

Facility Name & ID Number Elevate Care Irving Park

0056093 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	117	Skilled (SNF)	117	42,822	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	117	TOTALS	117	42,822	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	3,269	37	4,640	7,946	8
9	SNF/PED					9
10	ICF	18,527	207		18,734	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,796	244	4,640	26,680	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.30%

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

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

I. On what date did you start providing long term care at this location?
Date started 12/1/2019

J. Was the facility purchased or leased after January 1, 1978?
YES Date 12/1/2019 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 117 and days of care provided 2,867

Medicare Intermediary Wisconsin Physicans Service

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES 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 Elevate Care Irving Park # 0056093 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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	321,723	30,770	12,336	364,829		364,829		364,829		1
2	Food Purchase		160,610		160,610		160,610	166	160,776		2
3	Housekeeping	220,910	51,151		272,061		272,061	276	272,337		3
4	Laundry	83,511	10,645	8,311	102,467		102,467		102,467		4
5	Heat and Other Utilities			119,673	119,673		119,673	(12,217)	107,456		5
6	Maintenance	72,507	18,704	122,682	213,893		213,893	25,019	238,912		6
7	Other (specify):*							883	883		7
8	TOTAL General Services	698,651	271,880	263,002	1,233,533		1,233,533	14,126	1,247,659		8
	B. Health Care and Programs										
9	Medical Director			24,200	24,200		24,200		24,200		9
10	Nursing and Medical Records	2,305,704	348,658	359,837	3,014,199		3,014,199	(13,711)	3,000,488		10
10a	Therapy	110,234			110,234		110,234		110,234		10a
11	Activities	110,325	12,617	1,197	124,139		124,139	5,625	129,764		11
12	Social Services	183,268		3,152	186,420		186,420		186,420		12
13	CNA Training										13
14	Program Transportation			11,950	11,950		11,950		11,950		14
15	Other (specify):*							4,949	4,949		15
16	TOTAL Health Care and Programs	2,709,531	361,275	400,336	3,471,142		3,471,142	(3,136)	3,468,006		16
	C. General Administration										
17	Administrative	117,597		350,385	467,982		467,982	(313,182)	154,800		17
18	Directors Fees										18
19	Professional Services			223,977	223,977		223,977	(2,787)	221,190		19
20	Dues, Fees, Subscriptions & Promotions			46,902	46,902		46,902	(9,577)	37,325		20
21	Clerical & General Office Expenses	103,714		214,612	318,326		318,326	(36,238)	282,088		21
22	Employee Benefits & Payroll Taxes			624,743	624,743		624,743		624,743		22
23	Inservice Training & Education										23
24	Travel and Seminar			594	594		594	284	878		24
25	Other Admin. Staff Transportation			130	130		130	2,742	2,872		25
26	Insurance-Prop.Liab.Malpractice			229,468	229,468		229,468		229,468		26
27	Other (specify):*							18,386	18,386		27
28	TOTAL General Administration	221,311		1,690,811	1,912,122		1,912,122	(340,371)	1,571,751		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,629,493	633,155	2,354,149	6,616,797		6,616,797	(329,381)	6,287,416		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			7,142	7,142		7,142	422	7,564		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			17,129	17,129		17,129	(2,864)	14,265		32
33	Real Estate Taxes			222,462	222,462		222,462	1,288	223,750		33
34	Rent-Facility & Grounds			200,952	200,952		200,952	120	201,072		34
35	Rent-Equipment & Vehicles			6,026	6,026		6,026	2,302	8,328		35
36	Other (specify):*			29,544	29,544		29,544	(29,544)	0		36
37	TOTAL Ownership			483,255	483,255		483,255	(28,276)	454,979		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		134,769	409,130	543,899		543,899	(91,854)	452,045		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			183,425	183,425		183,425		183,425		42
43	Other (specify):*	86,538		27,859	114,397		114,397	(114,397)	0		43
44	TOTAL Special Cost Centers	86,538	134,769	620,414	841,721		841,721	(206,251)	635,470		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,716,031	767,924	3,457,818	7,941,773		7,941,773	(563,907)	7,377,866		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 Elevate Care Irving Park

0056093

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(12,701)	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	(6,317)	30		9
10	Interest and Other Investment Income	(4,509)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(15)	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)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(160,868)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(170,132)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (354,557)		\$	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	2	
		Amount	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)	(209,350)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (209,350)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (563,907)		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	2	3	4	
		Yes	No	Amount	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

Elevate Care Irving Park

ID# 0056093

Report Period Beginning: 01/01/20

Ending: 12/31/20

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non-Allowable Legal	\$ (4,075)	19	1
2	Credit Card Processing	(1,707)	21	2
3	Marketing Salaries	(86,538)	43	3
4	Promotional Products	(11,195)	43	4
5	Bank Charges	(2,689)	21	5
6	Website	(268)	21	6
7	Amortization	(29,544)	36	7
8	Additional R&M	17,302	06	8
9	Non Allowable Professional Fees	(1,900)	19	9
10	Non Allowable Seminar	(67)	24	10
11	PAC Dues	(10,331)	20	11
12	Advertising/Marketing	(16,664)	43	12
13	Capitalized R&M	(2,931)	06	13
14	Veterans Expenses	(19,525)	10	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	(170,132)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elevate Care Irving Park# 0056093

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(15)		181									166	2
3	Housekeeping			49		227							276	3
4	Laundry													4
5	Heat and Other Utilities	(12,701)				484							(12,217)	5
6	Maintenance	14,371		9,877		771							25,019	6
7	Other (specify):*			883									883	7
8	TOTAL General Services	1,655		10,990		1,482							14,126	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(19,525)		5,769		45							(13,711)	10
10a	Therapy													10a
11	Activities			5,625									5,625	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			4,949									4,949	15
16	TOTAL Health Care and Programs	(19,525)		16,343		45							(3,136)	16
	C. General Administration													
17	Administrative			(313,182)									(313,182)	17
18	Directors Fees													18
19	Professional Services	(5,975)		5,335	2,308	884		(5,179)				(160)	(2,787)	19
20	Fees, Subscriptions & Promotions	(10,331)		408	343	4							(9,577)	20
21	Clerical & General Office Expenses	(165,548)		51,468	77,137	706							(36,238)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(67)		317	34								284	24
25	Other Admin. Staff Transportation			2,742									2,742	25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*			8,961	9,425								18,386	27
28	TOTAL General Administration	(181,921)		(243,951)	89,247	1,594		(5,179)				(160)	(340,371)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(199,791)		(216,618)	89,247	3,120		(5,179)				(160)	(329,381)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elevate Care Irving Park # 0056093 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 (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(6,317)			145	6,594							422	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,509)				1,645							(2,864)	32
33	Real Estate Taxes					1,288							1,288	33
34	Rent-Facility & Grounds					120							120	34
35	Rent-Equipment & Vehicles			1,505	194	603							2,302	35
36	Other (specify):*	(29,544)											(29,544)	36
37	TOTAL Ownership	(40,370)		1,505	339	10,250							(28,276)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(27,975)	(63,879)			(91,854)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(114,397)											(114,397)	43
44	TOTAL Special Cost Centers	(114,397)							(27,975)	(63,879)			(206,251)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(354,557)		(215,113)	89,586	13,370		(5,179)	(27,975)	(63,879)		(160)	(563,907)	45

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. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number

Elevate Care Irving Park

0056093

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	Meir Meystel	30.00%	Aperion Care Bradley	Bradley	Aperion Care Demotte	Demotte, IN	ALF	1
2	Declaration of Trust of Yosef Meystel	30.00%	Aperion Care Bridgeport	Bridgeport	Aperion Care, Inc.	Lincolnwood	Corporate Manager	2
3	Keystone Holding Group, LLC	30.00%	Aperion Care Burbank	Burbank	Aperion Consulting, LLC	Lincolnwood	Consulting Co.	3
4	Frederick S. Frankel Trust	1.00%	Aperion Care Capitol	Capitol	Aperion Estates Peru	Peru, IN	ALF	4
5	Amanda Andrews	1.00%	Aperion Care Chicago Heights	Chicago Heights	Aperion Financial, LLC	Lincolnwood	Bookkeeping	5
6	Jacob Bogoff	1.00%	Aperion Care Demotte	Demotte, IN	Aperion Incorporated Cell	Burlington, VT	Insurance	6
7	Jimmy Thengil	1.00%	Aperion Care Dolton	Dolton	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	7
8	Jordan Reifer	1.00%	Aperion Care Elgin	Elgin	Chase Office, LLC	Lincolnwood	Building Co.	8
9	Aaron Pancer	4.00%	Aperion Care Evanston	Evanston	Concerto Dialysis	Lincolnwood	Dialysis	9
10	Yerucham Winer	1.00%	Aperion Care Fairfield	Fairfield	Eco-Brite Linen	Skokie	Laundry	10
11			Aperion Care Forest Park	Forest Park	Elevate Care, Inc.	Skokie	Consulting	11
12			Aperion Care Glenwood	Glenwood	EMSA Purchasing Group	Lincolnwood	Purchasing	12
13			Aperion Care Highwood	Highwood	Interbuild Construction	Chicago	Bldg Improvements	13
14			Aperion Care International	Chicago	Lifescan Labs of Illinois, LLC	Skokie	Laboratory	14
15			Aperion Care Jacksonville	Jacksonville	OnTray, LLC	Lincolnwood	Kitchen Management	15
16			Aperion Care Kokomo	Kokomo, IN	Pointe Group Care, LLC	Boston, MA	Bookkeeping	16
17			Aperion Care Litchfield	Litchfield	Pointe Property, LLC	Boston, MA	Property Management	17
18			Aperion Care Marion	Marion, IN	PropayHR	Evanston	Payroll Services	18
19			Aperion Care Marseilles	Marseilles	Renewal Rehab, LLC	Lincolnwood	Therapy Services	19
20			Aperion Care Mascoutah	Mascoutah	San Antonio Property, LLC	San Antonio, TX	Building Co.	20
21			Aperion Care Midlothian	Midlothian				21
22			Aperion Care Morton Villa	Morton				22
23			Aperion Care Oak Lawn	Oak Lawn				23
24			Aperion Care Peoria Heights	Peoria Heights				24
25			Aperion Care Peru	Peru, IN				25
26			Aperion Care Plum Grove	Palatine				26
27			Aperion Care Princeton	Princeton				27
28			Aperion Care Spring Valley	Spring Valley				28
29			Aperion Care Springfield	Springfield				29
30			Aperion Care St. Elmo	St. Elmo				30

Facility Name & ID Number

Elevate Care Irving Park

0056093

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			Aperion Care Tolleston Park	Gary, IN				1
2			Aperion Care Toluca	Toluca				2
3			Aperion Care West Chicago	Springfield				3
4			Aperin Care West Ridge	Chicago				4
5			Aperion Care Wilmington	Wilmington				5
6			Arbors at Michigan City	Michigan City, IN				6
7			Elevate Care Chicago North	Chicago				7
8			Elevate Care Niles	Niles				8
9			Elevate Care North Branch	Niles				9
10			Elevate Care Northbrook	Northbrook				10
11			Elevate Care Riverwoods	Riverwoods				11
12			Elevate Care Waukegan	Waukegan				12
13			Arcadia of Bloomington	Bloomington				13
14			Arcadia of Danville	Danville				14
15			Arcadia of Clifton	Clifton				15
16			Glennon Place	Bolivar, MO				16
17			Hallmark Living Benton Harbor	Benton Harbo, MI				17
18			Legend Healthcare	Tonganoxie, KS				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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	3 <u>Housekeeping</u>	\$	<u>Elevate Care, Inc.</u>		\$ 49	\$ 49
16	V	6 <u>Repairs & Maintenance</u>		<u>Elevate Care, Inc.</u>		9,877	9,877
17	V	11 <u>Activity Expense</u>		<u>Elevate Care, Inc.</u>		5,625	5,625
18	V	2 <u>Food</u>		<u>Elevate Care, Inc.</u>		181	181
19	V	17 <u>Administrative</u>		<u>Elevate Care, Inc.</u>		37,203	37,203
20	V	19 <u>Professional Fees</u>		<u>Elevate Care, Inc.</u>		5,335	5,335
21	V	20 <u>Fees, Subscriptions</u>		<u>Elevate Care, Inc.</u>		408	408
22	V	21 <u>Clerical & General</u>		<u>Elevate Care, Inc.</u>		51,468	51,468
23	V	24 <u>Seminars</u>		<u>Elevate Care, Inc.</u>		317	317
24	V	25 <u>Auto & Travel</u>		<u>Elevate Care, Inc.</u>		2,742	2,742
25	V	26 <u>Insurance</u>		<u>Elevate Care, Inc.</u>			
26	V	35 <u>Equipment Rental</u>		<u>Elevate Care, Inc.</u>		276	276
27	V	35 <u>Auto Lease</u>		<u>Elevate Care, Inc.</u>		1,229	1,229
28	V	7 <u>Payroll Tax/Group Insurance</u>		<u>Elevate Care, Inc.</u>		883	883
29	V	10 <u>Nursing</u>		<u>Elevate Care, Inc.</u>		47,769	47,769
30	V	15 <u>Payroll Tax/Group Insurance</u>		<u>Elevate Care, Inc.</u>		4,949	4,949
31	V	27 <u>Emp. Ben. - Gen. Admin.</u>		<u>Elevate Care, Inc.</u>		8,961	8,961
32	V	17 <u>Management Fee Income</u>	350,385	<u>Elevate Care, Inc.</u>			(350,385)
33	V	10 <u>Consulting Income</u>	42,000	<u>Elevate Care, Inc.</u>			(42,000)
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 392,385			\$ 177,272	\$ * (215,113)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	19 Professional Fees		Aperion Financial, LLC		2,308	\$	2,308	15
16	V	20 Fees, Subscriptions		Aperion Financial, LLC		343		343	16
17	V	21 Clerical & General		Aperion Financial, LLC		43,548		43,548	17
18	V	24 Seminars		Aperion Financial, LLC		34		34	18
19	V	25 Auto & Travel		Aperion Financial, LLC					19
20	V	27 Emp. Ben. - Gen. Admin.		Aperion Financial, LLC		5,278		5,278	20
21	V	30 Depreciaton		Aperion Financial, LLC		145		145	21
22	V	32 Interest		Aperion Financial, LLC					22
23	V	35 Equipment Rental		Aperion Financial, LLC		194		194	23
24	V	21 Clerical & General -IL Only		Aperion Financial, LLC		33,589		33,589	24
25	V	27 Emp. Ben. - Gen. Admin.- IL Only		Aperion Financial, LLC		4,147		4,147	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		\$			89,586	\$ *	89,586	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 Utilities	\$	Chase Office, LLC		\$ 484	\$	484	15
16	V	6 Repairs & Maintenance		Chase Office, LLC		771		771	16
17	V	3 Housekeeping		Chase Office, LLC		227		227	17
18	V	10 Medical Supplies		Chase Office, LLC		45		45	18
19	V	19 Professional Fees		Chase Office, LLC		884		884	19
20	V	20 Dues & Subscriptions		Chase Office, LLC		4		4	20
21	V	21 Office Expense		Chase Office, LLC		706		706	21
22	V	30 Depreciation		Chase Office, LLC		6,594		6,594	22
23	V	32 Interest Expense		Chase Office, LLC		1,645		1,645	23
24	V	33 Real Estate Taxes		Chase Office, LLC		1,288		1,288	24
25	V	35 Equipment Rental		Chase Office, LLC		603		603	25
26	V	34 Rent		Chase Office, LLC		120		120	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		\$			\$ 13,370	\$ *	13,370	39

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

Facility Name & ID Number Elevate Care Irving Park

0056093

Report Period Beginning: 01/01/20

Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	04 Laundry Services	\$ 8,311	EcoBrite Linen		\$ 8,311	\$	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		\$ 8,311			\$ 8,311	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Payroll Services	\$ 22,607	ProPay HR LLC		\$ 17,428	\$ (5,179)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 22,607			\$ 17,428	\$ * (5,179)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 Laboratory	\$ 49,140	Lifescan Labs of Illinois		\$ 21,165	\$ (27,975)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 49,140			\$ 21,165	\$ * (27,975)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 Therapy Services	\$ 418,266	Renewal Rehab, LLC		\$ 354,387	\$ (63,879)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 418,266			\$ 354,387	\$ * (63,879)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	26 Insurance	\$ 187,383	Aperion Incorporated Cell		\$ 187,383	\$	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		\$ 187,383			\$ 187,383	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Data Processing	\$ 1,050	EMSA Purchasing Group		\$ 890	\$ (160)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,050			\$ 890	\$ * (160)

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

Facility Name & ID Number

Elevate Care Irving Park

0056093

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	Yosef Meystel	Relative	Administrative	0	See Attached	0.56	1.40%	Alloc Salary	\$ 3,511	17-7	1	
2	Jay Meystel	Relative	Clerical	0	See Attached	0.56	1.40%	Alloc Salary	826	21-7	2	
3	Elisheva Adest	Relative	Clerical	0	See Attached	0.38	1.40%	Alloc Salary	435	21-7	3	
4	Meir Meystel	Relative	Administrative	0	See Attached	2.98	7.44%	Alloc Salary	18,601	17-7	4	
5	Aaron Prancer	Relative	Administrative	0	See Attached	2.98	7.44%	Alloc Salary	18,601	17-7	5	
6	Fred Frankel	Relative	Administrative	0	See Attached	0.56	1.40%	Alloc Salary	3,511	17-7	6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 45,485		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 Elevate Care Irving Park

0056093

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 Elevate Care Irving Park

0056093

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

Elevate Care, Inc.

Street Address

5454 Fargo Ave.

City / State / Zip Code

Skokie, IL 60077

Phone Number

(847) 674-5454

Fax Number

(

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	3	Housekeeping	Census	358,576	7	\$ 660	\$ 26,680	\$ 49	1	
2	6	Repairs & Maintenance	Census	358,576	7	132,748	127,841	26,680	9,877	2
3	11	Activity Expense	Census	358,576	7	75,597	74,420	26,680	5,625	3
4	2	Food	Census	358,576	7	2,426		26,680	181	4
5	17	Administrative	Census	358,576	7	500,000	500,000	26,680	37,203	5
6	19	Professional Fees	Census	358,576	7	71,707		26,680	5,335	6
7	20	Fees, Subscriptions	Census	358,576	7	5,482		26,680	408	7
8	21	Clerical & General	Census	358,576	7	691,717	662,888	26,680	51,468	8
9	24	Seminars	Census	358,576	7	4,267		26,680	317	9
10	25	Auto & Travel	Census	358,576	7	36,847		26,680	2,742	10
11	26	Insurance	Census	358,576	7			26,680		11
12	35	Equipment Rental	Census	358,576	7	3,714		26,680	276	12
13	35	Auto Lease	Census	358,576	7	16,511		26,680	1,229	13
14	7	Payroll Tax/Group Insurance	Census	358,576	7	11,870		26,680	883	14
15	10	Nursing	Census	358,576	7	642,014	642,014	26,680	47,769	15
16	15	Payroll Tax/Group Insurance	Census	358,576	7	66,518		26,680	4,949	16
17	27	Emp. Ben. - Gen. Admin.	Census	358,576	7	120,438		26,680	8,961	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,382,516	\$ 2,007,163	\$	177,272	25

Facility Name & ID Number Elevate Care Irving Park

0056093

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Aperion Financial, LLC

Street Address

4655 W. Chase Ave.

City / State / Zip Code

Lincolnwood, Illinois 60712

Phone Number

(847) 262-3800

Fax Number

(

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Professional Fees	Census	1,899,996	65	164,380	26,680	2,308	1
2	20	Fees, Subscriptions	Census	1,899,996	65	24,450	26,680	343	2
3	21	Clerical & General	Census	1,899,996	65	3,101,245	3,044,021	43,548	3
4	24	Seminars	Census	1,899,996	65	2,428	26,680	34	4
5	25	Auto & Travel	Census	1,899,996	65		26,680		5
6	27	Emp. Ben. - Gen. Admin.	Census	1,899,996	65	375,858	26,680	5,278	6
7	30	Depreciaton	Census	1,899,996	65	10,323	26,680	145	7
8	32	Interest	Census	1,899,996	65		26,680		8
9	35	Equipment Rental	Census	1,899,996	65	13,849	26,680	194	9
10	21	Clerical & General -IL Only	Census/Direct Alloc	1,208,651	46	1,767,260	1,767,260	33,589	10
11	27	Emp. Ben. - Gen. Admin.- IL Only	Census/Direct Alloc	1,208,651	46	218,211	26,680	4,147	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					\$ 5,678,004	\$ 4,811,281	\$ 89,586	25

Facility Name & ID Number Elevate Care Irving Park

0056093

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 Chase Office, LLC
 Street Address 4655 W. Chase Ave.
 City / State / Zip Code Lincolnwood, Illinois 60712
 Phone Number (847) 262-3800
 Fax Number (

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Actual Census	1,899,996	65	\$ 34,497	\$ 26,680	\$ 484	1
2	6	Repairs & Maintenance	Actual Census	1,899,996	65	54,886	26,680	771	2
3	3	Housekeeping	Actual Census	1,899,996	65	16,134	26,680	227	3
4	10	Medical Supplies	Actual Census	1,899,996	65	3,211	26,680	45	4
5	19	Professional Fees	Actual Census	1,899,996	65	62,958	26,680	884	5
6	20	Dues & Subscriptions	Actual Census	1,899,996	65	256	26,680	4	6
7	21	Office Expense	Actual Census	1,899,996	65	50,267	26,680	706	7
8	30	Depreciation	Actual Census	1,899,996	65	469,583	26,680	6,594	8
9	32	Interest Expense	Actual Census	1,899,996	65	117,136	26,680	1,645	9
10	33	Real Estate Taxes	Actual Census	1,899,996	65	91,748	26,680	1,288	10
11	35	Equipment Rental	Actual Census	1,899,996	65	8,550	26,680	603	11
12	34	Rent	Actual Census	1,899,996	65	42,922	26,680	120	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					\$ 952,148	\$	\$ 13,370	25

Facility Name & ID Number Elevate Care Irving Park

0056093

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

()

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	4	Laundry Services	Direct		\$	\$		\$ 8,311	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 8,311	25

Facility Name & ID Number Elevate Care Irving Park

0056093

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

ProPay HR LLC

Street Address

2201 W. Main St.

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

(847) 905 3268

Fax Number

()

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct		\$	\$		\$ 17,428	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				\$	\$		\$ 17,428	25

Facility Name & ID Number Elevate Care Irving Park

0056093

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 LIFESCAN LABS OF ILLINOIS, LLC
 Street Address 5255 GOLF RD
 City / State / Zip Code SKOKIE, IL 60077
 Phone Number (847) 663 - 8300
 Fax Number ()

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Laboratory	Direct		\$	\$		\$ 21,165	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				\$	\$		\$ 21,165	25

Facility Name & ID Number Elevate Care Irving Park

0056093

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 Renewal Rehab, LLC
 Street Address 7358 N. Lincoln Ave., Suite 160
 City / State / Zip Code Lincolnwood, IL 60712
 Phone Number (847) 938-8750
 Fax Number (847) 410-9720

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Therapy Services	Direct	59	\$	\$		\$ 354,387	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				\$	\$		\$ 354,387	25

Facility Name & ID Number Elevate Care Irving Park

0056093

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Aperion Incorporated Cell

Street Address

30 Main Street, Suite 330

City / State / Zip Code

Burlington, Vermont 05401

Phone Number

()

Fax Number

()

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	26	Insurance	Direct Allocation		\$	\$		\$ 187,383	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				\$	\$		\$ 187,383	25

Facility Name & ID Number Elevate Care Irving Park

0056093

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

EMSA Purchasing Group

Street Address

4655 W. Chase Ave.

City / State / Zip Code

Lincolnwood, Illinois 60712

Phone Number

(847) 262-3800

Fax Number

()

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Data Processing	Direct		\$	\$		\$ 890	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				\$	\$		\$ 890	25

Facility Name & ID Number Elevate Care Irving Park # 0056093 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						\$	\$		\$	1										
2						\$	\$		\$	2										
3						\$	\$		\$	3										
4						\$	\$		\$	4										
5						\$	\$		\$	5										
Working Capital																				
6	Congessional Bank	X	Line of Credit				174,851		17,129	6										
7							-		-	7										
8										8										
9	TOTAL Facility Related					\$	\$ 174,851		\$ 17,129	9										
B. Non-Facility Related*																				
10	Interest Income	X							(4,509)	10										
11	Allocated from Chase Office								1,645	11										
12									-	12										
13										13										
14	TOTAL Non-Facility Related					\$	\$		\$ (2,864)	14										
15	TOTALS (line 9+line14)					\$	\$ 174,851		\$ 14,265	15										

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2019 report.	\$	216,778	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.)	\$	220,908	2
3. Under or (over) accrual (line 2 minus line 1).	\$	4,130	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	219,620	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	223,750	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	149,495	8
	2016	163,376	9
	2017	184,296	10
	2018	189,733	11
	2019	219,620	12

2020 Accrual = 2019 Real Estate Tax Allocated from Chase Office \$1,288

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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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 Elevate Care Irving Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0056093

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)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>13-15-404-035-0000</u>	<u>4340 North Keystone, Chicago IL</u>	\$ <u>219,620</u>	\$ <u>219,620</u>
2. <u>10-27-307-027-0000</u>	<u>Allocated from Chase Office</u>	\$ <u>72,111</u>	\$ <u>962</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>291,730</u></u>	\$ <u><u>220,582</u></u>

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 Elevate Care Irving Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0056093

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)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
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 Elevate Care Irving Park

0056093

Report Period Beginning:

01/01/20

Ending:

12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,200 B. General Construction Type: Exterior Brick Frame Concrete & Steel Number of Stories 3

C. Does the Operating Entity? (a) Own the Facility (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (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 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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and an unlabeled column. Row 1: 1, 2, 3, \$, 1. Row 2: 2, Allocated from Chase Office LLC, 828, 2. Row 3: 3, TOTALS, \$, 828, 3.

Facility Name & ID Number Elevate Care Irving Park

0056093

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

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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								67
68			52,131	3,553		2,425	(1,129)	10,003
69				7,142			(7,142)	
70			\$ 52,131	\$ 10,696		\$ 2,425	\$ (8,271)	\$ 10,003

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

Facility Name & ID Number Elevate Care Irving Park

0056093

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		\$ 52,131	\$ 10,696		\$ 2,425	\$ (8,271)	\$ 10,003	1
2	Install, Identify, Terminate And Test 58 Cat6 Cables	2019	18,560		20	928	928	928	2
3	Electrical Wiring Work In Basement & Kitchen; New Wiring For	2020	3,750		20	188	188	188	3
4	Phone System Set Up	2020	9,105		20	455	455	455	4
5	Repaired Water Boiler - Replaced Tubes	2020	2,931		20	293	293	293	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)		\$ 86,477	\$ 10,696		\$ 4,288	\$ (6,407)	\$ 11,867	34

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

Facility Name & ID Number Elevate Care Irving Park

0056093

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 86,477	\$ 10,696		\$ 4,288	\$ (6,407)	\$ 11,867	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		\$ 86,477	\$ 10,696		\$ 4,288	\$ (6,407)	\$ 11,867	34

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

Facility Name & ID Number Elevate Care Irving Park

0056093

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 86,477	\$ 10,696		\$ 4,288	\$ (6,407)	\$ 11,867	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)	\$ 86,477	\$ 10,696		\$ 4,288	\$ (6,407)	\$ 11,867	34

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

Facility Name & ID Number Elevate Care Irving Park

0056093

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 86,477	\$ 10,696		\$ 4,288	\$ (6,407)	\$ 11,867	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)	\$ 86,477	\$ 10,696		\$ 4,288	\$ (6,407)	\$ 11,867	34

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

Facility Name & ID Number Elevate Care Irving Park

0056093

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.

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
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.

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Related Party		\$	\$		\$	\$		1
2	Buildings:								2
3	Allocated from Chase Office LLC	2016	7,455	191	20	191		844	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Chase Office LLC	2020	149		20	7	7	7	9
10	Allocated from Chase Office LLC	2019	3,797	172	20	190	17	380	10
11	Allocated from Chase Office LLC	2018	34	2	20	2	(0)	5	11
12	Allocated from Chase Office LLC	2017	1,726	422	20	86	(336)	345	12
13	Allocated from Chase Office LLC	2016	37,783	2,766	20	1,889	(877)	8,344	13
14									14
15	Allocated from Elevate Care, Inc.	2019	368		20	18	18	37	15
16	Allocated from Elevate Care, Inc.	2020	820		20	41	41	41	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)		\$ 52,131	\$ 3,553		\$ 2,425	\$ (1,129)	\$ 10,003	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 52,131	\$ 3,553		\$ 2,425	\$ (1,129)	\$ 10,003	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)	\$ 52,131	\$ 3,553		\$ 2,425	\$ (1,129)	\$ 10,003	34

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

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	\$ 25,560	\$ 3,185	\$ 2,556	\$ (630)	10	\$ 8,473	71
72	Current Year Purchases	7,198		720	720	10	720	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 32,758	\$ 3,185	\$ 3,276	\$ 90		\$ 9,193	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)	\$ 120,063	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 13,881	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 7,564	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (6,317)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 21,060	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Elston Real Estate & Development, LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. 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:	<u>1971</u>	<u>117</u>		\$ <u>200,952</u>			3
4	Additions							4
5	<u>Allocated from Chase Office</u>				<u>120</u>			5
6								6
7	TOTAL		117		\$ <u>201,072</u>			7

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2021</u>	\$ _____
13.	<u>/2022</u>	\$ _____
14.	<u>/2023</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 5,554

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	<u>Facility</u>	<u>GM</u>	\$ <u>386</u>	\$ <u>1,545</u>	17
18	<u>Allocated from Elevate Care</u>			<u>1,229</u>	18
19					19
20					20
21	TOTAL		\$ <u>386</u>	\$ <u>2,774</u>	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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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.)

	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	\$		\$ 159,528	\$		\$ 159,528	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			77,950			77,950	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			171,652			171,652	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				115,005		115,005	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):						19,764		19,764	13
14	TOTAL			\$		\$ 409,130	\$ 134,769		\$ 543,899	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 Elevate Care Irving Park

0056093

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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 140,814	\$	1
2	Cash-Patient Deposits	760		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	919,679		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	10,632		6
7	Other Prepaid Expenses	9,316		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached</u>	415,281		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,496,482	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	24,710		15
16	Equipment, at Historical Cost	42,601		16
17	Accumulated Depreciation (book methods)	(7,314)		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): <u>See Attached</u>	106,826		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 166,823	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,663,305	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 166,954	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	174,851		29
30	Accrued Salaries Payable	173,409		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,017		31
32	Accrued Real Estate Taxes(Sch.IX-B)	219,620		32
33	Accrued Interest Payable	2,382		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached</u>	763,183		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,504,416	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached</u>	2,726		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,726	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,507,142	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 156,163	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,663,305	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 281,684	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 281,684	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(108,854)	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	(16,667)	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)	\$ (125,521)	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)	\$ 156,163	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Elevate Care Irving Park

0056093

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.

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,069,841	1
2	Discounts and Allowances for all Levels	759,996	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,829,837	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	159,223	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 159,223	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	2,502	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	665	19
20	Radiology and X-Ray	98	20
21	Other Medical Services	16,797	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 20,062	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,509	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,509	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	819,288	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 819,288	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,832,919	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,233,533	31
32	Health Care	3,471,142	32
33	General Administration	1,912,122	33
B. Capital Expense			
34	Ownership	483,255	34
C. Ancillary Expense			
35	Special Cost Centers	658,296	35
36	Provider Participation Fee	183,425	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,941,773	40
41	Income before Income Taxes (line 30 minus line 40)**	(108,854)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (108,854)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,100,491	44
45	Private Pay - Net Inpatient Revenue	57,974	45
46	Medicare - Net Inpatient Revenue	1,845,830	46
47	Other-(specify) <u>Insurance/Managed Care</u>	3,677,028	47
48	Other-(specify) <u>Veterans/PPHP</u>	148,514	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,829,837	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 Elevate Care Irving Park

0056093

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	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,952	2,505	\$ 124,776	\$ 49.81	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,292	15,997	534,551	33.42	3
4	Licensed Practical Nurses	22,076	24,181	711,977	29.44	4
5	CNAs & Orderlies	49,077	54,513	893,568	16.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,646	4,246	110,234	25.96	8
9	Activity Director	2,056	2,362	39,472	16.71	9
10	Activity Assistants	4,602	4,814	70,853	14.72	10
11	Social Service Workers	5,944	6,507	183,268	28.16	11
12	Dietician					12
13	Food Service Supervisor	2,136	2,436	54,922	22.55	13
14	Head Cook	5,086	5,396	84,036	15.57	14
15	Cook Helpers/Assistants	10,754	12,249	182,765	14.92	15
16	Dishwashers					16
17	Maintenance Workers	2,404	2,766	72,507	26.21	17
18	Housekeepers	12,833	14,051	220,910	15.72	18
19	Laundry	4,651	5,090	83,511	16.41	19
20	Administrator	1,892	1,994	117,597	58.98	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,074	6,551	103,714	15.83	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	1,992	2,190	40,832	18.64	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	2,064	2,160	86,538	40.06	33
34	TOTAL (lines 1 - 33)	153,531	170,008	\$ 3,716,031 *	\$ 21.86	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 12,336	01-03	35
36	Medical Director	Monthly	24,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	42,000	10-03	38
39	Pharmacist Consultant	Monthly	6,010	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	25	1,197	11-03	44
45	Social Service Consultant	89	3,152	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	114	\$ 88,895		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,184	\$ 51,951	10-03	50
51	Licensed Practical Nurses	3,374	141,994	10-03	51
52	Certified Nurse Assistants/Aides	3,430	117,882	10-03	52
53	TOTAL (lines 50 - 52)	7,988	\$ 311,827		53

Facility Name & ID Number Elevate Care Irving Park

0056093

Report Period Beginning: 01/01/20

Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
Jordan LaQuanta	Administrator		\$ 17,044	Workers' Compensation Insurance	\$ 65,720	IDPH License Fee	\$ 2,307	
Ben Benyomin Kramer	Administrator		100,553	Unemployment Compensation Insurance	45,016	Advertising: Employee Recruitment	3,464	
				FICA Taxes	284,276	Health Care Worker Background Check		
				Employee Health Insurance	63,413	(Indicate # of checks performed 32)	316	
				Employee Meals	18,163	Patient Background Checks	113 1,130	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	28,286	
				Employee Physicals	15,141	Licenses & Fees	1,068	
				Employee Benefits	22,448			
				Union Pension Fund	27,848			
				Hospitalization Ins - Union	81,819	See Supplemental Schedule	754	
				401K Expense	900	Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 117,597	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 624,743		\$ 37,325		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees - Elevate Care Inc.			\$ 350,385				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 350,385				Seminar Expense	527
C. Professional Services				TOTAL			See Supplemental Schedule	351
Vendor/Payee	Type		Amount				Entertainment Expense	()
National Datacare Corporation	Resident Trust Fund Service		\$ 2,124				(agree to Sch. V, line 24, col. 8)	
Aperion Care	Data Processing		258				TOTAL	
Creative Technology Solutions	IT Consulting		35,836				\$ 879	
Elevate Care Inc	Data Processing		33,883					
EMSA Purchasing Group, LLC	Procurement Solutions		1,050					
PointClickCare Technologies Inc.	Data Processing		37,283					
Reside Admissions LLC	Data Processing		4,635					
Telemedicine Solutions LLC	Data Processing		8,400					
Propay HR	Payroll Processing		22,607					
Marcum LLP	Accounting Fees		4,120					
See Attached	Legal		9,528					
See Supplemental Schedule			64,253					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 223,976					

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HCCI \$20,662
- (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. \$ 30,044 Line 10-02
- (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. \$ 183,425
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. \$ 18,163 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 - c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
 - d. Have vehicle usage logs been maintained? Yes
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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.