FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0052423

Facility Name: Avantara Evergreen Park

Address: 10124 South Kedzie (Number) — Evergreen Park (City) — 60805 (Zip Code)

County: Cook

Telephone Number: (708) 907-7000 **Fax #** (708) 907-7003

HFS ID Number:

Date of Initial License for Current Owners: 8/1/2013

Type of Ownership:

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

IRS Exemption Code

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/20 to 12/31/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) ____ 04/29/2021
** Subject to the attached Accountants' Consulting Report* (Date)
(Print Name and Title) Steven N. Lavenda, CPA
Partner
(Firm Name & Address) Marcum, LLP
9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	242	Skilled (SNF)	242	88,572	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	242	TOTALS	242	88,572	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	25,358	3,694	18,233	47,285	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,358	3,694	18,233	47,285	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.39%

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 8/1/2013

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/1/2013 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 242 and days of care provided 10,225

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: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary		497	1,287,720	1,288,217		1,288,217	4,568	1,292,785			1
2	Food Purchase		71		71		71	8,690	8,761			2
3	Housekeeping		3,029	394,163	397,192		397,192	2,962	400,154			3
4	Laundry		283,585		283,585		283,585	201	283,786			4
5	Heat and Other Utilities			255,286	255,286		255,286	(12,477)	242,809			5
6	Maintenance	109,796	12,814	219,088	341,698		341,698	2,957	344,655			6
7	Other (specify):*											7
8	TOTAL General Services	109,796	299,996	2,156,257	2,566,049		2,566,049	6,901	2,572,950			8
	B. Health Care and Programs											
9	Medical Director			58,125	58,125		58,125		58,125			9
10	Nursing and Medical Records	5,470,089	563,102	62,945	6,096,136		6,096,136	95,011	6,191,147			10
10a	Therapy	271,230	966		272,196		272,196		272,196			10a
11	Activities	116,348	6,670	866	123,884		123,884	12	123,896			11
12	Social Services	575,539		3,942	579,481		579,481	7,935	587,416			12
13	CNA Training											13
14	Program Transportation			144,549	144,549		144,549		144,549			14
15	Other (specify):*							8,230	8,230			15
16	TOTAL Health Care and Programs	6,433,206	570,738	270,427	7,274,371		7,274,371	111,188	7,385,559			16
	C. General Administration											
17	Administrative	152,271			152,271		152,271	88,326	240,597			17
18	Directors Fees											18
19	Professional Services			337,067	337,067	(3,279)	333,788	(6,212)	327,576			19
20	Dues, Fees, Subscriptions & Promotions			103,672	103,672		103,672	(37,038)	66,634			20
21	Clerical & General Office Expenses	201,398	3,173	699,019	903,590		903,590	(145,459)	758,131			21
22	Employee Benefits & Payroll Taxes			1,105,447	1,105,447		1,105,447		1,105,447			22
23	Inservice Training & Education											23
24	Travel and Seminar			433	433		433	197	630			24
25	Other Admin. Staff Transportation			1,566	1,566		1,566	6,603	8,169			25
26	Insurance-Prop.Liab.Malpractice			489,568	489,568		489,568	562	490,130			26
27	Other (specify):*							35,402	35,402			27
28	TOTAL General Administration	353,669	3,173	2,736,772	3,093,614	(3,279)	3,090,335	(57,619)	3,032,716			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,896,671	873,907	5,163,456	12,934,034	(3,279)	12,930,755	60,470	12,991,225			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			511,750	511,750		511,750	303,457	815,207			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			35,869	35,869		35,869	1,102,167	1,138,036			32
33	Real Estate Taxes			56,261	56,261	3,279	59,540	364,865	424,405			33
34	Rent-Facility & Grounds			1,786,185	1,786,185		1,786,185	(1,774,661)	11,524			34
35	Rent-Equipment & Vehicles			20,466	20,466		20,466	6,414	26,880			35
36	Other (specify):*			680,000	680,000		680,000	(680,000)				36
37	**TOTAL Ownership**			3,090,531	3,090,531	3,279	3,093,810	(677,757)	2,416,053			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		844,513	2,075,287	2,919,800		2,919,800	(41,607)	2,878,193			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			299,680	299,680		299,680		299,680			42
43	Other (specify):*			933,889	933,889		933,889	(933,889)	0			43
44	**TOTAL Special Cost Centers**		844,513	3,308,856	4,153,369		4,153,369	(975,496)	3,177,873			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,896,671	1,718,420	11,562,843	20,177,934		20,177,934	(1,592,783)	18,585,151			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 Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(14,022)	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	96,696	30		9
10	Interest and Other Investment Income	(2,759)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		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	(6,522)	21		18
19	Entertainment	(1,450)	21		19
20	Contributions	(15,750)	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	(423,479)	21		24
25	Fund Raising, Advertising and Promotional	(8,998)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,858,807)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,235,091)		$	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)	642,308		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 642,308		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,592,783)		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 Evergreen Park

ID# 0052423

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Personal Items	$ (3,509)	10	1
2	Bank Charges	(14,990)	21	2
3	Sequestration Expense	(80,252)	21	3
4	Pharmacy Discounts	(13,602)	10	4
5	Rebates	(37,057)	10	5
6	Miscellaneous Income	(1,387)	21	6
7	Swag Store	(103)	21	7
8	Non-Allowable Expense	(924,385)	43	8
9	Capitalized R&M	(13,389)	06	9
10	PAC Dues	(16,722)	20	10
11	Non-Allowable Expense	(1,504)	43	11
12	Non-Allowable Consulting	(8,000)	43	12
13	Non-Allowable Legal	(29,920)	19	13
14	Building Co. - Accounting Fees	(3,886)	19	14
15	Building Co. - Amortization	(29,582)	36	15
16	Amortization	(680,000)	36	16
17	Prior Year Dues	(519)	20	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**	(1,858,807)		49

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

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

STATE OF ILLINOIS **Page 5B**

Avantara Evergreen Park

ID# 0052423
Report Period Beginning: 01/01/20
Ending: 12/31/20

	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

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			4,568									4,568	1
2	Food Purchase			8,690									8,690	2
3	Housekeeping			2,962									2,962	3
4	Laundry			201									201	4
5	Heat and Other Utilities	(14,022)				1,545							(12,477)	5
6	Maintenance	(13,389)		14,849		1,497							2,957	6
7	Other (specify):*													7
8	**TOTAL General Services**	(27,411)		31,270		3,042							6,901	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(54,168)		151,892			(2,713)						95,011	10
10a	Therapy													10a
11	Activities			12									12	11
12	Social Services			7,935									7,935	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				8,230								8,230	15
16	**TOTAL Health Care and Programs**	(54,168)		159,839	8,230		(2,713)						111,188	16
	C. General Administration													
17	Administrative			88,326									88,326	17
18	Directors Fees													18
19	Professional Services	(33,806)	6,636	28,997		649		(8,688)					(6,212)	19
20	Fees, Subscriptions & Promotions	(41,989)		4,951		1							(37,038)	20
21	Clerical & General Office Expenses	(528,183)		382,365		359							(145,459)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			197									197	24
25	Other Admin. Staff Transportation			6,603									6,603	25
26	Insurance-Prop.Liab.Malpractice			174		388							562	26
27	Other (specify):*			35,402									35,402	27
28	**TOTAL General Administration**	(603,978)	6,636	547,015		1,397		(8,688)					(57,619)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(685,557)	6,636	738,124	8,230	4,439	(2,713)	(8,688)					60,470	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	96,696	197,233			9,528							303,457	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,759)	1,099,572			5,354							1,102,167	32
33	Real Estate Taxes		360,000			4,865							364,865	33
34	Rent-Facility & Grounds		(1,774,799)	44,838		(44,700)							(1,774,661)	34
35	Rent-Equipment & Vehicles				6,414								6,414	35
36	Other (specify):*	(709,582)	29,582										(680,000)	36
37	**TOTAL Ownership**	(615,645)	(88,412)	44,838	6,414	(24,952)							(677,757)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers									(41,607)			(41,607)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(933,889)											(933,889)	43
44	**TOTAL Special Cost Centers**	(933,889)								(41,607)			(975,496)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(2,235,091)	(81,776)	782,961	14,644	(20,513)	(2,713)	(8,688)		(41,607)			(1,592,783)	45

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,774,799	FNR EG LLC		$	$ (1,774,799)	1
2	V	33	Real Estate		FNR EG LLC		360,000	360,000	2
3	V	19	Appraisal		FNR EG LLC		2,750	2,750	3
4	V	30	Depreciation		FNR EG LLC		197,233	197,233	4
5	V	19	Accounting Fees		FNR EG LLC		3,886	3,886	5
6	V	32	Interest		FNR EG LLC		1,099,572	1,099,572	6
7	V	36	Amortization		FNR EG LLC		29,582	29,582	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,774,799			$ 1,693,023	$ * (81,776)	14

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

STATE OF ILLINOIS

Page 6-Supplemental

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	CHAIM RAJCHENBACH	27.12%	Astoria Place Skilled Nursing Facility LLC	Chicago	FNR EG LLC		Building Company	1
2	MENACHEM SHABAT	27.12%	Avantara Arlington	Arlington, SD	Legacy HC & Financial Services	Lincolnwood	Home Office/Bookkeeping	2
3	RONALD SHABAT	10.38%	Avantara Armour	Armour, SD	CF St. Louis LLC	Skokie	Building Company	3
4	RAJCHENBACH 2015 FAMILY TRUST	6.69%	Avantara Arrowhead	Rapid City, SD	ML Group Design & Development	Skokie	Asset Management	4
5	SUSAN FRIEDMAN	5.00%	Avantara Aurora	Aurora	ReMED Services LLC	Lincolnwood	Nursing Equipment	5
6	JACK RAJCHENBACH	1.95%	Avantara Billings	Billings, MT	Propay HR	Evanston	Payroll Processing	6
7	YOSEPH & NAOMI RAJCHENBACH	0.44%	Avantara Clark	Clark, SD	Ecobrite Linen	Skokie	Laundry Supplies	7
8	AVRUM & CHANA RAJCHENBACH	0.44%	Avantara Elgin	Elgin	Aurora Supportive Living	Aurora	Supportive Living	8
9	SHLOMO ZALMAN BUSEL & CHAVA BUSEL	0.44%	Avantara Groton	Groton, SD	Terrace Gardens	Morton Grove	Assisted Living	9
10	PINCHAS & NAHAMA SCHWARTZ	0.44%	Avantara Huron	Huron, SD	Lincolnshire Assisted Living Center	Lincolnshire	Assisted Living	10
11	MENACHEM BERGER	10.10%	Avantara Ipswich	Ipswich, SD	Wellshire Park Place	Milbank, SD	Assisted Living	11
12	TODD STERN	4.95%	Avantara Lake Norden	Lake Norden, SD	Wellshire Huron	Huron, SD	Assisted Living	12
13	BENJAMIN ISRAEL	4.95%	Avantara Long Grove	Long Grove	Lifescan Labs of Illinois	Skokie	Laboratory	13
14			Avantara Milbank	Milbank, SD				14
15			Avantara Mountainview	Rapid City, SD				15
16			Avantara North	Rapid City, SD				16
17			Avantara Norton	Sioux Falls, SD				17
18			Avantara Park Ridge	Park Ridge				18
19			Avantara Pierre	Pierre, SD				19
20			Avantara Redfield	Redfield, SD				20
21			Avantara Salem	Salem, SD				21
22			Avantara St. Cloud	Rapid City, SD				22
23			Avantara Watertown	Watertown, SD				23
24			Bella Terra Streamwood	Streamwood				24
25			Bella Terra Wheeling	Wheeling				25
26			Bethany Terrace	Morton Grove				26
27			Carlton Skilled Nursing Facility LLC	Chicago				27
28			Chalet Skilled Nursing Facility LLC	Chicago				28
29			Clark Skilled Nursing Facility	Chicago				29
30			Elmbrook Skilled Nursing Facility LLC	Elmhurst				30

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

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

STATE OF ILLINOIS

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietician Salary	$	Legacy Healthcare Financial Services		$ 4,544	$ 4,544	15
16	V	01	Dietary Supplies		Legacy Healthcare Financial Services		24	24	16
17	V	02	Food		Legacy Healthcare Financial Services		8,690	8,690	17
18	V	03	Housekeeping		Legacy Healthcare Financial Services		2,962	2,962	18
19	V	04	Linen Replacement		Legacy Healthcare Financial Services		201	201	19
20	V	06	Maintenance Salary		Legacy Healthcare Financial Services		14,017	14,017	20
21	V	06	Repairs & Maintenance		Legacy Healthcare Financial Services		832	832	21
22	V	10	Nursing Salary		Legacy Healthcare Financial Services		116,017	116,017	22
23	V	10	Nurse/Medical Director Consultant		Legacy Healthcare Financial Services		10,950	10,950	23
24	V	10	Medical Supplies		Legacy Healthcare Financial Services		24,925	24,925	24
25	V	12	Social Service Salary		Legacy Healthcare Financial Services		7,903	7,903	25
26	V	11	Activities Program		Legacy Healthcare Financial Services		12	12	26
27	V	12	Social Service Consultant		Legacy Healthcare Financial Services		31	31	27
28	V	17	COO / Administrative Salary		Legacy Healthcare Financial Services		88,326	88,326	28
29	V	19	Professional Fees		Legacy Healthcare Financial Services		28,997	28,997	29
30	V	20	Dues / Licenses / Permits		Legacy Healthcare Financial Services		4,951	4,951	30
31	V	21	Clerical & General Wages		Legacy Healthcare Financial Services		356,377	356,377	31
32	V	21	Clerical & Office Expense		Legacy Healthcare Financial Services		25,988	25,988	32
33	V	24	Education & Seminars		Legacy Healthcare Financial Services		197	197	33
34	V	25	Travel		Legacy Healthcare Financial Services		6,603	6,603	34
35	V	26	Insurance - General		Legacy Healthcare Financial Services		174	174	35
36	V	27	Non-Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		35,402	35,402	36
37	V	34	Rent		Legacy Healthcare Financial Services		44,700	44,700	37
38	V	34	Offsite Storage / Parking		Legacy Healthcare Financial Services		138	138	38
39	Total			$			$ 782,961	$ * 782,961	39

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

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Equipment Rental		Legacy Healthcare Financial Services		597	$ 597	15
16	V	35	Auto Rental		Legacy Healthcare Financial Services		5,818	5,818	16
17	V	15	Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		8,230	8,230	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			$			$ 14,644	$ * 14,644	39

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

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	CF St. Louis LLC		$ 1,545	$ 1,545	15
16	V	6	Repairs & Maintenance		CF St. Louis LLC		1,497	1,497	16
17	V	19	Property Valuation Fee		CF St. Louis LLC		529	529	17
18	V	19	Accounting Fees		CF St. Louis LLC		120	120	18
19	V	20	Dues & Subscriptions		CF St. Louis LLC		1	1	19
20	V	21	Office Expense		CF St. Louis LLC		359	359	20
21	V	26	Insurance		CF St. Louis LLC		388	388	21
22	V	30	Depreciation		CF St. Louis LLC		9,528	9,528	22
23	V	32	Interest Expense		CF St. Louis LLC		5,354	5,354	23
24	V	33	Real Estate Taxes		CF St. Louis LLC		4,865	4,865	24
25	V								25
26	V	34	Rent	44,700	CF St. Louis LLC			(44,700)	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			$ 44,700			$ 24,187	$ * (20,513)	39

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

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Medical Supplies	$ 9,000	ReMED Services		$ 6,287	$ (2,713)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,000			$ 6,287	$ * (2,713)	39

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

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	$ 37,922	ProPay HR LLC		$ 29,234	$ (8,688)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 37,922			$ 29,234	$ * (8,688)	39

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

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	04	Laundry	$ 145,841	EcoBrite Linen		$ 145,841	$	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			$ 145,841			$ 145,841	$ *	39

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

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Laboratory	$ 102,229	Lifescan Labs of Illinois		$ 60,622	$ (41,607)	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			$ 102,229			$ 60,622	$ * (41,607)	39

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

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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 Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
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 Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	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 Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietician Salary	Available Bed Days	2,540,133	53	$ 130,303	$ 130,303	88,572	$ 4,544	1
2	01	Dietary Supplies	Available Bed Days	2,540,133	53	697		88,572	24	2
3	02	Food	Available Bed Days	2,540,133	53	249,220		88,572	8,690	3
4	03	Housekeeping	Available Bed Days	2,540,133	53	84,952		88,572	2,962	4
5	04	Linen Replacement	Available Bed Days	2,540,133	53	5,771		88,572	201	5
6	06	Maintenance Salary	Available Bed Days	2,540,133	53	401,986	401,986	88,572	14,017	6
7	06	Repairs & Maintenance	Available Bed Days	2,540,133	53	23,857		88,572	832	7
8	10	Nursing Salary	Available Bed Days	2,540,133	53	3,327,223	3,327,223	88,572	116,017	8
9	10	Nurse/Medical Director Consulta	Available Bed Days	2,540,133	53	314,035		88,572	10,950	9
10	10	Medical Supplies	Available Bed Days	2,540,133	53	714,824		88,572	24,925	10
11	12	Social Service Salary	Available Bed Days	2,540,133	53	226,662	226,662	88,572	7,903	11
12	11	Activities Program	Available Bed Days	2,540,133	53	335		88,572	12	12
13	12	Social Service Consultant	Available Bed Days	2,540,133	53	893		88,572	31	13
14	17	COO / Administrative Salary	Available Bed Days	2,540,133	53	2,533,078	2,533,078	88,572	88,326	14
15	19	Professional Fees	Available Bed Days	2,540,133	53	831,592		88,572	28,997	15
16	20	Dues / Licenses / Permits	Available Bed Days	2,540,133	53	141,983		88,572	4,951	16
17	21	Clerical & General Wages	Available Bed Days	2,540,133	53	10,220,453	10,220,453	88,572	356,377	17
18	21	Clerical & Office Expense	Available Bed Days	2,540,133	53	745,293		88,572	25,988	18
19	24	Education & Seminars	Available Bed Days	2,540,133	53	5,655		88,572	197	19
20	25	Travel	Available Bed Days	2,540,133	53	189,364		88,572	6,603	20
21	26	Insurance - General	Available Bed Days	2,540,133	53	4,997		88,572	174	21
22	27	Non-Nursing Payroll Taxes / Bene	Available Bed Days	2,540,133	53	1,015,274		88,572	35,402	22
23	34	Rent	Available Bed Days	2,540,133	53	1,281,940		88,572	44,700	23
24	34	Offsite Storage / Parking	Available Bed Days	2,540,133	53	3,949		88,572	138	24
25	TOTALS					$ 22,454,338	$ 16,839,706		$ 782,961	25

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	35	Equipment Rental	Available Bed Days	2,540,133	53	17,109		88,572	597	1
2	35	Auto Rental	Available Bed Days	2,540,133	53	166,843		88,572	5,818	2
3	15	Nursing Payroll Taxes / Benefits	Available Bed Days	2,540,133	53	236,021		88,572	8,230	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 419,973	$		$ 14,644	25

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Available Bed Days	2,540,133	53	$ 44,301	$	88,572	$ 1,545	1
2	6	Repairs & Maintenance	Available Bed Days	2,540,133	53	42,932		88,572	1,497	2
3	19	Property Valuation Fee	Available Bed Days	2,540,133	53	15,181		88,572	529	3
4	19	Accounting Fees	Available Bed Days	2,540,133	53	3,453		88,572	120	4
5	20	Dues & Subscriptions	Available Bed Days	2,540,133	53	23		88,572	1	5
6	21	Office Expense	Available Bed Days	2,540,133	53	10,298		88,572	359	6
7	26	Insurance	Available Bed Days	2,540,133	53	11,124		88,572	388	7
8	30	Depreciation	Available Bed Days	2,540,133	53	273,261		88,572	9,528	8
9	32	Interest Expense	Available Bed Days	2,540,133	53	153,558		88,572	5,354	9
10	33	Real Estate Taxes	Available Bed Days	2,540,133	53	139,524		88,572	4,865	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 693,655	$		$ 24,187	25

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Medical Supplies	Direct			$	$		$ 6,287	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 6,287	25

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct			$	$		$ 29,234	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					$	$		$ 29,234	25

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: EcoBrite Linen
Street Address: 3712 Jarvis Avenue
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 582-4000
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	04	Laundry	Direct			$	$		$ 145,841	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					$	$		$ 145,841	25

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Lifescan Labs of Illinois, LLC
Street Address: 5255 Golf Road
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 663 - 8300
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Laboratory	Direct			$	$		$ 60,622	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					$	$		$ 60,622	25

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	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 Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

	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 Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	CIBC		X	Mortgage Payable				19,779,559			1,099,572	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Interest Only		X								35,869	6
7												7
8												8
9	TOTAL Facility Related						$	$ 19,779,559			$ 1,135,441	9
	B. Non-Facility Related*											
10	Interest Income		X								(2,759)	10
11	Allocated from CF St. Louis		X								5,354	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 2,595	14
15	TOTALS (line 9+line14)						$	$ 19,779,559			$ 1,138,036	15

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

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

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

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Description		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$	348,451	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.)	$	313,873	2
3. Under or (over) accrual (line 2 minus line 1).	$	(34,578)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	455,704	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.)**	$	3,279	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.	$	424,405	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2015	288,617	8
2016	288,033	9
2017	332,224	10
2018	302,839	11
2019	309,008	12

2020 Accrual = $309,008 x 1.47 = $455,704 (rounded)

Allocated from CF St. Louis LLC: $4,865

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIOI	$	16

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Avantara Evergreen Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0052423

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

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

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-11-411-014-0000	Long Term Care Property	$ 309,007.70	$ 309,007.70
2.	10-23-406-034-0000	Home Office Allocation	$ 459,532.44	$ 4,865.06
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 768,540.14	$ 313,872.76

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

IMPORTANT NOTICE

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

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

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

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Avantara Evergreen Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0052423

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

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

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

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 82,212 B. General Construction Type: Exterior Brick Frame Number of Stories 1

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

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

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

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

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

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2019	$ 2,884,055	1
2	Allocated from CF St. Louis, LLC			6,882	2
3	TOTALS			$ 2,890,937	3

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	242		2019	1963	$ 14,710,152	$ 197,233	35	$ 420,290	$ 223,057	$ 805,556	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2013	135,588		20	6,779	6,779	49,246	9
10	Various			2014	548,913		20	27,446	27,446	209,034	10
11	Various			2015	57,549		20	2,877	2,877	17,265	11
12	Various			2016	18,436		20	922	922	4,609	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 Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		323,875	8,784		15,400	6,615	68,894	68
69	Financial Statement Depreciation			511,750			(511,750)		69
70	TOTAL (lines 4 thru 69)		$ 15,794,514	$ 717,767		$ 473,714	$ (244,053)	$ 1,154,603	70

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

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 15,794,514	$ 717,767		$ 473,714	$ (244,053)	$ 1,154,603	1
2	Repair Water Leak In Boiler Room	2017	5,499		20	275	275	1,100	2
3	New Boiler Combustion Blower	2017	2,721		20	136	136	544	3
4	Replace Magnetic Locks In Corridor 300	2017	3,898		20	195	195	780	4
5	Hot Water Heater Repair	2017	8,914		20	446	446	1,783	5
6	Repair Walk In Freezer Compressor	2017	2,828		20	141	141	566	6
7	Front Lobby, Office, Hallways, Gym, Library, Dining Rm,	2017	1,547,758		20	77,388	77,388	354,845	7
8	100-500 Wing Floorings, Walls, Painting, Shades For New Office	2017			20				8
9	Hvac Replacement	2017	18,750		20	938	938	3,750	9
10	Code Locks & Code Alert	2018	11,599		20	580	580	1,740	10
11	Replace Copper Water Line	2018	4,450		20	223	223	668	11
12	Install Condenser Fan	2018	3,455		20	173	173	518	12
13	Wander Mgmt Code Alert System	2018	21,814		20	1,091	1,091	3,272	13
14	Replace Fan Motor In Condensors	2018	3,852		20	193	193	578	14
15	Boiler Repair - Leaking Pipe	2018	2,504		20	125	125	376	15
16	Sprinkler Repair	2018	3,124		20	156	156	469	16
17	Entrance Sign Face Change	2018	10,086		20	504	504	1,009	17
18	Install 18 Yards Of Trees/Shrubs-Front Of Building ($50000)	2019	48,455		20	2,423	2,423	4,367	18
19	85 Half Shades Throughout Facility	2019	4,165		20	208	208	833	19
20	Replace Heat Exchanger	2019	4,787		20	239	239	1,037	20
21	Replace Rooftop Unit	2019	12,644		20	632	632	2,950	21
22	Code Alert Wanderer Alarm System ($9001.03)	2019	8,723		20	436	436	1,486	22
23	12 New Magnetic Locks For 500 Units	2019	27,201		20	1,360	1,360	2,170	23
24	Repair & Paint: Walls & Bathrm In Ambulance Entryway & 100 V	2019	5,375		20	269	269	717	24
25	Ac Installation - Parts And Labor ($5728.7)	2019	5,552		20	278	278	564	25
26	Boiler - Install New Control Board, Steel Burners ($4,051)	2019	3,926		20	196	196	264	26
27	Wall Mounted Ac Units - Rms 302/304 ($6687.92)	2019	6,481		20	324	324	658	27
28	Sign - Install New Bk Lit Letters And Logo ($21031.4)	2019	20,382		20	1,019	1,019	2,596	28
29	Replace Pipes Of Heating System ($4850)	2019	4,700		20	235	235	356	29
30	Seepage Pits, Sump Pump Repair ($2850)	2019	2,762		20	138	138	257	30
31	Install Slider Doors ($2950)	2019	2,859		20	143	143	241	31
32	Front Entrance Door Replacement	2019	20,500		20	1,025	1,025	2,563	32
33	Wing 400 Shower Room Repairs - Tile Installation ($3850)	2019	3,731		20	187	187	283	33
34	TOTAL (lines 1 thru 33)		$ 17,628,009	$ 717,767		$ 565,389	$ (152,378)	$ 1,547,941	34

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

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 17,628,009	$ 717,767		$ 565,389	$ (152,378)	$ 1,547,941	1
2	Camera, Computer Cable Installation ($15,045)	2019	14,580		20	729	729	1,231	2
3	500 Wing Nursing Station - Paint Walls ($7500)	2019	7,268		20	363	363	863	3
4	Painting In Northern Sub Wing	2019	7,900		20	395	395	922	4
5	Removal Of Wallpaper In 500 Wing & Prep Work	2019	7,500		20	375	375	(188)	5
6	300 Wing Common Area Shower-Replace Damaged Tiles ($5350)	2019	5,185		20	259	259	482	6
7	Repair Roof Ductwork, Resident Rms Ceilings & Walls	2019	5,300		20	265	265	663	7
8	Signs ($2869.64)	2019	2,781		20	139	139	283	8
9	Installation Of Data Wiring	2019	16,950		20	847	847	1,695	9
10	2 New Magnetic Locks In 200 Hall & Kitchen Door	2019	5,272		20	264	264	527	10
11	Boiler # 3 Repair-Flow Switch,Pump,Motor ($3,508)	2020	3,422		20	171	171	171	11
12	Replace 25 Ton Rooftop Hvac Unit ($27,800)	2020	27,119		20	1,356	1,356	1,356	12
13	Rooftop Unit #18 Replacement ($8,866)	2020	8,648		20	432	432	432	13
14	Air Compressor Replacement & Air Piping ($7,456)	2020	7,273		20	364	364	364	14
15	Replacement Of Domestic Hot Water Heater ($63,500)	2020	61,944		20	3,097	3,097	3,097	15
16	Replace Fuse On Rooftop Unit - Wing 500 ($7,625)	2020	7,439		20	372	372	372	16
17	Walk In Cooler Compressor Repair ($2,600)	2020	2,536		20	127	127	127	17
18	Parking Lot - Mill And Pave And Striping ($13,615)	2020	13,281		20	664	664	664	18
19	Hot Boiler System Repair ($4,295)	2020	4,190		20	209	209	209	19
20	Roof Leak, Light Fixture, Support Wall, Pump Bearing Repairs ($2	2020	2,912		20	146	146	146	20
21	Replace Lights In Parking Lights ($2,500)	2020	2,439		20	122	122	122	21
22	Rooftop Unit Repair - Power Supply ($3,609)	2020	3,521		20	176	176	176	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)		$ 17,845,468	$ 717,767		$ 576,262	$ (141,505)	$ 1,561,655	34

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

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 17,845,468	$ 717,767		$ 576,262	$ (141,505)	$ 1,561,655	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		$ 17,845,468	$ 717,767		$ 576,262	$ (141,505)	$ 1,561,655	34

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

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 17,845,468	$ 717,767		$ 576,262	$ (141,505)	$ 1,561,655	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 17,845,468	$ 717,767		$ 576,262	$ (141,505)	$ 1,561,655	34

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

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
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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 Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party								1
2	Buildings:								2
3	Allocated from CF St. Louis, LLC	2016	37,054	1,720	35	1,059	(662)	5,293	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	230,056	5,675	20	11,503	5,827	57,514	9
10	Allocated from CF St. Louis, LLC	2017	5,340	132	20	267	135	1,068	10
11	Allocated from CF St. Louis, LLC	2019	48,397	1,194	20	2,420	1,226	4,840	11
12	Allocated from CF St. Louis, LLC	2019	2,545	63	20	127	64	127	12
13									13
14	Allocated from Legacy HC	2018	275		20	14	14	41	14
15	Allocated from Legacy HC	2020	207		20	10	10	10	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)		$ 323,875	$ 8,784		$ 15,400	$ 6,615	$ 68,894	34

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

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 323,875	$ 8,784		$ 15,400	$ 6,615	$ 68,894	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 323,875	$ 8,784		$ 15,400	$ 6,615	$ 68,894	34

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

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,363,923	$ 742	$ 236,392	$ 235,651	10	$ 708,191	71
72	Current Year Purchases	25,535	2	2,554	2,551	10	2,554	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,389,458	$ 744	$ 238,946	$ 238,202		$ 710,744	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)	$ 23,125,863	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 718,511	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 815,208	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 96,696	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,272,399	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	CIP	$ 15,900	92
93			93
94			94
95		$ 15,900	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Offsite Storage				11,386			5
6	Allocated from Legacy HC				138			6
7	TOTAL				$ 11,524 **			7

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

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

10. Effective dates of current rental agreement:
Beginning
Ending

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

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

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: $ 21,063 Description: See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Legacy HC		$	$ 5,818	17
18					18
19					19
20					20
21	TOTAL		$	$ 5,818	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 Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 681,156	$		$ 681,156	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			203,435			203,435	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			937,531			937,531	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				575,429		575,429	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					253,165	269,084		522,249	13
14	TOTAL			$		$ 2,075,287	$ 844,513		$ 2,919,800	14

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

Facility Name & ID Number Avantara Evergreen Park # 0052423 Report Period Beginning: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 294,460	$ 294,460	1
2	Cash-Patient Deposits	4,954	4,954	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,877,868	5,877,868	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,886	9,886	6
7	Other Prepaid Expenses	568,419	568,419	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	263,600	263,600	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 7,019,187	$ 7,019,187	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		2,000,000	13
14	Buildings, at Historical Cost		7,692,086	14
15	Leasehold Improvements, at Historical Cost	3,244,267	3,244,267	15
16	Equipment, at Historical Cost	834,138	4,342,052	16
17	Accumulated Depreciation (book methods)	(2,994,827)	(8,323,859)	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	1,983,181	3,240,609	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,066,759	$ 12,195,155	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 10,085,946	$ 19,214,342	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,175,919	$ 1,175,919	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	362,029	362,029	30
31	Accrued Taxes Payable (excluding real estate taxes)	301,331	301,331	31
32	Accrued Real Estate Taxes(Sch.IX-B)		455,704	32
33	Accrued Interest Payable		754,895	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	3,935,988	3,935,988	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,775,267	$ 6,985,866	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		19,779,559	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	5,220,021	4,270,176	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,220,021	$ 24,049,735	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 10,995,288	$ 31,035,601	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (909,342)	$ (11,821,259)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 10,085,946	$ 19,214,342	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,602,026	1
2	Restatements (describe):		2
3	Equity Adjustment	(3,579,845)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (977,819)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	68,477	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)**	$ 68,477	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)**	$ (909,342)	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	$ 17,808,820	1
2	Discounts and Allowances for all Levels	(8,697,175)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,111,645	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	8,463,360	6
7	Oxygen	1,274	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 8,464,634	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	581,853	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	219,491	19
20	Radiology and X-Ray	150	20
21	Other Medical Services	33,985	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 835,479	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,759	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,759	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Attached	1,831,894	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,831,894	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 20,246,411	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,566,049	31
32	Health Care	7,274,371	32
33	General Administration	3,093,614	33
	B. Capital Expense		
34	Ownership	3,090,531	34
	C. Ancillary Expense		
35	Special Cost Centers	3,853,689	35
36	Provider Participation Fee	299,680	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 20,177,934	40
41	**Income before Income Taxes (line 30 minus line 40)****	68,477	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 68,477	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,708,875	44
45	Private Pay - Net Inpatient Revenue	445,298	45
46	Medicare - Net Inpatient Revenue	2,766,366	46
47	Other-(specify) Insurance	1,191,106	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,111,645	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	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,100	2,226	$ 157,499	$ 70.75	1
2	Assistant Director of Nursing	2,047	2,282	99,696	43.69	2
3	Registered Nurses	25,633	27,655	1,071,169	38.73	3
4	Licensed Practical Nurses	58,705	63,426	2,173,998	34.28	4
5	CNAs & Orderlies	93,030	103,360	1,907,131	18.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,458	11,294	271,230	24.02	8
9	Activity Director	1,312	1,440	26,552	18.44	9
10	Activity Assistants	4,860	5,592	89,796	16.06	10
11	Social Service Workers	13,161	14,515	377,738	26.02	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,060	4,550	109,796	24.13	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,040	2,196	129,511	58.98	20
21	Assistant Administrator	664	757	22,760	30.07	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,195	11,759	201,398	17.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,376	2,534	59,138	23.34	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	12,978	13,708	199,260	14.54	33
34	TOTAL (lines 1 - 33)	244,619	267,294	$ 6,896,672 *	$ 25.80	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 1,287,720	01-03	35
36	Medical Director	Monthly	58,125	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	44,896	10-03	38
39	Pharmacist Consultant	Monthly	18,049	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	866	11-03	44
45	Social Service Consultant	Monthly	3,942	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 1,413,598		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Scott Morton	Administrator	0	$ 129,511
Lynniece Carter-Sims	Assistant Admin	0	10,830
Brandy Middleton	Assistant Admin	0	11,543
Lafayette Barlow	Assistant Admin	0	388
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 152,271

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
ProPay HR LLC	Payroll Processing	$ 37,922
Marcum LLP	Accounting	44,085
Achieve Accreditation	Accreditation	9,835
MTS Consulting	Tax Consultant	1,414
Telemedicine Solutions	Risk Prevention Software	7,000
Personnel Planners	Unemployment Consulting	1,998
Patient Ping	Telehealth	8,250
Compliagent	Compliance	3,843
Claimex LLC	Claims Consultant	3,543
Cortex Health	Data Processing	14,210
See Attached	Legal	191,290
See Supplemental Schedule		13,677
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 337,067

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 130,101
Unemployment Compensation Insurance	71,396
FICA Taxes	527,595
Employee Health Insurance	221,347
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	34,128
401K	4,683
Other Employee Benefits	29,988
Employee Physical Exams	22,312
Voluntary Benefit Contributions	63,897
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,105,447

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description		Amount
IDPH License Fee		$ 1,990
Advertising: Employee Recruitment		468
Health Care Worker Background Check		
(Indicate # of checks performed	97)	968
Patient Background Checks	662	6,615
Dues & Subscriptions		41,864
Licenses & Fees		9,778
See Supplemental Schedule		4,952
Less: Public Relations Expense		( )
Non-allowable advertising		( )
Yellow page advertising		( )
TOTAL (agree to Sch. V, line 20, col. 8)		$ 66,634

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	433
See Supplemental Schedule	197
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 630

**See instructions.

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA - $20,586, HCCI - $22,131**

(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. $ **48,070** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **299,680**
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? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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