FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 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 01/01/18 to 12/31/18 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
** 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: 01/01/18 Ending: 12/31/18

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	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	46,671	5,107	11,169	62,947	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,671	5,107	11,169	62,947	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.44%

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 9,552

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: 12/31/18 Fiscal Year: 12/31/18

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	446,287	41,290	118,112	605,689		605,689	1,275	606,964			1
2	Food Purchase		436,710		436,710		436,710	(18,453)	418,257			2
3	Housekeeping	288,966	61,776	44,758	395,500		395,500	2,006	397,506			3
4	Laundry	58,918	45,467		104,385		104,385	12	104,397			4
5	Heat and Other Utilities			190,489	190,489		190,489	(19,913)	170,576			5
6	Maintenance	89,167	31,406	210,273	330,846		330,846	18,183	349,029			6
7	Other (specify):*											7
8	**TOTAL General Services**	883,338	616,649	563,632	2,063,619		2,063,619	(16,889)	2,046,730			8
	B. Health Care and Programs											
9	Medical Director			53,582	53,582		53,582		53,582			9
10	Nursing and Medical Records	5,098,677	101,841	65,603	5,266,121		5,266,121	(93,345)	5,172,776			10
10a	Therapy	230,952			230,952		230,952		230,952			10a
11	Activities	185,462	8,512	760	194,734		194,734	80	194,814			11
12	Social Services	244,280		1,628	245,908		245,908	4,966	250,874			12
13	CNA Training											13
14	Program Transportation			57,455	57,455		57,455		57,455			14
15	Other (specify):*							9,147	9,147			15
16	**TOTAL Health Care and Programs**	5,759,371	110,353	179,028	6,048,752		6,048,752	(79,152)	5,969,600			16
	C. General Administration											
17	Administrative	176,082			176,082		176,082	105,621	281,703			17
18	Directors Fees											18
19	Professional Services			163,183	163,183		163,183	(22,643)	140,540			19
20	Dues, Fees, Subscriptions & Promotions			182,299	182,299		182,299	(126,166)	56,133			20
21	Clerical & General Office Expenses	667,283	9,001	738,865	1,415,149		1,415,149	(617,054)	798,095			21
22	Employee Benefits & Payroll Taxes			1,086,874	1,086,874		1,086,874	(103,255)	983,619			22
23	Inservice Training & Education											23
24	Travel and Seminar			332	332		332	3,499	3,831			24
25	Other Admin. Staff Transportation			6,585	6,585		6,585		6,585			25
26	Insurance-Prop.Liab.Malpractice			207,958	207,958		207,958	16,481	224,439			26
27	Other (specify):*							66,932	66,932			27
28	**TOTAL General Administration**	843,365	9,001	2,386,096	3,238,462		3,238,462	(676,585)	2,561,877			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	7,486,074	736,003	3,128,756	11,350,833		11,350,833	(772,626)	10,578,207			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: 01/01/18 Ending: 12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							647,995	647,995			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			76,904	76,904		76,904	540,137	617,041			32
33	Real Estate Taxes							133,596	133,596			33
34	Rent-Facility & Grounds			2,100,000	2,100,000		2,100,000	(2,099,817)	183			34
35	Rent-Equipment & Vehicles			12,545	12,545		12,545	4,775	17,320			35
36	Other (specify):*							201,054	201,054			36
37	**TOTAL Ownership**			2,189,449	2,189,449		2,189,449	(572,260)	1,617,189			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	26,900	582,330	1,736,873	2,346,103		2,346,103		2,346,103			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			429,167	429,167		429,167		429,167			42
43	Other (specify):*			861,455	861,455		861,455	(861,455)	(0)			43
44	**TOTAL Special Cost Centers**	26,900	582,330	3,027,495	3,636,725		3,636,725	(861,455)	2,775,270			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,512,974	1,318,333	8,345,700	17,177,007		17,177,007	(2,206,341)	14,970,666			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: 01/01/18 Ending: 12/31/18

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(21,106)	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	(27,955)	30		9
10	Interest and Other Investment Income	(201,581)	32		10
11	Discounts, Allowances, Rebates & Refunds	(18,120)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(354)	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	(11,011)	21		18
19	Entertainment	(11,635)	21		19
20	Contributions	(73,750)	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	(408,930)	21		24
25	Fund Raising, Advertising and Promotional	(35,567)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,101)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,058,963)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,875,073)		$	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)	(331,268)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (331,268)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,206,341)		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: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Personal Items	$ (5,659)	10	1
2	Bank Charges	(5,170)	21	2
3	Sequestration	(120,255)	21	3
4	Rebates	(1,819)	21	4
5	Non Allowable Expense	(860,320)	43	5
6	Bldg Co - Bank Fees	(359)	21	6
7	Bldg Co - Filing Fees	(75)	20	7
8	Bldg Co - Accounting Fees	(22,543)	19	8
9	Bldg Co - Amortization	(5,888)	36	9
10	Additional R&M	8,506	06	10
11	PAC Dues	(17,580)	20	11
12	Non Allowable Legal	(26,666)	19	12
13	Non Allowable Professional Fees	(1,135)	43	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,058,963)		49

Avantara Long Grove

ID# 0052639

Report Period Beginning: 01/01/18

Ending: 12/31/18

	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: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			1,275									1,275	1
2	Food Purchase	(18,474)		21									(18,453)	2
3	Housekeeping			2,006									2,006	3
4	Laundry			12									12	4
5	Heat and Other Utilities	(21,106)				1,193							(19,913)	5
6	Maintenance	8,506		10,016		1,606	(1,945)						18,183	6
7	Other (specify):*													7
8	**TOTAL General Services**	(31,074)		13,331		2,799	(1,945)						(16,889)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(5,659)		82,191	(169,618)				(259)				(93,345)	10
10a	Therapy													10a
11	Activities			80									80	11
12	Social Services			4,966									4,966	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				9,147								9,147	15
16	**TOTAL Health Care and Programs**	(5,659)		87,237	(160,471)				(259)				(79,152)	16
	C. General Administration													
17	Administrative			105,621									105,621	17
18	Directors Fees													18
19	Professional Services	(49,209)	22,543	12,841		50		(8,868)					(22,643)	19
20	Fees, Subscriptions & Promotions	(126,972)	75	730		1							(126,166)	20
21	Clerical & General Office Expenses	(565,280)	359	441,889	(494,414)	393							(617,054)	21
22	Employee Benefits & Payroll Taxes				(103,255)								(103,255)	22
23	Inservice Training & Education													23
24	Travel and Seminar			3,499									3,499	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice		10,076	5,945		460							16,481	26
27	Other (specify):*			66,932									66,932	27
28	**TOTAL General Administration**	(741,461)	33,053	637,457	(597,669)	904		(8,868)					(676,585)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(778,194)	33,053	738,024	(758,140)	3,703	(1,945)	(8,868)	(259)				(772,626)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Avantara Long Grove # 0052639 **Report Period Beginning:** 01/01/18 **Ending:** 12/31/18

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	(27,955)	675,950										647,995	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(201,581)	735,995	39		5,684							540,137	32
33	Real Estate Taxes		128,186			5,410							133,596	33
34	Rent-Facility & Grounds		(2,100,000)	49,330		(49,147)							(2,099,817)	34
35	Rent-Equipment & Vehicles				4,775								4,775	35
36	Other (specify):*	(5,888)	206,942										201,054	36
37	**TOTAL Ownership**	(235,424)	(352,926)	49,369	4,775	(38,054)							(572,260)	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):*	(861,455)											(861,455)	43
44	**TOTAL Special Cost Centers**	(861,455)											(861,455)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,875,073)	(319,873)	787,394	(753,366)	(34,350)	(1,945)	(8,868)	(259)				(2,206,341)	45

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 2,100,000	Buffalo Property Holdings LLC		$	$ (2,100,000)	1
2	V	32	Interest Income	646	Buffalo Property Holdings LLC			(646)	2
3	V	33	Real Estate Tax Expense		Buffalo Property Holdings LLC		128,186	128,186	3
4	V	26	Property Insurance Expense		Buffalo Property Holdings LLC		10,076	10,076	4
5	V	36	MIP - Mortgage Insurance Premium Expense		Buffalo Property Holdings LLC		201,054	201,054	5
6	V	21	Bank Fees		Buffalo Property Holdings LLC		359	359	6
7	V	20	Filing Fees		Buffalo Property Holdings LLC		75	75	7
8	V	19	Professional Fees - Accounting		Buffalo Property Holdings LLC		22,543	22,543	8
9	V	32	Interest Expense - Mortgage B		Buffalo Property Holdings LLC		736,641	736,641	9
10	V	30	Depreciation Expense		Buffalo Property Holdings LLC		675,950	675,950	10
11	V	36	Amortization Expense		Buffalo Property Holdings LLC		5,888	5,888	11
12	V								12
13	V								13
14	Total			$ 2,100,646			$ 1,780,773	$ * (319,873)	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: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETICIAN SALARY	$	Legacy Healthcare Financial Services		$ 1,202	$ 1,202	15
16	V	01	DIETARY SUPPLIES		Legacy Healthcare Financial Services		73	73	16
17	V	02	FOOD		Legacy Healthcare Financial Services		21	21	17
18	V	03	HOUSEKEEPING		Legacy Healthcare Financial Services		2,006	2,006	18
19	V	04	LINEN REPLACEMENT		Legacy Healthcare Financial Services		12	12	19
20	V	06	MAINTENANCE SALARY		Legacy Healthcare Financial Services		8,529	8,529	20
21	V	06	REPAIRS AND MAINTENANCE		Legacy Healthcare Financial Services		1,487	1,487	21
22	V	10	NURSING SALARY		Legacy Healthcare Financial Services		78,870	78,870	22
23	V	10	NURSE CONSULTANT		Legacy Healthcare Financial Services		3,230	3,230	23
24	V	10	MEDICAL SUPPLIES		Legacy Healthcare Financial Services		90	90	24
25	V	12	SOCIAL SERVICE SALARY		Legacy Healthcare Financial Services		4,937	4,937	25
26	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services		80	80	26
27	V	12	SOCIAL SERVICE CONSULTANT		Legacy Healthcare Financial Services		29	29	27
28	V	17	CFO/ADMINISTRATIVE SALARY		Legacy Healthcare Financial Services		105,621	105,621	28
29	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services		12,841	12,841	29
30	V	20	DUES/LICENSE/PERMITS		Legacy Healthcare Financial Services		730	730	30
31	V	21	CLERICAL AND GENERAL WAGES		Legacy Healthcare Financial Services		429,467	429,467	31
32	V	21	CLERICAL AND OFFICE EXPENSE		Legacy Healthcare Financial Services		12,422	12,422	32
33	V	24	EDUCATION AND SEMINARS		Legacy Healthcare Financial Services		3,499	3,499	33
34	V	26	INSURANCE- GENERAL		Legacy Healthcare Financial Services		5,945	5,945	34
35	V	27	NON-NURSING PAYROLL TAXES/BENEFITS		Legacy Healthcare Financial Services		66,932	66,932	35
36	V	32	INTEREST		Legacy Healthcare Financial Services		39	39	36
37	V	34	RENT		Legacy Healthcare Financial Services		49,147	49,147	37
38	V	34	OFFSITE STORAGE/PARKING		Legacy Healthcare Financial Services		183	183	38
39	Total			$			$ 787,394	$ * 787,394	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: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services		256	$ 256	15
16	V	35	AUTO RENTAL		Legacy Healthcare Financial Services		4,519	4,519	16
17	V	15	NURSING PAYROLL TAXES/BENEFITS		Legacy Healthcare Financial Services		9,147	9,147	17
18	V								18
19	V	10	NURSE SALARY	169,618	Legacy Healthcare Financial Services			(169,618)	19
20	V	21	ADMINISTRATIVE SALARY	494,414	Legacy Healthcare Financial Services			(494,414)	20
21	V	22	REIMB PAYROLL TAXES	103,255	Legacy Healthcare Financial Services			(103,255)	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			$ 767,287			$ 13,921	$ * (753,366)	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: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	CF St. Louis LLC		$ 1,193	$ 1,193	15
16	V	6	REPAIRS & MAINTENANCE		CF St. Louis LLC		1,606	1,606	16
17	V	19	PROFESSIONAL FEES		CF St. Louis LLC		50	50	17
18	V	20	DUES & SUBSCRIPTIONS		CF St. Louis LLC		1	1	18
19	V	21	OFFICE EXPENSE		CF St. Louis LLC		393	393	19
20	V	26	INSURANCE		CF St. Louis LLC		460	460	20
21	V	32	INTEREST EXPENSE		CF St. Louis LLC		5,684	5,684	21
22	V	33	REAL ESTATE TAXES		CF St. Louis LLC		5,410	5,410	22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	49,147	CF St. Louis LLC			(49,147)	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			$ 49,147			$ 14,797	$ * (34,350)	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: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance	$ 26,140	ML Group Design & Development		$ 24,195	$ (1,945)	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			$ 26,140			$ 24,195	$ * (1,945)	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: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Processing	$ 33,872	ProPay HR LLC		$ 25,004	$ (8,868)	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			$ 33,872			$ 25,004	$ * (8,868)	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: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Medical Supplies	$ 9,000	ReMED Services		$ 8,741	$ (259)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,000			$ 8,741	$ * (259)	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: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

VII. RELATED PARTIES

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

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								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: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	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: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [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: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETICIAN SALARY	AVAIL. BED DAYS	1,918,919	34	$ 33,257	$ 33,257	69,350	$ 1,202	1
2	01	DIETARY SUPPLIES	AVAIL. BED DAYS	1,918,919	34	2,031		69,350	73	2
3	02	FOOD	AVAIL. BED DAYS	1,918,919	34	595		69,350	21	3
4	03	HOUSEKEEPING	AVAIL. BED DAYS	1,918,919	34	55,512		69,350	2,006	4
5	04	LINEN REPLACEMENT	AVAIL. BED DAYS	1,918,919	34	343		69,350	12	5
6	06	MAINTENANCE SALARY	AVAIL. BED DAYS	1,918,919	34	235,999	235,999	69,350	8,529	6
7	06	REPAIRS AND MAINTENANCE	AVAIL. BED DAYS	1,918,919	34	41,154		69,350	1,487	7
8	10	NURSING SALARY	AVAIL. BED DAYS	1,918,919	34	2,182,345	2,182,345	69,350	78,870	8
9	10	NURSE CONSULTANT	AVAIL. BED DAYS	1,918,919	34	89,384		69,350	3,230	9
10	10	MEDICAL SUPPLIES	AVAIL. BED DAYS	1,918,919	34	2,503		69,350	90	10
11	12	SOCIAL SERVICE SALARY	AVAIL. BED DAYS	1,918,919	34	136,611	136,611	69,350	4,937	11
12	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,918,919	34	2,204		69,350	80	12
13	12	SOCIAL SERVICE CONSULTAN	AVAIL. BED DAYS	1,918,919	34	800		69,350	29	13
14	17	CFO/ADMINISTRATIVE SALAR	AVAIL. BED DAYS	1,918,919	34	2,922,553	2,922,553	69,350	105,621	14
15	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,918,919	34	355,302		69,350	12,841	15
16	20	DUES/LICENSE/PERMITS	AVAIL. BED DAYS	1,918,919	34	20,207		69,350	730	16
17	21	CLERICAL AND GENERAL WA	AVAIL. BED DAYS	1,918,919	34	11,883,371	11,883,371	69,350	429,467	17
18	21	CLERICAL AND OFFICE EXPE	AVAIL. BED DAYS	1,918,919	34	343,715		69,350	12,422	18
19	24	EDUCATION AND SEMINARS	AVAIL. BED DAYS	1,918,919	34	96,819		69,350	3,499	19
20	26	INSURANCE- GENERAL	AVAIL. BED DAYS	1,918,919	34	164,496		69,350	5,945	20
21	27	NON-NURSING PAYROLL TAX	AVAIL. BED DAYS	1,918,919	34	1,852,008		69,350	66,932	21
22	32	INTEREST	AVAIL. BED DAYS	1,918,919	34	1,074		69,350	39	22
23	34	RENT	AVAIL. BED DAYS	1,918,919	34	1,359,900		69,350	49,147	23
24	34	OFFSITE STORAGE/PARKING	AVAIL. BED DAYS	1,918,919	34	5,072		69,350	183	24
25	TOTALS					$ 21,787,253	$ 17,394,136		$ 787,394	25

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,918,919	34	7,088		69,350	256	1
2	35	AUTO RENTAL	AVAIL. BED DAYS	1,918,919	34	125,028		69,350	4,519	2
3	15	NURSING PAYROLL TAXES/BE	AVAIL. BED DAYS	1,918,919	34	253,092		69,350	9,147	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					$ 385,208	$		$ 13,921	25

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. BED DAYS	1,916,917	34	$ 32,982	$	69,350	$ 1,193	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,916,917	34	44,396		69,350	1,606	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,916,917	34	1,378		69,350	50	3
4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,916,917	34	23		69,350	1	4
5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,916,917	34	10,860		69,350	393	5
6	26	INSURANCE	AVAIL. BED DAYS	1,916,917	34	12,721		69,350	460	6
7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,916,917	34	157,106		69,350	5,684	7
8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,916,917	34	149,528		69,350	5,410	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 408,994	$		$ 14,797	25

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: 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			$	$		$ 24,195	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					$	$		$ 24,195	25

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: ProPay HR LLC
Street Address: 2201 W Main 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			$	$		$ 25,004	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					$	$		$ 25,004	25

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: ReMED Services LLC
Street Address: 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			$	$		$ 8,741	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					$	$		$ 8,741	25

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/18 Ending: 12/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** 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	Private Bank		X	Mortgage			$	$ 21,140,351			$ 736,641	1
2	Note Payable		X	Note Payable				425,000			76,904	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 21,565,351			$ 813,545	9
	B. Non-Facility Related*											
10	Interest Income		X								(201,581)	10
11	Interest Income - Bldg Co		X								(646)	11
12	Allocated from CF St. Louis	X									5,684	12
13	See Supplemental Schedule										39	13
14	TOTAL Non-Facility Related						$	$			$ (196,504)	14
15	TOTALS (line 9+line14)						$	$ 21,565,351			$ 617,041	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 201,054 Line # 36

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

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 121,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 126,964	2
3. Under or (over) accrual (line 2 minus line 1).		$ 5,964	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 127,632	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 133,596	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	118,391	8
	2014	110,083	9
	2015	115,237	10
	2016	117,436	11
	2017	121,554	12

2018 Accrual = $121,554 x 1.05 = $127,632
Allocated from CF St Louis = $5,410
Beginning Accrual Adjusted

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Avantara Long Grove COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0052639

CONTACT PERSON REGARDING THIS REPORT

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 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-31-201-082	Long Term Care Property	$ 114,066.55	$ 114,066.55
2.	15-31-201-083	Long Term Care Property	$ 7,487.89	$ 7,487.89
3.	10-23-406-034-0000	Home Office Allocation	$ 492,481.94	$ 5,409.60
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 614,036.38	$ 126,964.04

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2017 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 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Avantara Long Grove COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0052639

CONTACT PERSON REGARDING THIS REPORT

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 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/18 Ending: 12/31/18

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			7,140	2
3	TOTALS			$ 1,489,516	3

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	195		2016		$ 12,961,389	$ 675,950	35	$ 370,325	$ (305,625)	$ 1,110,975	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2014	167,468		20	8,375	8,375	41,870	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: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		282,962			13,324	13,324	39,667	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 13,411,819	$ 675,950		$ 392,024	$ (283,926)	$ 1,192,512	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: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 13,411,819	$ 675,950		$ 392,024	$ (283,926)	$ 1,192,512	1
2	Sprinkler System	2015	6,237		20	312	312	1,248	2
3	Resid Rms - 36 Receptacles And Wiring	2015	7,810		20	391	391	1,563	3
4	Roof Repairs	2015	37,100		20	1,855	1,855	7,420	4
5	Exterior Concrete And Gravel Base	2015	12,780		20	639	639	2,556	5
6	Open Cell On Roof	2015	13,500		20	675	675	2,700	6
7	Repaired Chiller	2015	2,921		20	146	146	584	7
8	Repaired Pumps	2015	23,873		20	1,194	1,194	4,775	8
9	Repaired Pavement, Sewer/Sealcoating/Restriping	2015	11,430		20	572	572	2,287	9
10	Installed Fire Alarm System	2015	13,665		20	683	683	2,733	10
11	Installed Two Elevator Pit Ladders	2015	2,500		20	125	125	500	11
12	Repaired 3 Pump Bodies And Pipes	2015	5,389		20	269	269	1,077	12
13	Signage For Library/Office/Pt/Ot/Conference Rms	2015	5,910		20	295	295	1,181	13
14	Wanderguard System - Lower/Upper Levels For 100-400 Wings	2015	40,744		20	2,037	2,037	8,148	14
15	Repaired Fence	2015	3,200		20	160	160	640	15
16	Installed Storage Tank For Plumbing	2015	3,900		20	195	195	780	16
17	Repaired Plumbing In Kitchen	2015	3,268		20	163	163	653	17
18	Wiring For Phone Systems	2015	3,597		20	180	180	720	18
19	New Unit Interior Signage	2015	4,334		20	217	217	867	19
20	Installed Fire Alarm System	2015	38,639		20	1,932	1,932	7,728	20
21	Corridor Light Fixtures	2015	4,557		20	228	228	912	21
22	30 Corridor Wall Sconces And 36 Flush Mount	2015	17,372		20	869	869	3,475	22
23	Canopy Light Fixtures	2015	2,925		20	146	146	585	23
24	Faucets	2015	7,439		20	372	372	1,488	24
25	Chandelier	2015	5,654		20	283	283	1,131	25
26	Bathroom Mirrors	2015	3,733		20	187	187	747	26
27	Corridor Light Fixtures	2015	4,331		20	217	217	867	27
28	Lobby Drapery	2015	2,584		20	129	129	516	28
29	Patient Room Shades	2015	10,785		20	539	539	2,157	29
30	62 Handrails And 46 Casings For Doors In Corridor	2015	20,448		20	1,022	1,022	4,089	30
31	Bathroom Shower Curtains	2015	3,582		20	179	179	716	31
32	Resident Room Bedside Sconces	2015	10,052		20	503	503	2,011	32
33	Installed A/C Units In Lower Level Office Area	2015	8,182		20	409	409	1,636	33
34	TOTAL (lines 1 thru 33)		$ 13,754,259	$ 675,950		$ 409,147	$ (266,803)	$ 1,261,002	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: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 13,754,259	$ 675,950		$ 409,147	$ (266,803)	$ 1,261,002	1
2	Hr Office/Storage Rooms/Elevator/Lobby - Prep/Prime/Paint Walls	2015	14,665		20	733	733	2,933	2
3	Demolition/Concrete/Excavation/Masonry For Exterior Signs	2015	34,850		20	1,743	1,743	6,971	3
4	Outside Sprinkler System Repair/Installed Entrance Tree	2015	31,724		20	1,586	1,586	6,344	4
5	Installed 2 Guard Rails And Ramp Rails	2016	6,400		20	320	320	960	5
6	Installed Zone Dampers In Front Office And Lobby	2016	8,636		20	432	432	1,296	6
7	Related Architect/Enginneering Fees	2016	1,822,062		20	91,103	91,103	273,309	7
8	Kitchen Floor Repair/Demo/Installed New Tiling	2016	3,915		20	196	196	588	8
9	1St Floor South Wing, Office, Hallway - Repaired Boiler/Installed I	2016	3,238		20	74	74	223	9
10	Pcc Kiosk	2016	3,550		20	118	118	355	10
11	Installed New Post Holes, Railing, And Concrete	2016	3,800		20	111	111	332	11
12	Installed Two Commercial Storage Tanks/Pipes/Valves	2016	7,800		20	195	195	585	12
13	Kitchen Heat Machine	2016	13,675		20	760	760	2,279	13
14	Repaired Pipes In Pt Room	2016	7,603		20	95	95	285	14
15	Repaired Radiator In Cooling System	2016	7,659		20	383	383	1,149	15
16	Front Entry Door Landscaping - Soil, Mulch, Lane Repairs	2016	16,641		20	438	438	1,315	16
17	Install New Door/Frame/Hardware	2017	11,516		20	576	576	1,152	17
18	New Ceiling & Floor In Dinnig Room, New Drywall/Floor In Utility	2017	55,960		20	2,565	2,565	5,130	18
19	Water Pump Work	2017	9,159		20	382	382	764	19
20	Deep Well Replacement	2017	41,615		20	1,387	1,387	2,774	20
21	New Concrete In Front Of The Ramp	2017	3,000		20	75	75	150	21
22	Repairs To Outside Walls, Foundation, Storage Room	2017	4,250		20	89	89	178	22
23	Furnished & Installed Domestic Hot Water Storage Tank	2017	23,977		20	500	500	1,000	23
24	Elevator- Door Restrictors, Car Identification Plates, And Stencil Ir	2017	3,453		20	460	460	920	24
25	Installed Fire Alarm System For Corridor	2017	6,066		20	303	303	607	25
26	Installed Hot Water Booster	2017	14,455		20	723	723	1,446	26
27	Repaired Metal Stairway East Side Of Building	2017	4,250		20	213	213	425	27
28	Installed Breaker Panel And Connected To Transfer Switch-1St Fl	2017	10,570		20	529	529	1,057	28
29	Repaired Ac System In Office	2017	6,788		20	339	339	679	29
30	Repiped Boiler	2017	4,679		20	4,679	4,679	4,679	30
31	Ductless Ac (7,500)	2018	6,942		20	188	188	188	31
32	Replace Kitchen Drain (4,600)	2018	4,258		20	173	173	173	32
33	Hot Water Motorized Valve With Digital Controller (2,900)	2018	2,684		20	97	97	97	33
34	TOTAL (lines 1 thru 33)		$ 15,954,100	$ 675,950		$ 520,712	$ (155,238)	$ 1,581,345	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: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 15,954,100	$ 675,950		$ 520,712	$ (155,238)	$ 1,581,345	1
2	Built In Booster Heater (7,700)	2018	7,127		20	1,155	1,155	1,155	2
3	Replacement Of Compressor (2,550)	2018	2,360		20	383	383	383	3
4	Kitchen Plumbing, Electrical, Tile, Make Window (36,000)	2018	33,322		20	3,300	3,300	3,300	4
5	Repair Sprinkler Pipes In Room 343 (2,650)	2018	2,453		20	123	123	123	5
6	Mill & Pave West Side Lot (12,300)	2018	11,385		20	569	569	569	6
7	Design Fee - Kitchen Plumbing, Electrical, Tile, Make Window (21,	2018	19,438		20	972	972	972	7
8	Add Longer Drain In Kitchen (8,700)	2018	8,053		20	403	403	403	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)		$ 16,038,237	$ 675,950		$ 527,617	$ (148,333)	$ 1,588,249	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: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 16,038,237	$ 675,950		$ 527,617	$ (148,333)	$ 1,588,249	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 16,038,237	$ 675,950		$ 527,617	$ (148,333)	$ 1,588,249	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: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	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: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 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
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: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party								1
2	Buildings:								2
3	Allocated from CF St. Louis, LLC	2016	38,445		35	1,098	1,098	3,295	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	238,692		20	11,935	11,935	35,804	9
10	Allocated from CF St. Louis, LLC	2017	5,540		20	277	277	554	10
11									11
12									12
13	Allocated from Legacy HC	2018	285		20	14	14	14	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)		$ 282,962	$		$ 13,324	$ 13,324	$ 39,667	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: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 282,962	$		$ 13,324	$ 13,324	$ 39,667	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 282,962	$		$ 13,324	$ 13,324	$ 39,667	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: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,134,910	$	$ 117,269	$ 117,269	10	$ 446,417	71
72	Current Year Purchases	30,270		3,110	3,110	10	3,110	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,165,180	$	$ 120,379	$ 120,379		$ 449,526	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)	$ 18,692,933	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 675,950	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 647,995	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (27,955)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,037,775	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: 01/01/18 Ending: 12/31/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated Legacy HC				183			6
7	TOTAL				$ 183 **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 12,801 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		$	$ 4,519	17
18					18
19					19
20					20
21	TOTAL		$	$ 4,519	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: 01/01/18 Ending: 12/31/18

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 573,802	$		$ 573,802	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			170,430			170,430	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			889,745			889,745	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				369,176		369,176	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):			26,900		102,896	213,154		342,950	13
14	TOTAL			$ 26,900		$ 1,736,873	$ 582,330		$ 2,346,103	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: 01/01/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 34,215	$ 262,435	1
2	Cash-Patient Deposits	41,317	41,317	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,957,596	2,957,596	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	45,200	145,236	6
7	Other Prepaid Expenses	98,492	98,492	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	32,011	140,898	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,208,831	$ 3,645,974	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	1,149,513	3,376,181	15
16	Equipment, at Historical Cost	880,765	1,485,464	16
17	Accumulated Depreciation (book methods)	(751,708)	(2,047,076)	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	2,877,012	4,155,520	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,155,582	$ 21,413,855	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,364,413	$ 25,059,829	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,683,636	$ 1,714,751	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	412,462	412,462	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,155	21,155	31
32	Accrued Real Estate Taxes(Sch.IX-B)		127,632	32
33	Accrued Interest Payable		60,955	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	187,889	187,889	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,305,142	$ 2,524,844	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	425,000	425,000	39
40	Mortgage Payable		21,140,351	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	1,563,697	167,780	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,988,697	$ 21,733,131	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,293,839	$ 24,257,975	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,070,574	$ 801,854	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,364,413	$ 25,059,829	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,756,195	1
2	Restatements (describe):		2
3	**Prior Year Rent**	62,331	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,818,526	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	252,048	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)**	$ 252,048	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,070,574	24 *

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 20,373,075	1
2	Discounts and Allowances for all Levels	(9,622,765)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,750,310	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,025,799	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 6,025,799	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	364,066	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	51,307	19
20	Radiology and X-Ray	55	20
21	Other Medical Services	15,998	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 431,426	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	201,581	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 201,581	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	19,939	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 19,939	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,429,055	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,063,619	31
32	Health Care	6,048,752	32
33	General Administration	3,238,462	33
	B. Capital Expense		
34	Ownership	2,189,449	34
	C. Ancillary Expense		
35	Special Cost Centers	3,207,558	35
36	Provider Participation Fee	429,167	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,177,007	40
41	**Income before Income Taxes (line 30 minus line 40)****	252,048	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 252,048	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 9,183,048	44
45	Private Pay - Net Inpatient Revenue	792,170	45
46	Medicare - Net Inpatient Revenue	651,102	46
47	Other-(specify) Insurance	123,990	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,750,310	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	1,896	2,118	$ 103,867	$ 49.04	1
2	Assistant Director of Nursing	1,848	2,080	93,836	45.11	2
3	Registered Nurses	39,978	43,932	1,571,746	35.78	3
4	Licensed Practical Nurses	41,973	46,276	1,408,856	30.44	4
5	CNAs & Orderlies	109,346	117,749	1,894,377	16.09	5
6	CNA Trainees					6
7	Licensed Therapist	657	753	26,900	35.72	7
8	Rehab/Therapy Aides	9,539	10,589	230,952	21.81	8
9	Activity Director	1,688	1,948	39,308	20.18	9
10	Activity Assistants	9,931	11,230	146,154	13.01	10
11	Social Service Workers	9,632	10,440	244,280	23.40	11
12	Dietician					12
13	Food Service Supervisor	1,888	2,040	51,151	25.07	13
14	Head Cook	11,129	12,095	185,864	15.37	14
15	Cook Helpers/Assistants	15,750	16,557	209,272	12.64	15
16	Dishwashers					16
17	Maintenance Workers	3,530	4,042	89,167	22.06	17
18	Housekeepers	22,753	24,745	288,966	11.68	18
19	Laundry	4,892	5,286	58,918	11.15	19
20	Administrator	1,992	2,176	115,674	53.16	20
21	Assistant Administrator	1,744	1,928	60,408	31.33	21
22	Other Administrative					22
23	Office Manager	1,935	2,119	39,186	18.49	23
24	Clerical	31,669	35,583	628,097	17.65	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	912	1,124	25,995	23.13	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	324,682	354,809	$ 7,512,974 *	$ 21.17	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	$ 118,112	01-03	35
36	Medical Director	Monthly	53,582	09-03	36
37	Medical Records Consultant	Monthly	400	10-03	37
38	Nurse Consultant	Monthly	45,529	10-03	38
39	Pharmacist Consultant	Monthly	19,674	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	760	11-03	44
45	Social Service Consultant	Monthly	1,628	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 239,685		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lily Osei	Administrator	0	$ 115,674
Aleksandra Rozental	Asst. Admin	0	60,408
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 176,082

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	$ 47,944
See Attached	Legal Fees	34,639
Compliance Resources	Compliance Audit	169
Paycor	Payroll Processing	33,872
Agile MD Inc.	E.H.R. Consultant	594
Achieve Accreditation LLC	Accreditation	11,560
IIT/Sourcetech	Data Processing	2,205
Integra Scripts LLC	Data Processing	19,871
Lighthouse Services, Inc	Reporting Hotline Consultant	271
MTS Consulting	Tax Consultant	1,522
Personnel Planners	Unemployment Consultant	1,260
See Supplemental Schedule		9,277
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 163,183

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 173,551
Unemployment Compensation Insurance	35,310
FICA Taxes	508,973
Employee Health Insurance	197,390
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Voluntary Benefits Contributions	10,110
401K Expense	27,040
Employee Physical Exams	8,753
Other Employee Benefits	22,492
TOTAL (agree to Schedule V, line 22, col.8)	$ 983,619

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,327
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 156)	1,568
Patient Background Checks 454	4,548
Dues & Subscriptions	33,769
Licenses & Permits	14,190
Allocated from Legacy HC	730
Allocated from CF St. Louis	1
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 56,133

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	332
Allocated from Legacy HC	3,499
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,831

* Attach copy of IMRF notifications

**See instructions.

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI $27,144 ; IHCA $12,578**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **57,113** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **429,167**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

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

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

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

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