938
IIT/Source Tech	Energy Management	1,095
Paycor	Payroll Processing	32,801
Personnel Planners	Unemployment Tax Consult	1,448
Prospect Resources	Energy Procurement	900
Second to None	Data Processing	6,029
Documentation Solutions	Compliance Audit	4,907
See Supplemental Schedule		29,557
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 465,832

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 187,665
Unemployment Compensation Insurance	92,784
FICA Taxes	457,067
Employee Health Insurance	188,113
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	3,000
Employee Physical Exam	7,110
Other Employee Benefits	55,458
TOTAL (agree to Schedule V, line 22, col.8)	$ 991,196

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	$ 1,990
Advertising: Employee Recruitment	8,419
Health Care Worker Background Check	
(Indicate # of checks performed ____)	
Patient Background Checks	
Dues and Subscriptions	35,989
License and Permits	8,084
Allocated from Legacy HC Financial Serv	1,135
Allocated from Progressive HC	94
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 55,710

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	17,368
Allocated from Legacy HC Financial Serv	1,143
Allocated from Progressive HC	91
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 18,602

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Avantara Long Grove # 0052639 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC $16,043**

(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. $ **47,819** 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. $ **403,979**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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