FOR BHF USE

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

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

I. IDPH License ID Number: 0052639

Facility Name: Avantara Long Grove

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

County: Lake

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/20 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 (Date)
** Subject to the attached Accountants' Consulting Report*
(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 Long Grove # 0052639 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	195	Skilled (SNF)	195	71,370	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	195	TOTALS	195	71,370	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	42,273	3,700	9,800	55,773	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,273	3,700	9,800	55,773	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.15%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 195 and days of care provided 8,525

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 Long Grove # 0052639 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		2,507	1,200,461	1,202,968		1,202,968	3,586	1,206,554			1
2	Food Purchase		1,344		1,344		1,344	6,822	8,166			2
3	Housekeeping	657	7,522	541,415	549,594		549,594	2,326	551,920			3
4	Laundry	117,281	34,822	755	152,858		152,858	158	153,016			4
5	Heat and Other Utilities			187,451	187,451		187,451	(31,355)	156,096			5
6	Maintenance	111,411	25,845	192,812	330,068		330,068	8,825	338,893			6
7	Other (specify):*											7
8	TOTAL General Services	229,349	72,040	2,122,894	2,424,283		2,424,283	(9,638)	2,414,645			8
	B. Health Care and Programs											
9	Medical Director			22,000	22,000		22,000		22,000			9
10	Nursing and Medical Records	5,893,794	396,810	102,314	6,392,918		6,392,918	116,081	6,508,999			10
10a	Therapy	236,110			236,110		236,110		236,110			10a
11	Activities	197,734	6,258	1,461	205,453		205,453	9	205,462			11
12	Social Services	373,767		2,718	376,485		376,485	6,230	382,715			12
13	CNA Training											13
14	Program Transportation			41,815	41,815		41,815		41,815			14
15	Other (specify):*							6,461	6,461			15
16	TOTAL Health Care and Programs	6,701,405	403,068	170,308	7,274,781		7,274,781	128,782	7,403,563			16
	C. General Administration											
17	Administrative	110,534			110,534		110,534	69,347	179,881			17
18	Directors Fees											18
19	Professional Services			102,650	102,650	(416)	102,234	(6,255)	95,979			19
20	Dues, Fees, Subscriptions & Promotions			138,335	138,335		138,335	(91,934)	46,401			20
21	Clerical & General Office Expenses	202,416	5,644	728,295	936,355		936,355	(279,707)	656,648			21
22	Employee Benefits & Payroll Taxes			979,726	979,726		979,726		979,726			22
23	Inservice Training & Education											23
24	Travel and Seminar			284	284		284	155	439			24
25	Other Admin. Staff Transportation			716	716		716	5,184	5,900			25
26	Insurance-Prop.Liab.Malpractice			312,963	312,963		312,963	16,216	329,179			26
27	Other (specify):*							27,795	27,795			27
28	TOTAL General Administration	312,950	5,644	2,262,969	2,581,563	(416)	2,581,147	(259,200)	2,321,947			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,243,704	480,752	4,556,171	12,280,627	(416)	12,280,211	(140,056)	12,140,155			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Avantara Long Grove #0052639 Report Period Beginning: 01/01/20 Ending: 12/31/20

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							654,209	654,209			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,855	10,855		10,855	714,505	725,360			32
33	Real Estate Taxes					416	416	144,613	145,028			33
34	Rent-Facility & Grounds			1,680,000	1,680,000		1,680,000	(1,679,892)	108			34
35	Rent-Equipment & Vehicles			13,211	13,211		13,211	5,036	18,247			35
36	Other (specify):*							133,809	133,809			36
37	**TOTAL Ownership**			1,704,066	1,704,066	416	1,704,482	(27,720)	1,676,761			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		539,934	1,570,916	2,110,850		2,110,850	(46,952)	2,063,898			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			363,293	363,293		363,293		363,293			42
43	Other (specify):*			804,180	804,180		804,180	(804,180)				43
44	**TOTAL Special Cost Centers**		539,934	2,738,389	3,278,323		3,278,323	(851,132)	2,427,191			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,243,704	1,020,686	8,998,626	17,263,016		17,263,016	(1,018,909)	16,244,107			45

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(32,568)	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	(29,222)	30		9
10	Interest and Other Investment Income	(2,407)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1)	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	(16,488)	21		18
19	Entertainment	(5,479)	21		19
20	Contributions	(69,119)	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	(412,878)	21		24
25	Fund Raising, Advertising and Promotional	(6,362)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(10,925)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,037,434)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,622,883)		$	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)	603,974		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 603,974		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,018,909)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Avantara Long Grove

ID# 0052639

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Rebates	$ (9,852)	21	1
2	Patient Personal Items	(686)	10	2
3	Bank Charges	(86,128)	21	3
4	Sequestration	(38,443)	21	4
5	Bldg Co - Filing Fees	(75)	20	5
6	Bldg Co - Accounting Fees	(13,540)	19	6
7	Bldg Co - Amortization	(5,888)	36	7
8	Capitalized R&M	(3,420)	06	8
9	Chamber of Commerce Dues	(510)	20	9
10	PAC Dues	(19,831)	20	10
11	Non Allowable Expense	(802,993)	43	11
12	Non Allowable Legal	(23,025)	19	12
13	Marketing License	(1,187)	43	13
14	Therapy Discount	(31,856)	39	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,037,434)		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 Long Grove

IDH **0052639**

Report Period Beginning: **01/01/20**

Ending: **12/31/20**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		b		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 1 Reference 2 Reference 3 Reference 4 Reference 5 Reference 6 Reference 7 Reference 9 Reference 10 Reference 10a Reference 11 Reference 12 Reference 13 Reference 14 Reference 15 Reference 17 Reference 18 Reference 19 Reference 20 Reference 21 Reference 22 Reference 23 Reference 24 Reference 25 Reference 26 Reference 27 Reference 30 Reference 31 Reference 32 Reference 33 Reference 34 Reference 35 Reference 36 Reference 38 Reference 39 Reference 40 Reference 41 Reference 42 Reference 43

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Avantara Long Grove # 0052639 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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			3,586									3,586	1
2	Food Purchase	(1)		6,823									6,822	2
3	Housekeeping			2,326									2,326	3
4	Laundry			158									158	4
5	Heat and Other Utilities	(32,568)				1,213							(31,355)	5
6	Maintenance	(3,420)		11,658		1,175	(588)						8,825	6
7	Other (specify):*													7
8	**TOTAL General Services**	(35,989)		24,551		2,388	(588)						(9,638)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(686)		119,254					(2,487)				116,081	10
10a	Therapy													10a
11	Activities			9									9	11
12	Social Services			6,230									6,230	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				6,461								6,461	15
16	**TOTAL Health Care and Programs**	(686)		125,493	6,461				(2,487)				128,782	16
	C. General Administration													
17	Administrative			69,347									69,347	17
18	Directors Fees													18
19	Professional Services	(36,565)	13,540	22,766		511		(6,507)					(6,255)	19
20	Fees, Subscriptions & Promotions	(95,897)	75	3,887		1							(91,934)	20
21	Clerical & General Office Expenses	(580,193)		300,204		282							(279,707)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			155									155	24
25	Other Admin. Staff Transportation			5,184									5,184	25
26	Insurance-Prop.Liab.Malpractice		15,775	137		305							16,216	26
27	Other (specify):*			27,795									27,795	27
28	**TOTAL General Administration**	(712,655)	29,390	429,474		1,098		(6,507)					(259,200)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(749,330)	29,390	579,518	6,461	3,486	(588)	(6,507)	(2,487)				(140,056)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Avantara Long Grove # 0052639 **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	(29,222)	675,950			7,481							654,209	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,407)	712,708			4,204							714,505	32
33	Real Estate Taxes		140,793			3,820							144,613	33
34	Rent-Facility & Grounds		(1,680,000)	35,203		(35,095)							(1,679,892)	34
35	Rent-Equipment & Vehicles				5,036								5,036	35
36	Other (specify):*	(5,888)	139,697										133,809	36
37	TOTAL Ownership	(37,517)	(10,852)	35,203	5,036	(19,591)							(27,720)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(31,856)									(15,096)		(46,952)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(804,180)											(804,180)	43
44	TOTAL Special Cost Centers	(836,036)									(15,096)		(851,132)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,622,883)	18,538	614,721	11,497	(16,105)	(588)	(6,507)	(2,487)		(15,096)		(1,018,909)	45

Facility Name & ID Number Avantara Long Grove # 0052639 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	Rental Income	$ 1,680,000	Buffalo Property Holdings, LLC		$	$ (1,680,000)	1
2	V	32	Interest	618	Buffalo Property Holdings, LLC		713,326	712,708	2
3	V	33	Real Estate Tax		Buffalo Property Holdings, LLC		140,793	140,793	3
4	V	26	Property Insurance		Buffalo Property Holdings, LLC		15,775	15,775	4
5	V	36	MIP Expense		Buffalo Property Holdings, LLC		133,809	133,809	5
6	V	20	Filing Fees		Buffalo Property Holdings, LLC		75	75	6
7	V	19	Accounting Fees		Buffalo Property Holdings, LLC		13,540	13,540	7
8	V	30	Depreciation		Buffalo Property Holdings, LLC		675,950	675,950	8
9	V	36	Amortization		Buffalo Property Holdings, LLC		5,888	5,888	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,680,618			$ 1,699,156	$ * 18,538	14

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 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	GPN Family Trust	50.00%	Astoria Place Skilled Nursing Facility LLC	Chicago	Buffalo Property Holdings LLC	Long Grove	Building Company	1
2	Doros Generation Trust	50.00%	Avantara Arlington	Arlington, SD	Legacy HC & Financial Services	Lincolnwood	Home Office/Bookkeeping	2
3			Avantara Armour	Armour, SD	CF St. Louis LLC	Skokie	Building Company	3
4			Avantara Arrowhead	Rapid City, SD	ML Group Design & Development	Skokie	Asset Management	4
5			Avantara Aurora	Aurora	ReMED Services LLC	Lincolnwood	Nursing Equipment	5
6			Avantara Billings	Billings, MT	Propay HR	Evanston	Payroll Processing	6
7			Avantara Clark	Clark, SD	Ecobrite Linen	Skokie	Laundry Supplies	7
8			Avantara Elgin	Elgin	Aurora Supportive Living	Aurora	Supportive Living	8
9			Avantara Evergreen Park	Evergreen Park	Terrace Gardens	Morton Grove	Assisted Living	9
10			Avantara Groton	Groton, SD	Lincolnshire Assisted Living Center	Lincolnshire	Assisted Living	10
11			Avantara Huron	Huron, SD	Wellshire Park Place	Milbank, SD	Assisted Living	11
12			Avantara Ipswich	Ipswich, SD	Wellshire Huron	Huron, SD	Assisted Living	12
13			Avantara Lake Norden	Lake Norden, SD	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 Long Grove # 0052639 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

Facility Name & ID Number Avantara Long Grove # 0052639 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietician Salary	$	Legacy Healthcare Financial Services		$ 3,567	$ 3,567	15
16	V	01	Dietary Supplies		Legacy Healthcare Financial Services		19	19	16
17	V	02	Food		Legacy Healthcare Financial Services		6,823	6,823	17
18	V	03	Housekeeping		Legacy Healthcare Financial Services		2,326	2,326	18
19	V	04	Linen Replacement		Legacy Healthcare Financial Services		158	158	19
20	V	06	Maintenance Salary		Legacy Healthcare Financial Services		11,005	11,005	20
21	V	06	Repairs & Maintenance		Legacy Healthcare Financial Services		653	653	21
22	V	10	Nursing Salary		Legacy Healthcare Financial Services		91,088	91,088	22
23	V	10	Nurse/Medical Director Consultant		Legacy Healthcare Financial Services		8,597	8,597	23
24	V	10	Medical Supplies		Legacy Healthcare Financial Services		19,569	19,569	24
25	V	12	Social Service Salary		Legacy Healthcare Financial Services		6,205	6,205	25
26	V	11	Activities Program		Legacy Healthcare Financial Services		9	9	26
27	V	12	Social Service Consultant		Legacy Healthcare Financial Services		24	24	27
28	V	17	COO / Administrative Salary		Legacy Healthcare Financial Services		69,347	69,347	28
29	V	19	Professional Fees		Legacy Healthcare Financial Services		22,766	22,766	29
30	V	20	Dues / Licenses / Permits		Legacy Healthcare Financial Services		3,887	3,887	30
31	V	21	Clerical & General Wages		Legacy Healthcare Financial Services		279,800	279,800	31
32	V	21	Clerical & Office Expense		Legacy Healthcare Financial Services		20,404	20,404	32
33	V	24	Education & Seminars		Legacy Healthcare Financial Services		155	155	33
34	V	25	Travel		Legacy Healthcare Financial Services		5,184	5,184	34
35	V	26	Insurance - General		Legacy Healthcare Financial Services		137	137	35
36	V	27	Non-Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		27,795	27,795	36
37	V	34	Rent		Legacy Healthcare Financial Services		35,095	35,095	37
38	V	34	Offsite Storage / Parking		Legacy Healthcare Financial Services		108	108	38
39	Total			$			$ 614,721	$ * 614,721	39

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Equipment Rental		Legacy Healthcare Financial Services		468	$ 468	15
16	V	35	Auto Rental		Legacy Healthcare Financial Services		4,568	4,568	16
17	V	15	Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		6,461	6,461	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			$			$ 11,497	$ * 11,497	39

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	CF St. Louis LLC		$ 1,213	$ 1,213	15
16	V	6	Repairs & Maintenance		CF St. Louis LLC		1,175	1,175	16
17	V	19	Property Valuation Fee		CF St. Louis LLC		416	416	17
18	V	19	Accounting Fees		CF St. Louis LLC		95	95	18
19	V	20	Dues & Subscriptions		CF St. Louis LLC		1	1	19
20	V	21	Office Expense		CF St. Louis LLC		282	282	20
21	V	26	Insurance		CF St. Louis LLC		305	305	21
22	V	30	Depreciation		CF St. Louis LLC		7,481	7,481	22
23	V	32	Interest Expense		CF St. Louis LLC		4,204	4,204	23
24	V	33	Real Estate Taxes		CF St. Louis LLC		3,820	3,820	24
25	V								25
26	V	34	Rent	35,095	CF St. Louis LLC			(35,095)	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			$ 35,095			$ 18,990	$ * (16,105)	39

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance	$ 24,000	ML Group Design and Development		$ 23,412	$ (588)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 24,000			$ 23,412	$ * (588)	39

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	$ 28,401	ProPay HR LLC		$ 21,894	$ (6,507)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 28,401			$ 21,894	$ * (6,507)	39

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Medical Supplies	$ 8,250	ReMED Services		$ 5,763	$ (2,487)	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			$ 8,250			$ 5,763	$ * (2,487)	39

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 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 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	04	Laundry	$ 97,252	EcoBrite Linen		$ 97,252	$	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			$ 97,252			$ 97,252	$ *	39

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 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 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	39	Laboratory	$ 37,090	Lifescan Labs of Illinois		$ 21,994	$ (15,096)	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			$ 37,090			$ 21,994	$ * (15,096)	39

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 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 Long Grove # 0052639 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 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]

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

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

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 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: Legacy Healthcare Financial Services
Street Address: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 679-9797
Fax Number: (847) 683-2900

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietician Salary	Available Bed Days	2,540,133	53	$ 130,303	$ 130,303	69,540	$ 3,567	1
2	01	Dietary Supplies	Available Bed Days	2,540,133	53	697		69,540	19	2
3	02	Food	Available Bed Days	2,540,133	53	249,220		69,540	6,823	3
4	03	Housekeeping	Available Bed Days	2,540,133	53	84,952		69,540	2,326	4
5	04	Linen Replacement	Available Bed Days	2,540,133	53	5,771		69,540	158	5
6	06	Maintenance Salary	Available Bed Days	2,540,133	53	401,986	401,986	69,540	11,005	6
7	06	Repairs & Maintenance	Available Bed Days	2,540,133	53	23,857		69,540	653	7
8	10	Nursing Salary	Available Bed Days	2,540,133	53	3,327,223	3,327,223	69,540	91,088	8
9	10	Nurse/Medical Director Consultan	Available Bed Days	2,540,133	53	314,035		69,540	8,597	9
10	10	Medical Supplies	Available Bed Days	2,540,133	53	714,824		69,540	19,569	10
11	12	Social Service Salary	Available Bed Days	2,540,133	53	226,662	226,662	69,540	6,205	11
12	11	Activities Program	Available Bed Days	2,540,133	53	335		69,540	9	12
13	12	Social Service Consultant	Available Bed Days	2,540,133	53	893		69,540	24	13
14	17	COO / Administrative Salary	Available Bed Days	2,540,133	53	2,533,078	2,533,078	69,540	69,347	14
15	19	Professional Fees	Available Bed Days	2,540,133	53	831,592		69,540	22,766	15
16	20	Dues / Licenses / Permits	Available Bed Days	2,540,133	53	141,983		69,540	3,887	16
17	21	Clerical & General Wages	Available Bed Days	2,540,133	53	10,220,453	10,220,453	69,540	279,800	17
18	21	Clerical & Office Expense	Available Bed Days	2,540,133	53	745,293		69,540	20,404	18
19	24	Education & Seminars	Available Bed Days	2,540,133	53	5,655		69,540	155	19
20	25	Travel	Available Bed Days	2,540,133	53	189,364		69,540	5,184	20
21	26	Insurance - General	Available Bed Days	2,540,133	53	4,997		69,540	137	21
22	27	Non-Nursing Payroll Taxes / Bene	Available Bed Days	2,540,133	53	1,015,274		69,540	27,795	22
23	34	Rent	Available Bed Days	2,540,133	53	1,281,940		69,540	35,095	23
24	34	Offsite Storage / Parking	Available Bed Days	2,540,133	53	3,949		69,540	108	24
25	TOTALS					$ 22,454,338	$ 16,839,706		$ 614,721	25

Facility Name & ID Number Avantara Long Grove # 0052639 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: Legacy Healthcare Financial Services
Street Address: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 679-9797
Fax Number: (847) 683-2900

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	35	Equipment Rental	Available Bed Days	2,540,133	53	17,109		69,540	468	1
2	35	Auto Rental	Available Bed Days	2,540,133	53	166,843		69,540	4,568	2
3	15	Nursing Payroll Taxes / Benefits	Available Bed Days	2,540,133	53	236,021		69,540	6,461	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	$		$ 11,497	25

Facility Name & ID Number Avantara Long Grove # 0052639 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	$	69,540	$ 1,213	1
2	6	Repairs & Maintenance	Available Bed Days	2,540,133	53	42,932		69,540	1,175	2
3	19	Property Valuation Fee	Available Bed Days	2,540,133	53	15,181		69,540	416	3
4	19	Accounting Fees	Available Bed Days	2,540,133	53	3,453		69,540	95	4
5	20	Dues & Subscriptions	Available Bed Days	2,540,133	53	23		69,540	1	5
6	21	Office Expense	Available Bed Days	2,540,133	53	10,298		69,540	282	6
7	26	Insurance	Available Bed Days	2,540,133	53	11,124		69,540	305	7
8	30	Depreciation	Available Bed Days	2,540,133	53	273,261		69,540	7,481	8
9	32	Interest Expense	Available Bed Days	2,540,133	53	153,558		69,540	4,204	9
10	33	Real Estate Taxes	Available Bed Days	2,540,133	53	139,524		69,540	3,820	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	$		$ 18,990	25

Facility Name & ID Number Avantara Long Grove # 0052639 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: ML Group Design and Development
Street Address: 3424 Oakton St
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 676-5300
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Direct			$	$		$ 23,412	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					$	$		$ 23,412	25

Facility Name & ID Number Avantara Long Grove # 0052639 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			$	$		$ 21,894	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
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 21,894	25

Facility Name & ID Number Avantara Long Grove # 0052639 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			$	$		$ 5,763	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					$	$		$ 5,763	25

Facility Name & ID Number Avantara Long Grove # 0052639 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			$	$		$ 97,252	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					$	$		$ 97,252	25

Facility Name & ID Number Avantara Long Grove # 0052639 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			$	$		$ 21,994	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					$	$		$ 21,994	25

Facility Name & ID Number Avantara Long Grove # 0052639 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 ☐

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

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

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 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	Capital One		X	Mortgage			$	$ 20,455,780			$ 713,326	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Interest Only										10,855	6
7												7
8												8
9	TOTAL Facility Related						$	$ 20,455,780			$ 724,181	9
	B. Non-Facility Related*											
10	Interest Income		X								(2,407)	10
11	Interest Income - Bldg Co		X								(618)	11
12	Allocated from CF St. Louis	X									4,204	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 1,179	14
15	TOTALS (line 9+line14)						$	$ 20,455,780			$ 725,360	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 133,809 Line # 36

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

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 132,176	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.)		$ 136,976	2
3. Under or (over) accrual (line 2 minus line 1).		$ 4,800	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 139,813	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.)		$ 416	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.		$ 145,028	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	115,237	8
	2016	117,436	9
	2017	121,554	10
	2018	125,881	11
	2019	133,156	12

2020 Accrual = 133,156 x 1.05 = 139,813

Allocated from CF St. Louis: $3,820

	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 CALCULATION	$	16

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Avantara Long Grove COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0052639

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 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-31-201-082	Long Term Care Property	$ 124,953.08	$ 124,953.08
2.	15-31-201-083	Long Term Care Property	$ 8,202.48	$ 8,202.48
3.	10-23-406-034-0000	Home Office Allocation	$ 459,532.44	$ 3,819.67
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 592,688.00	$ 136,975.23

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 Long Grove COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0052639

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.

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 1,482,376	1
2	Allocated from CF St. Louis, LLC			5,403	2
3	TOTALS			$ 1,487,779	3

Facility Name & ID Number Avantara Long Grove # 0052639 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	195		2016	1995	$ 12,961,389	$ 675,950	35	$ 370,325	$ (305,625)	$ 1,851,625	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2014	167,468		20	8,373	8,373	58,617	9
10	Various			2015	423,679		20	21,184	21,184	127,107	10
11	Various			2016	1,904,981		20	95,249	95,249	473,175	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 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)		254,282	6,897		12,091	5,194	54,090	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 15,711,799	$ 682,847		$ 507,222	$ (175,624)	$ 2,564,615	70

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 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		$ 15,711,799	$ 682,847		$ 507,222	$ (175,624)	$ 2,564,615	1
2	Install New Door/Frame/Hardware	2017	11,516		20	576	576	2,304	2
3	New Ceiling & Floor In Dinnig Room, New Drywall/Floor In Utili	2017	55,960		20	2,798	2,798	10,726	3
4	Water Pump Work	2017	9,159		20	458	458	1,680	4
5	Deep Well Replacement	2017	41,615		20	2,081	2,081	6,936	5
6	New Concrete In Front Of The Ramp	2017	3,000		20	150	150	450	6
7	Repairs To Outside Walls, Foundation, Storage Room	2017	4,250		20	213	213	603	7
8	Furnished & Installed Domestic Hot Water Storage Tank	2017	23,977		20	1,199	1,199	3,398	8
9	Elevator- Door Restrictors, Car Identification Plates, And Stencil	2017	3,453		20	173	173	1,265	9
10	Installed Fire Alarm System For Corridor	2017	6,066		20	303	303	1,213	10
11	Installed Hot Water Booster	2017	14,455		20	723	723	2,891	11
12	Repaired Metal Stairway East Side Of Building	2017	4,250		20	213	213	850	12
13	Installed Breaker Panel And Connected To Transfer Switch-1St F	2017	10,570		20	529	529	2,114	13
14	Repaired Ac System In Office	2017	6,788		20	339	339	1,358	14
15	Repiped Boiler	2017	4,679		20	234	234	4,679	15
16	Ductless Ac (7,500)	2018	6,942		20	347	347	882	16
17	Replace Kitchen Drain (4,600)	2018	4,258		20	213	213	599	17
18	Hot Water Motorized Valve With Digital Controller (2,900)	2018	2,684		20	134	134	365	18
19	Built In Booster Heater (7,700)	2018	7,127		20	356	356	1,868	19
20	Replacement Of Compressor (2,550)	2018	2,360		20	118	118	619	20
21	Kitchen Plumbing, Electrical, Tile, Make Window (36,000)	2018	33,322		20	1,666	1,666	6,632	21
22	Repair Sprinkler Pipes In Room 343 (2,650)	2018	2,453		20	123	123	368	22
23	Mill & Pave West Side Lot (12,300)	2018	11,385		20	569	569	1,708	23
24	Design Fee - Kitchen Plumbing, Electrical, Tile, Make Window (2	2018	19,438		20	972	972	2,916	24
25	Add Longer Drain In Kitchen (8,700)	2018	8,053		20	403	403	1,208	25
26	Well Rehabilitation ($30801.7)	2019	29,850		20	1,492	1,492	4,573	26
27	Sewer Line ($4845)	2019	4,695		20	235	235	598	27
28	Installation Of Drop Ceiling Tiles In Basement ($55,600)	2019	53,882		20	2,694	2,694	5,165	28
29	Door Protection Equipment ($16580.79)	2019	16,068		20	803	803	1,771	29
30	Installation Of New Drywall Sheets In Basement ($6,700)	2019	6,493		20	325	325	660	30
31	Fencing ($2850)	2019	2,762		20	138	138	281	31
32	Repipe Surface Protection ($2783)	2019	2,697		20	135	135	532	32
33	Mini-Split System ($5680)	2019	5,504		20	275	275	591	33
34	TOTAL (lines 1 thru 33)		$ 16,131,510	$ 682,847		$ 528,208	$ (154,639)	$ 2,636,415	34

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 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		$ 16,131,510	$ 682,847		$ 528,208	$ (154,639)	$ 2,636,415	1
2	Storage Tank ($6073.47)	2019	5,886		20	294	294	446	2
3	Replace Heat Exchanger In Water Heater (2,768)	2020	2,700		20	135	135	135	3
4	Repair Rooftop Exhausts & Replace Roof Top Motors (2,995)	2020	2,922		20	146	146	146	4
5	Install 2 Hot Water Storage Tanks (12,000)	2020	11,706		20	585	585	585	5
6	Replace Hot Water Heater (8,358)	2020	8,153		20	408	408	408	6
7	Repair Well Piping (5,112)	2020	4,986		20	249	249	249	7
8	Replace Boiler Control Boards (4,608)	2020	4,495		20	225	225	225	8
9	4" Leaking Piping Repair (3,420)	2020	3,336		20	167	167	167	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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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)		$ 16,175,694	$ 682,847		$ 530,417	$ (152,430)	$ 2,638,777	34

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 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		$ 16,175,694	$ 682,847		$ 530,417	$ (152,430)	$ 2,638,777	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 16,175,694	$ 682,847		$ 530,417	$ (152,430)	$ 2,638,777	34

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 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		$ 16,175,694	$ 682,847		$ 530,417	$ (152,430)	$ 2,638,777	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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19									19
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 16,175,694	$ 682,847		$ 530,417	$ (152,430)	$ 2,638,777	34

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 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
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 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	29,092	1,351	35	831	(520)	4,156	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	180,623	4,456	20	9,031	4,575	45,156	9
10	Allocated from CF St. Louis, LLC	2017	4,192	103	20	210	106	838	10
11	Allocated from CF St. Louis, LLC	2019	37,998	937	20	1,900	962	3,800	11
12	Allocated from CF St. Louis, LLC	2019	1,999	49	20	100	51	100	12
13									13
14	Allocated from Legacy HC	2018	216		20	11	11	32	14
15	Allocated from Legacy HC	2020	163		20	8	8	8	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)		$ 254,282	$ 6,897		$ 12,091	$ 5,194	$ 54,090	34

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 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		$ 254,282	$ 6,897		$ 12,091	$ 5,194	$ 54,090	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 254,282	$ 6,897		$ 12,091	$ 5,194	$ 54,090	34

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 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	$ 1,181,033	$ 582	$ 118,103	$ 117,521	10	$ 683,963	71
72	Current Year Purchases	56,885	2	5,689	5,687	10	5,689	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,237,918	$ 584	$ 123,792	$ 123,208		$ 689,651	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 18,901,391	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 683,431	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 654,209	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (29,222)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,328,428	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	Allocated from Legacy Healthcare				108			5
6								6
7	TOTAL				$ 108 **			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: $ 13,679 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 Healthcare		$	$ 4,568	17
18					18
19					19
20					20
21	TOTAL		$	$ 4,568	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 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.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 596,086	$		$ 596,086	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			123,259			123,259	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			760,411			760,411	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				335,091		335,091	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					91,160	204,843		296,003	13
14	TOTAL			$		$ 1,570,916	$ 539,934		$ 2,110,850	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 Long Grove # 0052639 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	$ 147,756	$ 658,764	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,000,621	1,000,621	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		10,323	6
7	Other Prepaid Expenses	652,981	652,981	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	582,307	794,426	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,383,665	$ 3,117,115	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	70,844	1,553,221	13
14	Buildings, at Historical Cost		12,961,389	14
15	Leasehold Improvements, at Historical Cost	1,224,994	3,451,662	15
16	Equipment, at Historical Cost	980,648	1,585,347	16
17	Accumulated Depreciation (book methods)	(1,309,972)	(3,957,240)	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	6,075,073	6,554,693	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,041,587	$ 22,149,072	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,425,252	$ 25,266,187	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,044,884	$ 1,044,938	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	259,699	259,699	30
31	Accrued Taxes Payable (excluding real estate taxes)	313,705	313,705	31
32	Accrued Real Estate Taxes(Sch.IX-B)		139,813	32
33	Accrued Interest Payable		58,981	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	2,740,438	2,740,438	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,358,726	$ 4,557,574	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		20,455,780	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	1,895,833	427,268	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,895,833	$ 20,883,048	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,254,559	$ 25,440,622	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,170,693	$ (174,435)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,425,252	$ 25,266,187	48

*(See instructions.)

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,091,659	1
2	Restatements (describe):		2
3	Depreciation	(203,671)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,887,988	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	282,705	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)**	$ 282,705	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,170,693	24 *

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

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 18,751,195	1
2	Discounts and Allowances for all Levels	(6,862,579)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,888,616	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,789,167	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,789,167	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	318,885	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	71,993	19
20	Radiology and X-Ray		20
21	Other Medical Services	21,216	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 412,094	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,407	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,407	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	1,453,437	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,453,437	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,545,721	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,424,283	31
32	Health Care	7,274,781	32
33	General Administration	2,581,563	33
	B. Capital Expense		
34	Ownership	1,704,066	34
	C. Ancillary Expense		
35	Special Cost Centers	2,915,030	35
36	Provider Participation Fee	363,293	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,263,016	40
41	**Income before Income Taxes (line 30 minus line 40)****	282,705	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 282,705	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,876,761	44
45	Private Pay - Net Inpatient Revenue	440,305	45
46	Medicare - Net Inpatient Revenue	2,352,205	46
47	Other-(specify) Insurance	219,345	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,888,616	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.**

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,120	2,273	$ 166,052	$ 73.05	1
2	Assistant Director of Nursing	1,952	2,112	113,452	53.72	2
3	Registered Nurses	37,108	45,239	1,915,300	42.34	3
4	Licensed Practical Nurses	37,349	44,815	1,664,459	37.14	4
5	CNAs & Orderlies	72,270	91,482	1,894,582	20.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,980	10,137	236,110	23.29	8
9	Activity Director	2,112	2,248	41,965	18.67	9
10	Activity Assistants	8,309	9,131	155,769	17.06	10
11	Social Service Workers	7,928	8,816	244,131	27.69	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,471	4,923	111,411	22.63	17
18	Housekeepers	41	41	657	16.02	18
19	Laundry	7,397	8,620	117,281	13.61	19
20	Administrator	2,040	2,160	110,534	51.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,024	2,152	46,880	21.78	23
24	Clerical	7,782	8,490	155,536	18.32	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,960	2,176	80,697	37.09	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	6,448	7,580	188,888	24.92	33
34	TOTAL (lines 1 - 33)	210,291	252,394	$ 7,243,704 *	$ 28.70	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 1,200,461	01-03	35
36	Medical Director	Monthly	22,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	54,695	10-03	38
39	Pharmacist Consultant	Monthly	6,206	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	1,461	11-03	44
45	Social Service Consultant	Monthly	2,718	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 1,287,541		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	171	12,852	10-03	51
52	Certified Nurse Assistants/Aides	680	28,561	10-03	52
53	TOTAL (lines 50 - 52)	851	$ 41,413		53

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Victoria Gomboc	Administrator	0	$ 110,534
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 110,534

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 1,457
ProPay HR	Payroll Processing	28,401
Onyx Procurement Solutions	Procurement Services	12,770
Achieve Accreditation	Accreditation Services	10,592
Telemedicine Solutions	Risk Prevention Services	5,308
Compliagent	Compliance	2,043
Cortex Health Inc	Data Processing	10,365
Hygieneering, Inc.	Hygiene & Safety Consulting	1,103
Personnel Planners	Unemployment Consult	1,410
Prospect Resources	Energy Procurement	900
See Attached	Legal	28,302
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 102,651

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 130,783
Unemployment Compensation Insurance	18,570
FICA Taxes	554,143
Employee Health Insurance	199,211
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	19,264
401K Expense	34,790
Voluntary Benefit Contributions	20,060
Employee Physical Exams	2,905
TOTAL (agree to Schedule V, line 22, col.8)	$ 979,726

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	468
Health Care Worker Background Check	1,061
(Indicate # of checks performed 106)	
Patient Background Checks 77	779
Dues & Subscriptions	37,107
Licenses & Fees	1,108
See Supplemental Schedule	3,888
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 46,401

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	284
See Supplemental Schedule	155
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 439

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Avantara Long Grove # 0052639 Report Period Beginning: 01/01/20 Ending: 12/31/20

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $19,227 ; HCCI $29,094**

(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. $ **50,198** 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. $ **363,293**
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? **Yes** Indicate the amount. $ **N/A**

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

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.