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.

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

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: Steven N. Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/17 to 12/31/17 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

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

Paid Preparer

(Signed) (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/17 Ending: 12/31/17

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	195	Skilled (SNF)	195	71,175	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	195	TOTALS	195	71,175	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	48,009	4,601	12,056	64,666	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,009	4,601	12,056	64,666	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.85%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 195 and days of care provided 10,468

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Avantara Long Grove # 0052639 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	515,563	49,992	20,175	585,730		585,730		585,730			1
2	Food Purchase		469,564		469,564		469,564	(32,241)	437,323			2
3	Housekeeping	349,524	67,730	1,241	418,495		418,495	253	418,748			3
4	Laundry	56,723	47,671		104,394		104,394	7	104,401			4
5	Heat and Other Utilities			185,230	185,230		185,230	(21,183)	164,047			5
6	Maintenance	83,602	32,213	214,902	330,717		330,717	60,405	391,122			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,005,412	667,170	421,548	2,094,130		2,094,130	7,240	2,101,370			8
	B. Health Care and Programs											
9	Medical Director			81,371	81,371		81,371	775	82,146			9
10	Nursing and Medical Records	4,966,913	134,811	70,027	5,171,751		5,171,751	22,453	5,194,204			10
10a	Therapy	240,454			240,454		240,454		240,454			10a
11	Activities	189,506	7,169	3,038	199,713		199,713	5,891	205,604			11
12	Social Services	218,399		3,085	221,484		221,484	2,115	223,599			12
13	CNA Training											13
14	Program Transportation			36,050	36,050		36,050		36,050			14
15	Other (specify):*							20,216	20,216			15
16	**TOTAL Health Care and Programs**	5,615,272	141,980	193,571	5,950,823		5,950,823	51,450	6,002,273			16
	C. General Administration											
17	Administrative	174,381			174,381		174,381	202,562	376,943			17
18	Directors Fees											18
19	Professional Services			122,788	122,788	(271)	122,517	(15,899)	106,618			19
20	Dues, Fees, Subscriptions & Promotions			165,737	165,737		165,737	(116,728)	49,009			20
21	Clerical & General Office Expenses	587,615	10,996	778,265	1,376,876		1,376,876	(666,334)	710,542			21
22	Employee Benefits & Payroll Taxes			1,102,831	1,102,831		1,102,831	(68,470)	1,034,361			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,904	5,904		5,904	2,336	8,240			24
25	Other Admin. Staff Transportation			5,028	5,028		5,028		5,028			25
26	Insurance-Prop.Liab.Malpractice			131,748	131,748		131,748	4,307	136,055			26
27	Other (specify):*							84,781	84,781			27
28	**TOTAL General Administration**	761,996	10,996	2,312,301	3,085,293	(271)	3,085,022	(573,445)	2,511,577			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	7,382,680	820,146	2,927,420	11,130,246	(271)	11,129,975	(514,754)	10,615,221			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:** 01/01/17 **Ending:** 12/31/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							639,934	639,934			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			123,852	123,852		123,852	699,842	823,694			32
33	Real Estate Taxes			125,048	125,048	271	125,319	5,454	130,773			33
34	Rent-Facility & Grounds			1,800,930	1,800,930		1,800,930	(1,426,662)	374,268			34
35	Rent-Equipment & Vehicles			16,672	16,672		16,672	5,364	22,036			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,066,502	2,066,502	271	2,066,773	(76,068)	1,990,705			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	15,088	794,693	2,112,892	2,922,673		2,922,673		2,922,673			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			447,382	447,382		447,382		447,382			42
43	Other (specify):*			898,993	898,993		898,993	(898,993)				43
44	**TOTAL Special Cost Centers**	15,088	794,693	3,459,267	4,269,048		4,269,048	(898,993)	3,370,055			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,397,768	1,614,839	8,453,189	17,465,796		17,465,796	(1,489,815)	15,975,981			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: 01/01/17 Ending: 12/31/17

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(22,656)	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	638,956	30		9
10	Interest and Other Investment Income	(8,724)	32		10
11	Discounts, Allowances, Rebates & Refunds	(31,987)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(333)	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	(836)	21		18
19	Entertainment	(11,409)	21		19
20	Contributions	(86,112)	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	(432,047)	21		24
25	Fund Raising, Advertising and Promotional	(19,532)	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	(1,116,667)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,091,347)		$	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)	(398,468)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (398,468)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,489,815)		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: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Personal Items	$ (16,548)	10	1
2	Direct Mail	(322)	20	2
3	Bank Charges	(10,301)	21	3
4	Sequestration	(134,303)	21	4
5	Misc Other Professional	(2,941)	21	5
6	Non Allowable Legal Fees	(25,799)	19	6
7	PAC Dues	(12,013)	20	7
8	Bldg Co - Bank Charges	(15)	21	8
9	Bldg Co - Professional Fees	(8,750)	19	9
10	Bldg Co - Filing Fees	(250)	21	10
11	Bldg Co - Accounting	(2,884)	19	11
12	Bldg Co - Legal	(5,573)	19	12
13	Additional R&M	6,704	06	13
14	Capitalized R&M	(4,679)	06	14
15	Non Allowable Expense	(898,993)	43	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**	(1,116,667)		49

Avantara Long Grove

ID# 0052639

Report Period Beginning: 01/01/17

Ending: 12/31/17

	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			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Avantara Long Grove # 0052639 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(32,320)		57	22								(32,241)	2
3	Housekeeping			253									253	3
4	Laundry			7									7	4
5	Heat and Other Utilities	(22,656)				1,473							(21,183)	5
6	Maintenance	2,025		3,410	53,108	1,862							60,405	6
7	Other (specify):*													7
8	**TOTAL General Services**	(52,951)		3,726	53,130	3,335							7,240	8
	B. Health Care and Programs													
9	Medical Director			775									775	9
10	Nursing and Medical Records	(16,548)		48	130,087	(89,965)	(1,169)						22,453	10
10a	Therapy													10a
11	Activities			5,868	22								5,891	11
12	Social Services			93	2,023								2,115	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				20,216								20,216	15
16	**TOTAL Health Care and Programs**	(16,548)		6,784	152,348	(89,965)	(1,169)						51,450	16
	C. General Administration													
17	Administrative			26,676	175,886								202,562	17
18	Directors Fees													18
19	Professional Services	(43,006)	17,207	18,123	444	370			(9,038)				(15,899)	19
20	Fees, Subscriptions & Promotions	(117,979)		1,031	217	3							(116,728)	20
21	Clerical & General Office Expenses	(592,102)	265	211,635	(286,133)	1							(666,334)	21
22	Employee Benefits & Payroll Taxes					(68,470)							(68,470)	22
23	Inservice Training & Education													23
24	Travel and Seminar			1,362	974								2,336	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			1,142	2,783	381							4,307	26
27	Other (specify):*			43,426	41,355								84,781	27
28	**TOTAL General Administration**	(753,087)	17,472	303,395	(64,473)	(67,714)			(9,038)				(573,445)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(822,586)	17,472	313,906	141,005	(154,344)	(1,169)		(9,038)				(514,754)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Avantara Long Grove** **#** **0052639** **Report Period Beginning:** **01/01/17** **Ending:** **12/31/17**

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	638,956			978								639,934	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(8,724)	701,890	22		6,654							699,842	32
33	Real Estate Taxes					5,454							5,454	33
34	Rent-Facility & Grounds		(1,426,847)	52,807	76	(52,697)							(1,426,662)	34
35	Rent-Equipment & Vehicles			3,867	1,497								5,364	35
36	Other (specify):*													36
37	**TOTAL Ownership**	630,232	(724,957)	56,695	2,551	(40,589)							(76,068)	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):*	(898,993)											(898,993)	43
44	**TOTAL Special Cost Centers**	(898,993)											(898,993)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,091,347)	(707,485)	370,601	143,556	(194,933)	(1,169)		(9,038)				(1,489,815)	45

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,800,000	Buffalo Property Holdings LLC	100.00%	$	$ (1,800,000)	1
2	V	32	Interest Income	19	Buffalo Property Holdings LLC	100.00%		(19)	2
3	V	34	Rent Expense		Buffalo Property Holdings LLC	100.00%	373,153	373,153	3
4	V	21	Bank Fees		Buffalo Property Holdings LLC	100.00%	15	15	4
5	V	21	Filing Fees		Buffalo Property Holdings LLC	100.00%	250	250	5
6	V	19	Professional Fees		Buffalo Property Holdings LLC	100.00%	8,750	8,750	6
7	V	19	Accounting Fees		Buffalo Property Holdings LLC	100.00%	2,884	2,884	7
8	V	19	Legal Fees		Buffalo Property Holdings LLC	100.00%	5,573	5,573	8
9	V	32	Interest Expense - Mortgage		Buffalo Property Holdings LLC	100.00%	701,909	701,909	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,800,019			$ 1,092,534	$ * (707,485)	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: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	FOOD	$	Legacy Healthcare Financial Services	100.00%	$ 57	$ 57	15
16	V	3	HOUSEKEEPING SUPPLIES		Legacy Healthcare Financial Services	100.00%	253	253	16
17	V	4	LINEN REPLACEMENT		Legacy Healthcare Financial Services	100.00%	7	7	17
18	V	6	UTILITIES		Legacy Healthcare Financial Services	100.00%	14	14	18
19	V	6	GROUNDS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	3,395	3,395	19
20	V	9	MEDICAL DIRECTOR CONSULTANT		Legacy Healthcare Financial Services	100.00%	775	775	20
21	V	10	MEDICAL SUPPLIES		Legacy Healthcare Financial Services	100.00%	48	48	21
22	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services	100.00%	5,868	5,868	22
23	V	12	SOCIAL SERVICE CONSULTANT		Legacy Healthcare Financial Services	100.00%	93	93	23
24	V	17	ADMINISTRATIVE SALARY		Legacy Healthcare Financial Services	100.00%	26,676	26,676	24
25	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	18,123	18,123	25
26	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	1,031	1,031	26
27	V	21	CLERICAL & GENERAL WAGES		Legacy Healthcare Financial Services	100.00%	205,943	205,943	27
28	V	21	CLERICAL & GENERAL OTHER COSTS		Legacy Healthcare Financial Services	100.00%	5,691	5,691	28
29	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	1,362	1,362	29
30	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	1,142	1,142	30
31	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	43,426	43,426	31
32	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	22	22	32
33	V	34	RENT		Legacy Healthcare Financial Services	100.00%	52,697	52,697	33
34	V	34	STORAGE		Legacy Healthcare Financial Services	100.00%	110	110	34
35	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services	100.00%	27	27	35
36	V	35	AUTO RENTAL		Legacy Healthcare Financial Services	100.00%	3,840	3,840	36
37	V								37
38	V								38
39	Total			$			$ 370,601	$ * 370,601	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: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	FOOD	$	Progressive Healthcare Consulting	100.00%	$ 22	$ 22	15
16	V	6	MAINTENANCE SALARY		Progressive Healthcare Consulting	100.00%	52,950	52,950	16
17	V	6	BUILDING MAINTENANCE AND R&M		Progressive Healthcare Consulting	100.00%	158	158	17
18	V	10	NURSING SALARIES		Progressive Healthcare Consulting	100.00%	130,087	130,087	18
19	V	11	ACTIVITIES PROGRAM		Progressive Healthcare Consulting	100.00%	22	22	19
20	V	12	CLERGY CONSULTANT		Progressive Healthcare Consulting	100.00%	2,018	2,018	20
21	V	12	SOCIAL SERVICE		Progressive Healthcare Consulting	100.00%	5	5	21
22	V	15	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	20,216	20,216	22
23	V	17	ADMIN SALARY- NON OWNER		Progressive Healthcare Consulting	100.00%	175,886	175,886	23
24	V	19	PROFESSIONAL FEES		Progressive Healthcare Consulting	100.00%	444	444	24
25	V	20	DUES, SUBSCRIPTIONS, LICENSES		Progressive Healthcare Consulting	100.00%	217	217	25
26	V	21	CLERICAL WAGES		Progressive Healthcare Consulting	100.00%	37,279	37,279	26
27	V	21	CLERICAL & GENERAL - OTHER		Progressive Healthcare Consulting	100.00%	398	398	27
28	V	24	SEMINARS		Progressive Healthcare Consulting	100.00%	974	974	28
29	V	27	EMP. BEN.-NON-NURSING		Progressive Healthcare Consulting	100.00%	41,355	41,355	29
30	V	26	INSURANCE		Progressive Healthcare Consulting	100.00%	2,783	2,783	30
31	V	30	DEPRECIATION		Progressive Healthcare Consulting	100.00%	978	978	31
32	V	34	STORAGE RENTAL		Progressive Healthcare Consulting	100.00%	76	76	32
33	V	35	AUTO RENTAL		Progressive Healthcare Consulting	100.00%	1,497	1,497	33
34	V								34
35	V	21	ADMINISTRATIVE SALARY	323,809	Progressive Healthcare Consulting	100.00%		(323,809)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 323,809			$ 467,365	$ * 143,556	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: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	CF ST. LOUIS, LLC	100.00%	$ 1,473	$ 1,473	15
16	V	6	REPAIRS & MAINTENANCE		CF ST. LOUIS, LLC	100.00%	1,862	1,862	16
17	V	19	PROFESSIONAL FEES		CF ST. LOUIS, LLC	100.00%	370	370	17
18	V	20	DUES & SUBSCRIPTIONS		CF ST. LOUIS, LLC	100.00%	3	3	18
19	V	21	OFFICE EXPENSE		CF ST. LOUIS, LLC	100.00%	1	1	19
20	V	26	INSURANCE		CF ST. LOUIS, LLC	100.00%	381	381	20
21	V	32	INTEREST EXPENSE		CF ST. LOUIS, LLC	100.00%	6,654	6,654	21
22	V	33	REAL ESTATE TAXES		CF ST. LOUIS, LLC	100.00%	5,454	5,454	22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	52,697	CF ST. LOUIS, LLC	100.00%		(52,697)	26
27	V	10	NURSING SALARY	89,965	CF ST. LOUIS, LLC	100.00%		(89,965)	27
28	V	22	PAYROLL TAXES	68,470	CF ST. LOUIS, LLC	100.00%		(68,470)	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			$ 211,132			$ 16,199	$ * (194,933)	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: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Medical Supplies	$ 28,717	ReMED Services		$ 27,548	$ (1,169)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 28,717			$ 27,548	$ * (1,169)	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: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance	$ 24,000	ML Group Design and Development		$ 24,000	$	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			$ 24,000			$ 24,000	$ *	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: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	$ 37,662	ProPay HR LLC	24.00%	$ 28,624	$ (9,038)	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			$ 37,662			$ 28,624	$ * (9,038)	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: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ 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: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ 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: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ 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: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	GPN Family Trust	50.00%	ASTORIA PLACE SKILLED NURSING FACILITY LLC	CHICAGO	BUFFALO PROPERTY HOLDINGS		BUILDING COMPANY	1
2	Doros Generation Trust	50.00%	AVANTARA LONG GROVE	LONG GROVE	LEGACY HC & FINANCIAL SER	LINCOLNWOOD	HOME OFFICE/BOOKKEEPI	2
3			AVANTARA PARK RIDGE	PARK RIDGE	PROGRESSIVE HC	LINCOLNWOOD	NURSE CONSULTANT	3
4			AZRIA MIDTOWN	OMAHA, NE	ML GROUP DESIGN & DEV	SKOKIE	ASSET MANAGEMENT	4
5			AZRIA MONTCLAIR	OMAHA, NE	REMED SERVICES LLC	LINCOLNWOOD	NURSING EQUIPMENT	5
6			AZRIA OLATHE	OLATHE, KS	AURORA SUPPORTIVE LIVING	AURORA	SUPPORTIVE LIVING	6
7			BETHANY TERRACE	MORTON GROVE	TERRACE GARDENS	MORTON GROVE	ASSISTED LIVING	7
8			CARLTON SKILLED NURSING FACILITY LLC	CHICAGO	LINCOLNSHIRE ASSISTED LIVI	LINCOLNSHIRE	ASSISTED LIVING	8
9			CEDAR SKILLED NURSING FACILITY	CEDAR CITY, UT	CF ST. LOUIS LLC	SKOKIE	BUILDING COMPANY	9
10			CHALET SKILLED NURSING FACILITY LLC	CHICAGO	PROPAY HR	EVANSTON	PAYROLL PROCESSING	10
11			CLARK SKILLED NURSING FACILITY	CHICAGO				11
12			EVANSTON SKILLED NURSING FACILITY LLC	EVANSTON				12
13			GROVE AT THE LAKE SKILLED NURSING FACILITY LLC	ZION				13
14			GROVE OF FOX VALLEY	AURORA				14
15			LAGRANGE SKILLED NURSING FACILITY LLC	LAGRANGE PARK				15
16			LAKEFRONT SKILLED NURSING FACILITY LLC	CHICAGO				16
17			LINCOLN PARK SKILLED NURSING FACILITY LLC	CHICAGO				17
18			LINCOLNSHIRE LIVING & REHAB CENTER LLC	LINCOLNSHIRE				18
19			NORTHBROOK SKILLED NURSING FACILITY	NORTHBROOK				19
20			PARKER SKILLED NURSING FACILITY LLC	PARKER, CO				20
21			PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO				21
22			SKOKIE SKILLED NURSING FACILITY LLC	SKOKIE				22
23			ST. GEORGE SKILLED NURSING FACILITY	ST. GEORGE, UT				23
24			WARREN BARR LIVING AND REHAB	CHICAGO				24
25			WARREN BARR NORTH SHORE	HIGHLAND PARK				25
26			WARREN BARR SOUTH LOOP	CHICAGO				26
27								27
28								28
29								29
30								30

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								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: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] 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: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	FOOD	AVAIL. BED DAYS	1,789,215	30	$ 1,460	$	69,350	$ 57	1
2	3	HOUSEKEEPING SUPPLIES	AVAIL. BED DAYS	1,789,215	30	6,519		69,350	253	2
3	4	LINEN REPLACEMENT	AVAIL. BED DAYS	1,789,215	30	171		69,350	7	3
4	6	UTILITIES	AVAIL. BED DAYS	1,789,215	30	372		69,350	14	4
5	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	1,789,215	30	87,596		69,350	3,395	5
6	9	MEDICAL DIRECTOR CONSU	AVAIL. BED DAYS	1,789,215	30	20,000		69,350	775	6
7	10	MEDICAL SUPPLIES	AVAIL. BED DAYS	1,789,215	30	1,237		69,350	48	7
8	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,789,215	30	151,405		69,350	5,868	8
9	12	SOCIAL SERVICE CONSULTA	AVAIL. BED DAYS	1,789,215	30	2,392		69,350	93	9
10	17	ADMINISTRATIVE SALARY	AVAIL. BED DAYS	1,789,215	30	688,242	688,242	69,350	26,676	10
11	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,789,215	30	467,580		69,350	18,123	11
12	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,789,215	30	26,590		69,350	1,031	12
13	21	CLERICAL & GENERAL WAG	AVAIL. BED DAYS	1,789,215	30	5,313,296	5,313,296	69,350	205,943	13
14	21	CLERICAL & GENERAL OTH	AVAIL. BED DAYS	1,789,215	30	146,833		69,350	5,691	14
15	24	SEMINARS	AVAIL. BED DAYS	1,789,215	30	35,138		69,350	1,362	15
16	26	INSURANCE	AVAIL. BED DAYS	1,789,215	30	29,475		69,350	1,142	16
17	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	1,789,215	30	1,120,380		69,350	43,426	17
18	32	INTEREST	AVAIL. BED DAYS	1,789,215	30	561		69,350	22	18
19	34	RENT	AVAIL. BED DAYS	1,789,215	30	1,359,562		69,350	52,697	19
20	34	STORAGE	AVAIL. BED DAYS	1,789,215	30	2,842		69,350	110	20
21	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,789,215	30	694		69,350	27	21
22	35	AUTO RENTAL	AVAIL. BED DAYS	1,789,215	30	99,069		69,350	3,840	22
23										23
24										24
25	TOTALS					$ 9,561,416	$ 6,001,539		$ 370,601	25

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	FOOD	AVAIL. BED DAYS	1,374,590	21	$ 432	$	69,350	$ 22	1
2	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,374,590	21	1,049,531	1,049,531	69,350	52,950	2
3	6	BUILDING MAINTENANCE AI	AVAIL. BED DAYS	1,374,590	21	3,133		69,350	158	3
4	10	NURSING SALARIES	AVAIL. BED DAYS	1,374,590	21	2,578,462	2,578,462	69,350	130,087	4
5	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,374,590	21	443		69,350	22	5
6	12	CLERGY CONSULTANT	AVAIL. BED DAYS	1,374,590	21	39,998		69,350	2,018	6
7	12	SOCIAL SERVICE	AVAIL. BED DAYS	1,374,590	21	95		69,350	5	7
8	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,374,590	21	400,703		69,350	20,216	8
9	17	ADMIN SALARY- NON OWNE	AVAIL. BED DAYS	1,374,590	21	3,486,246	3,486,246	69,350	175,886	9
10	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,374,590	21	8,800		69,350	444	10
11	20	DUES, SUBSCRIPTIONS, LICE	AVAIL. BED DAYS	1,374,590	21	4,293		69,350	217	11
12	21	CLERICAL WAGES	AVAIL. BED DAYS	1,374,590	21	738,904	738,904	69,350	37,279	12
13	21	CLERICAL & GENERAL - OTI	AVAIL. BED DAYS	1,374,590	21	7,880		69,350	398	13
14	24	SEMINARS	AVAIL. BED DAYS	1,374,590	21	19,314		69,350	974	14
15	27	EMP. BEN.-NON-NURSING	AVAIL. BED DAYS	1,374,590	21	819,705		69,350	41,355	15
16	26	INSURANCE	AVAIL. BED DAYS	1,374,590	21	55,168		69,350	2,783	16
17	30	DEPRECIATION	AVAIL. BED DAYS	1,374,590	21	19,384		69,350	978	17
18	34	STORAGE RENTAL	AVAIL. BED DAYS	1,374,590	21	1,500		69,350	76	18
19	35	AUTO RENTAL	AVAIL. BED DAYS	1,374,590	21	29,674		69,350	1,497	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 9,263,664	$ 7,853,142		$ 467,365	25

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. BED DAYS	1,789,215	30	$ 37,998	$	69,350	$ 1,473	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,789,215	30	48,042		69,350	1,862	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,789,215	30	9,551		69,350	370	3
4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,789,215	30	76		69,350	3	4
5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,789,215	30	32		69,350	1	5
6	26	INSURANCE	AVAIL. BED DAYS	1,789,215	30	9,839		69,350	381	6
7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,789,215	30	171,679		69,350	6,654	7
8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,789,215	30	140,710		69,350	5,454	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					$ 417,927	$		$ 16,199	25

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: ReMED Services LLC
Street Address: 3424 Oakton St Suite 102
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 440-2600
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Medical Supplies	Direct			$	$		$ 27,548	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 27,548	25

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: ML Group Design and Development
Street Address: 3424 Oakton St
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 676-5300
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Direct			$	$		$ 24,000	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 24,000	25

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: ProPay HR LLC
Street Address: 2201 W Main St
City / State / Zip Code: Evanston, IL 60202
Phone Number: (847) 905-3268
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct			$	$		$ 28,624	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					$	$		$ 28,624	25

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ 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: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ 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: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ 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: 01/01/17 Ending: 12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** 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	The Private Bank		X	Mortgage			$	$ 20,907,520			$ 701,909	1
2	Note Payable		X	Note Payable				850,000			123,852	2
3												3
4												4
5												5
	Working Capital											
6	CD		X	Line of Credit				1,500,000				6
7												7
8												8
9	TOTAL Facility Related						$	$ 23,257,520			$ 825,761	9
	B. Non-Facility Related*											
10	Allocated from Legacy HC		X	Interest							22	10
11	Allocated CF St Louis		X	Interest							6,654	11
12	Interest Income-Fac & Bldg Co		X	Interest							(8,743)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,067)	14
15	TOTALS (line 9+line14)						$	$ 23,257,520			$ 823,694	15

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

*** 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:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	165,232	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.)	$	122,890	2
3. Under or (over) accrual (line 2 minus line 1).	$	(42,342)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	172,844	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.)**	$	271	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	130,773	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2012		8
2013	118,391	9
2014	110,083	10
2015	115,237	11
2016	117,436	12

Beginning Accrual Adjusted
Allocated from CF St Louis = $5,454
2017 Accrual = 165,232 x 1.05

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Avantara Long Grove COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0052639

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-31-201-082	Long Term Care Property	$ 110,202.63	$ 110,202.63
2.	15-31-201-083	Long Term Care Property	$ 7,234.28	$ 7,234.28
3.	10-23-406-034-0000	Home Office Allocation	$ 463,439.48	$ 5,454.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 580,876.39	$ 122,890.91

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2016 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 2016 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2016.

Please complete the Real Estate Tax Statement below and include it in the 2017 cost report along with a copy of your 2016 real estate tax bill.

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

2016 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) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2016.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,302 B. General Construction Type: Exterior Divit/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 [ ] (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	Facility			$ 1,482,376	1
2	Allocated CF St Louis			25,194	2
3	TOTALS			$ 1,507,570	3

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	195		2016		$ 12,961,389	$	35	$ 370,325	$ 370,325	$ 740,650	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: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		302,853			14,260	14,260	28,224	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 13,264,242	$		$ 384,585	$ 384,585	$ 768,874	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: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 13,264,242	$		$ 384,585	$ 384,585	$ 768,874	1
2	Roof Repairs	2014	6,375		20	319	319	1,275	2
3	Water Softening System	2014	10,800		20	540	540	2,160	3
4	Landscaping	2014	10,180		20	509	509	2,036	4
5	Bathroom, Dining Room, Play Room - Plaster And Painting	2014	9,850		20	493	493	1,970	5
6	Security System Cameras And Cable Wiring	2014	20,590		20	1,030	1,030	4,119	6
7	Resid Rms Electric Cabling, Drywall/Paint, Replaced Stair	2014	67,050		20	3,352	3,352	13,409	7
8	Repair Generator Circuit Breaker	2014	2,874		20	144	144	575	8
9	West Wing - Doors, Receptacles, Light Fixtures, Plywood	2014	21,775		20	1,089	1,089	4,355	9
10	Front Entrance - Plant And Flower Installation	2014	9,465		20	473	473	1,893	10
11	Signage	2014	8,510		20	426	426	1,703	11
12	Sprinkler System	2015	6,237		20	312	312	936	12
13	Resid Rms - 36 Receptacles And Wiring	2015	7,810		20	391	391	1,172	13
14	Roof Repairs	2015	37,100		20	1,855	1,855	5,565	14
15	Exterior Concrete And Gravel Base	2015	12,780		20	639	639	1,917	15
16	Open Cell On Roof	2015	13,500		20	675	675	2,025	16
17	Repaired Chiller	2015	2,921		20	146	146	438	17
18	Repaired Pumps	2015	23,873		20	1,194	1,194	3,581	18
19	Repaired Pavement, Sewer/Sealcoating/Restriping	2015	11,430		20	572	572	1,715	19
20	Installed Fire Alarm System	2015	13,665		20	683	683	2,050	20
21	Installed Two Elevator Pit Ladders	2015	2,500		20	125	125	375	21
22	Repaired 3 Pump Bodies And Pipes	2015	5,389		20	269	269	808	22
23	Signage For Library/Office/Pt/Ot/Conference Rms	2015	5,910		20	295	295	886	23
24	Wanderguard System - Lower/Upper Levels For 100-400 Wings	2015	40,744		20	2,037	2,037	6,111	24
25	Repaired Fence	2015	3,200		20	160	160	480	25
26	Installed Storage Tank For Plumbing	2015	3,900		20	195	195	585	26
27	Repaired Plumbing In Kitchen	2015	3,268		20	163	163	490	27
28	Wiring For Phone Systems	2015	3,597		20	180	180	540	28
29	New Unit Interior Signage	2015	4,334		20	217	217	650	29
30	Installed Fire Alarm System	2015	38,639		20	1,932	1,932	5,796	30
31	Corridor Light Fixtures	2015	4,557		20	228	228	684	31
32	30 Corridor Wall Sconces And 36 Flush Mount	2015	17,372		20	869	869	2,606	32
33	Canopy Light Fixtures	2015	2,925		20	146	146	439	33
34	TOTAL (lines 1 thru 33)		$ 13,697,360	$		$ 406,243	$ 406,243	$ 842,218	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: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 13,697,360	$		$ 406,243	$ 406,243	$ 842,218	1
2	Faucets	2015	7,439		20	372	372	1,116	2
3	Chandelier	2015	5,654		20	283	283	848	3
4	Bathroom Mirrors	2015	3,733		20	187	187	560	4
5	Corridor Light Fixtures	2015	4,331		20	217	217	650	5
6	Lobby Drapery	2015	2,584		20	129	129	387	6
7	Patient Room Shades	2015	10,785		20	539	539	1,618	7
8	62 Handrails And 46 Casings For Doors In Corridor	2015	20,448		20	1,022	1,022	3,067	8
9	Bathroom Shower Curtains	2015	3,582		20	179	179	537	9
10	Resident Room Bedside Sconces	2015	10,052		20	503	503	1,508	10
11	Installed A/C Units In Lower Level Office Area	2015	8,182		20	409	409	1,227	11
12	Hr Office/Storage Rooms/Elevator/Lobby - Prep/Prime/Paint Wal	2015	14,665		20	733	733	2,200	12
13	Demolition/Concrete/Excavation/Masonry For Exterior Signs	2015	34,850		20	1,743	1,743	5,228	13
14	Outside Sprinkler System Repair/Installed Entrance Tree	2015	31,724		20	1,586	1,586	4,758	14
15	Installed 2 Guard Rails And Ramp Rails	2016	6,400		20	320	320	640	15
16	Installed Zone Dampers In Front Office And Lobby	2016	8,636		20	432	432	864	16
17	Related Architect/Enginneering Fees	2016	1,822,062		20	91,103	91,103	182,206	17
18	Kitchen Floor Repair/Demo/Installed New Tiling	2016	3,915		20	196	196	392	18
19	1St Floor South Wing, Office, Hallway - Repaired Boiler/Installed	2016	3,238		20	74	74	149	19
20	Pcc Kiosk	2016	3,550		20	118	118	237	20
21	Installed New Post Holes, Railing, And Concrete	2016	3,800		20	111	111	222	21
22	Installed Two Commercial Storage Tanks/Pipes/Valves	2016	7,800		20	195	195	390	22
23	Kitchen Heat Machine	2016	13,675		20	760	760	1,519	23
24	Repaired Pipes In Pt Room	2016	7,603		20	95	95	190	24
25	Repaired Radiator In Cooling System	2016	7,659		20	383	383	766	25
26	Front Entry Door Landscaping - Soil, Mulch, Lane Repairs	2016	16,641		20	438	438	877	26
27	Install New Door/Frame/Hardware	2017	11,516		20	576	576	576	27
28	New Ceiling & Floor In Dinnig Room, New Drywall/Floor In Utilit	2017	55,960		20	2,565	2,565	2,565	28
29	Water Pump Work	2017	9,159		20	382	382	382	29
30	Deep Well Replacement	2017	41,615		20	1,387	1,387	1,387	30
31	New Concrete In Front Of The Ramp	2017	3,000		20	75	75	75	31
32	Repairs To Outside Walls, Foundation, Storage Room	2017	4,250		20	89	89	89	32
33	Furnished & Installed Domestic Hot Water Storage Tank	2017	23,977		20	500	500	500	33
34	TOTAL (lines 1 thru 33)		$ 15,909,847	$		$ 513,944	$ 513,944	$ 1,059,947	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: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 15,909,847	$		$ 513,944	$ 513,944	$ 1,059,947	1
2	Elevator- Door Restrictors, Car Identification Plates, And Stencil	2017	3,453		20	460	460	460	2
3	Installed Fire Alarm System For Corridor	2017	6,066		20	303	303	303	3
4	Installed Hot Water Booster	2017	14,455		20	723	723	723	4
5	Repaired Metal Stairway East Side Of Building	2017	4,250		20	213	213	213	5
6	Installed Breaker Panel And Connected To Transfer Switch-1St F	2017	10,570		20	529	529	529	6
7	Repaired Ac System In Office	2017	6,788		20	339	339	339	7
8	Repiped Boiler	2017	4,679		20	4,679	4,679	4,679	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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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)		$ 15,960,107	$		$ 521,189	$ 521,189	$ 1,067,192	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: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 15,960,107	$		$ 521,189	$ 521,189	$ 1,067,192	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
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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)		$ 15,960,107	$		$ 521,189	$ 521,189	$ 1,067,192	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: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 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
13									13
14									14
15									15
16									16
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22									22
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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: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocacted CF St Louis	2016	41,189		35	1,177	1,177	2,354	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocacted CF St Louis	2016	255,728		20	12,786	12,786	25,573	9
10	Allocacted CF St Louis	2017	5,936		20	297	297	297	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)		$ 302,853	$		$ 14,260	$ 14,260	$ 28,224	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: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 302,853	$		$ 14,260	$ 14,260	$ 28,224	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)		$ 302,853	$		$ 14,260	$ 14,260	$ 28,224	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: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,128,951	$ 978	$ 115,770	$ 114,792	10	$ 330,050	71
72	Current Year Purchases	20,712		2,974	2,974	10	2,974	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,149,663	$ 978	$ 118,745	$ 117,767		$ 333,024	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 18,617,340	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 978	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 639,934	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 638,956	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,400,217	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/17 Ending: 12/31/17

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:		195		$ 373,153			3
4	Additions							4
5	Storage				930			5
6	Allocated Legacy HC/Progressive Consulting				186			6
7	TOTAL		195		$ 374,269 **			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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 16,701 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	Allocated Legacy HC		$	$ 3,840	17
18	Allocated Progressive Consulting			1,497	18
19					19
20					20
21	TOTAL		$	$ 5,337	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: 01/01/17 Ending: 12/31/17

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

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

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

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

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 773,393	$		$ 773,393	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			204,342			204,342	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			1,037,140			1,037,140	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				594,128		594,128	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			15,088		98,017	200,565		313,670	13
14	TOTAL			$ 15,088		$ 2,112,892	$ 794,693		$ 2,922,673	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:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,227	$ 302,002	1
2	Cash-Patient Deposits	41,317	41,317	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,354,301	3,354,301	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,889	16,889	6
7	Other Prepaid Expenses	12,217	12,217	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	55,255	328,360	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,482,206	$ 4,055,086	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,482,377	13
14	Buildings, at Historical Cost		12,961,389	14
15	Leasehold Improvements, at Historical Cost	1,224,558	1,224,558	15
16	Equipment, at Historical Cost	884,157	1,264,157	16
17	Accumulated Depreciation (book methods)	(476,893)	(531,103)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	4,921,525	9,757,160	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,553,347	$ 26,158,538	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 10,035,553	$ 30,213,624	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,445,719	$ 1,445,719	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		1,500,000	29
30	Accrued Salaries Payable	540,252	540,252	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,430	22,430	31
32	Accrued Real Estate Taxes(Sch.IX-B)		172,844	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	103,925	103,925	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,112,326	$ 3,785,170	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	850,000	850,000	39
40	Mortgage Payable		20,907,520	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	4,317,032	4,702,479	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,167,032	$ 26,459,999	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,279,358	$ 30,245,169	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,756,195	$ (31,545)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 10,035,553	$ 30,213,624	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,191,192	1
2	Restatements (describe):		2
3	Rounding	5	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,191,197	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	564,998	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)**	$ 564,998	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,756,195	24 *

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

Facility Name & ID Number Avantara Long Grove **#** 0052639 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 20,822,725	1
2	Discounts and Allowances for all Levels	(11,555,224)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,267,501	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	8,041,321	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 8,041,321	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	588,197	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	77,530	19
20	Radiology and X-Ray	275	20
21	Other Medical Services	15,259	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 681,261	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,724	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,724	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	31,987	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 31,987	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 18,030,794	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,094,130	31
32	Health Care	5,950,823	32
33	General Administration	3,085,293	33
	B. Capital Expense		
34	Ownership	2,066,502	34
	C. Ancillary Expense		
35	Special Cost Centers	3,821,666	35
36	Provider Participation Fee	447,382	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,465,796	40
41	**Income before Income Taxes (line 30 minus line 40)****	564,998	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 564,998	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 9,267,501	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,267,501	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	1,152	1,272	$ 60,886	$ 47.87	1
2	Assistant Director of Nursing	1,808	1,856	80,087	43.15	2
3	Registered Nurses	37,739	41,186	1,490,715	36.19	3
4	Licensed Practical Nurses	40,993	44,498	1,338,156	30.07	4
5	CNAs & Orderlies	118,754	125,423	1,945,773	15.51	5
6	CNA Trainees					6
7	Licensed Therapist	401	425	15,088	35.50	7
8	Rehab/Therapy Aides	11,455	12,431	240,454	19.34	8
9	Activity Director	1,928	2,040	42,248	20.71	9
10	Activity Assistants	10,719	11,281	147,258	13.05	10
11	Social Service Workers	9,738	10,368	218,399	21.06	11
12	Dietician					12
13	Food Service Supervisor	1,936	2,080	52,714	25.34	13
14	Head Cook	18,096	18,795	300,042	15.96	14
15	Cook Helpers/Assistants	12,086	12,941	162,807	12.58	15
16	Dishwashers					16
17	Maintenance Workers	3,902	4,272	83,602	19.57	17
18	Housekeepers	27,786	29,432	349,524	11.88	18
19	Laundry	4,748	5,042	56,723	11.25	19
20	Administrator	5,919	6,434	105,629	16.42	20
21	Assistant Administrator	1,872	1,976	68,752	34.79	21
22	Other Administrative					22
23	Office Manager	1,935	2,039	37,867	18.57	23
24	Clerical	29,218	31,759	549,748	17.31	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,896	2,080	51,296	24.66	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	344,081	367,630	$ 7,397,768 *	$ 20.12	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	Monthly	$ 20,175	01-03	35
36	Medical Director	Monthly	81,371	09-03	36
37	Medical Records Consultant	Monthly	4,800	10-03	37
38	Nurse Consultant	Monthly	45,229	10-03	38
39	Pharmacist Consultant	Monthly	18,718	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	3,038	11-03	44
45	Social Service Consultant	Monthly	3,085	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 176,416		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	51	1,280	10-03	52
53	TOTAL (lines 50 - 52)	51	$ 1,280		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lily Osei	Administrator	0	$ 54,294
James Farlee	Administrator	0	51,335
Aleksandra Rozental	Assnt Administrator	0	68,752
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 174,381

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting Fees	$ 9,110
See Attached	Legal Fees	50,423
Documentation Solutions	Compliance Audit	5,820
Compliance Resources	Compliance Audit	1,924
ProPay HR	Payroll	37,662
Achieve Accreditation	Accreditation	5,785
ITT/Source Tech	IT Services	1,870
Staruss' Data Consulting	Data Research	24
PSD Solutions	IT Services	890
Prospect Resources	Natural Gas Procurement	900
See Supplemental Schedule		8,380
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 122,788

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 177,005
Unemployment Compensation Insurance	74,305
FICA Taxes	518,334
Employee Health Insurance	193,853
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Voluntary Benefits Contributions	20,730
401K Expense	13,865
Employee Physical Exams	4,197
Other Employee Benefits	32,072
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,034,361

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	12
Health Care Worker Background Check	10,754
(Indicate # of checks performed 1088)	
Patient Background Checks 358	3,578
Dues and Subscriptions	17,062
Licenses	13,967
Permits	2,385
Allocated Legacy Healthcare	1,031
See Supplemental Schedule	220
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 49,009

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,904
Allocated from Legacy Healthcare	1,362
Allocated from Progressive Consulting	974
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,240

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Avantara Long Grove # 0052639 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC = $22,644, IHCA = $2,301**

(3) Did the nursing home make political contributions or payments to a politica
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. $ **50,765** 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 fo
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 Departmen
during this cost report period. $ **447,382**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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 fo
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
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