

		FOR BHF USE				

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

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

<p>I. IDPH License ID Number: <u>0055558</u></p> <p>Facility Name: <u>Elevate Care Northbrook</u></p> <p>Address: <u>270 Skokie Blvd</u> <u>Northbrook</u> <u>60062</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(847) 498-9320</u> Fax # <u>(847) 418-3998</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>12/1/2019</u></p> <p>Type of Ownership:</p> <table style="width:100%;"> <tr> <td style="width:33%;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/20</u> to <u>12/31/20</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td rowspan="5" style="vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ <i>* Subject to the attached Accountants' Consulting Report</i> (Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u></td> </tr> <tr> <td>(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td> </tr> <tr> <td>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Date) _____		(Title) _____	Paid Preparer	(Signed) _____ <i>* Subject to the attached Accountants' Consulting Report</i> (Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																	
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Facility Name & ID Number Elevate Care Northbrook

0055558 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	164	Skilled (SNF)	164	60,024	1
2		Skilled Pediatric (SNF/PED)			2
3	134	Intermediate (ICF)	134	49,044	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	298	TOTALS	298	109,068	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	16,793	177	4,118	21,088	8
9	SNF/PED					9
10	ICF	50,378	531		50,909	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	67,170	708	4,118	71,996	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.01%

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 150 and days of care provided 2,397

Medicare Intermediary Wisconsin Physicians Service Insurance Corporation

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Elevate Care Northbrook # 0055558 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	482,115	92,497	19,490	594,102		594,102		594,102		1
2	Food Purchase		386,595		386,595		386,595	449	387,044		2
3	Housekeeping	389,651	104,128		493,779		493,779	744	494,523		3
4	Laundry	32,190	8,912	170,507	211,609		211,609		211,609		4
5	Heat and Other Utilities			242,427	242,427		242,427	(18,062)	224,365		5
6	Maintenance	176,592	53,734	163,061	393,387		393,387	20,522	413,909		6
7	Other (specify):*							2,383	2,383		7
8	TOTAL General Services	1,080,548	645,866	595,485	2,321,899		2,321,899	6,036	2,327,935		8
	B. Health Care and Programs										
9	Medical Director			65,125	65,125		65,125		65,125		9
10	Nursing and Medical Records	5,063,454	692,828	720,938	6,477,220		6,477,220	39,027	6,516,247		10
10a	Therapy	272			272		272		272		10a
11	Activities	190,121	14,626	416	205,163		205,163	15,179	220,342		11
12	Social Services	273,635		861	274,496		274,496		274,496		12
13	CNA Training										13
14	Program Transportation			14,828	14,828		14,828		14,828		14
15	Other (specify):*							13,356	13,356		15
16	TOTAL Health Care and Programs	5,527,482	707,454	802,168	7,037,104		7,037,104	67,562	7,104,666		16
	C. General Administration										
17	Administrative	95,302		835,782	931,084		931,084	(735,390)	195,694		17
18	Directors Fees										18
19	Professional Services			404,406	404,406		404,406	(29,956)	374,450		19
20	Dues, Fees, Subscriptions & Promotions			80,524	80,524		80,524	(24,278)	56,246		20
21	Clerical & General Office Expenses	244,158		284,129	528,287		528,287	137,869	666,156		21
22	Employee Benefits & Payroll Taxes			1,127,766	1,127,766		1,127,766		1,127,766		22
23	Inservice Training & Education										23
24	Travel and Seminar			9,235	9,235		9,235	575	9,810		24
25	Other Admin. Staff Transportation			898	898		898	7,398	8,296		25
26	Insurance-Prop.Liab.Malpractice			298,059	298,059		298,059		298,059		26
27	Other (specify):*							49,616	49,616		27
28	TOTAL General Administration	339,460		3,040,799	3,380,259		3,380,259	(594,166)	2,786,093		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,947,490	1,353,320	4,438,452	12,739,262		12,739,262	(520,568)	12,218,694		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 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
	D. Ownership										
30	Depreciation			8,768	8,768		8,768	9,307	18,075		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			93,029	93,029		93,029	(11,955)	81,074		32
33	Real Estate Taxes			543,179	543,179		543,179	3,477	546,656		33
34	Rent-Facility & Grounds			2,405,047	2,405,047		2,405,047	324	2,405,371		34
35	Rent-Equipment & Vehicles			9,399	9,399		9,399	6,212	15,611		35
36	Other (specify):*			23,370	23,370		23,370	(23,370)	(0)		36
37	TOTAL Ownership			3,082,792	3,082,792		3,082,792	(16,006)	3,066,786		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers	428,095	367,617	423,669	1,219,381		1,219,381	(94,924)	1,124,457		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			510,540	510,540		510,540		510,540		42
43	Other (specify):*	87,050		29,518	116,568		116,568	(116,568)	0		43
44	TOTAL Special Cost Centers	515,145	367,617	963,727	1,846,489		1,846,489	(211,492)	1,634,997		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,462,635	1,720,937	8,484,971	17,668,543		17,668,543	(748,066)	16,920,477		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 Northbrook

0055558

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	(19,369)	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	(8,878)	30		9
10	Interest and Other Investment Income	(16,394)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(38)	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	(13)	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	(206,632)	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	(223,912)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (475,236)		\$	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)	(272,830)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (272,830)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (748,066)		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 Northbrook

ID# 0055558

Report Period Beginning: 01/01/20

Ending: 12/31/20

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non-Allowable Legal	\$ (41,393)	19	1
2	Supplemental Insurance	(285)	21	2
3	Credit Card Processing	(2,006)	21	3
4	Marketing Salaries	(87,050)	43	4
5	Advertising/Marketing	(17,461)	43	5
6	Marketing Food	(861)	43	6
7	Promotional Products	(11,196)	43	7
8	Bank Charges	(1,552)	21	8
9	Theft & Damage Loss	(297)	21	9
10	Website	(292)	21	10
11	Amotization	(23,370)	36	11
12	Additional R&M	9,263	06	12
13	Non Allowable Professional	(3,250)	19	13
14	PAC Dues	(26,314)	20	14
15	Non Allowable Seminar	(374)	24	15
16	Capitalized R&M	(17,475)	06	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
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34				34
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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	(223,912)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elevate Care Northbrook# 0055558

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	(38)		487									449	2
3	Housekeeping			132		611							744	3
4	Laundry													4
5	Heat and Other Utilities	(19,369)				1,307							(18,062)	5
6	Maintenance	(8,212)		26,654		2,080							20,522	6
7	Other (specify):*			2,383									2,383	7
8	TOTAL General Services	(27,619)		29,657		3,998							6,036	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			38,906		122							39,027	10
10a	Therapy													10a
11	Activities			15,179									15,179	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			13,356									13,356	15
16	TOTAL Health Care and Programs			67,440		122							67,562	16
	C. General Administration													
17	Administrative			(735,390)									(735,390)	17
18	Directors Fees													18
19	Professional Services	(44,643)		14,397	6,229	2,386		(8,165)	(160)				(29,956)	19
20	Fees, Subscriptions & Promotions	(26,314)		1,101	926	10							(24,278)	20
21	Clerical & General Office Expenses	(211,076)		138,885	208,155	1,905							137,869	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(374)		857	92								575	24
25	Other Admin. Staff Transportation			7,398									7,398	25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*			24,182	25,434								49,616	27
28	TOTAL General Administration	(282,407)		(548,570)	240,836	4,300		(8,165)	(160)				(594,166)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(310,026)		(451,474)	240,836	8,420		(8,165)	(160)				(520,568)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elevate Care Northbrook

005558

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	(8,878)			391	17,794							9,307	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(16,394)				4,439							(11,955)	32
33	Real Estate Taxes					3,477							3,477	33
34	Rent-Facility & Grounds					324							324	34
35	Rent-Equipment & Vehicles			4,061	525	1,626							6,212	35
36	Other (specify):*	(23,370)											(23,370)	36
37	TOTAL Ownership	(48,642)		4,061	916	27,659							(16,006)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers									(30,239)	(64,685)		(94,924)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(116,568)											(116,568)	43
44	TOTAL Special Cost Centers	(116,568)								(30,239)	(64,685)		(211,492)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(475,236)		(447,413)	241,752	36,080		(8,165)	(160)	(30,239)	(64,685)		(748,066)	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 Northbrook

0055558

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	Elevate HoldCo Op, LLC	100.00%	Aperion Care Bradley	Bradley	Aperion Care Demotte	Demotte, IN	ALF	1
2			Aperion Care Bridgeport	Bridgeport	Aperion Care, Inc.	Lincolnwood	Corporate Manager	2
3			Aperion Care Burbank	Burbank	Aperion Consulting, LLC	Lincolnwood	Consulting Co.	3
4			Aperion Care Capitol	Capitol	Aperion Estates Peru	Peru, IN	ALF	4
5			Aperion Care Chicago Heights	Chicago Heights	Aperion Financial, LLC	Lincolnwood	Bookkeeping	5
6			Aperion Care Demotte	Demotte, IN	Aperion Incorporated Cell	Burlington, VT	Insurance	6
7			Aperion Care Dolton	Dolton	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	7
8			Aperion Care Elgin	Elgin	Chase Office, LLC	Lincolnwood	Building Co.	8
9			Aperion Care Evanston	Evanston	Concerto Dialysis	Lincolnwood	Dialysis	9
10			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 Northbrook

0055558

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 Irving Park	Chicago				8
9			Elevate Care Niles	Niles				9
10			Elevate Care North Branch	Niles				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>		\$ 132	\$ 132
16	V	6 <u>Repairs & Maintenance</u>		<u>Elevate Care, Inc.</u>		26,654	26,654
17	V	11 <u>Activity Expense</u>		<u>Elevate Care, Inc.</u>		15,179	15,179
18	V	2 <u>Food</u>		<u>Elevate Care, Inc.</u>		487	487
19	V	17 <u>Administrative</u>		<u>Elevate Care, Inc.</u>		100,392	100,392
20	V	19 <u>Professional Fees</u>		<u>Elevate Care, Inc.</u>		14,397	14,397
21	V	20 <u>Fees, Subscriptions</u>		<u>Elevate Care, Inc.</u>		1,101	1,101
22	V	21 <u>Clerical & General</u>		<u>Elevate Care, Inc.</u>		138,885	138,885
23	V	24 <u>Seminars</u>		<u>Elevate Care, Inc.</u>		857	857
24	V	25 <u>Auto & Travel</u>		<u>Elevate Care, Inc.</u>		7,398	7,398
25	V	26 <u>Insurance</u>		<u>Elevate Care, Inc.</u>			
26	V	35 <u>Equipment Rental</u>		<u>Elevate Care, Inc.</u>		746	746
27	V	35 <u>Auto Lease</u>		<u>Elevate Care, Inc.</u>		3,315	3,315
28	V	7 <u>Payroll Tax/Group Insurance</u>		<u>Elevate Care, Inc.</u>		2,383	2,383
29	V	10 <u>Nursing</u>		<u>Elevate Care, Inc.</u>		128,906	128,906
30	V	15 <u>Payroll Tax/Group Insurance</u>		<u>Elevate Care, Inc.</u>		13,356	13,356
31	V	27 <u>Emp. Ben. - Gen. Admin.</u>		<u>Elevate Care, Inc.</u>		24,182	24,182
32	V	17 <u>Management Fee Income</u>	835,782	<u>Elevate Care, Inc.</u>			(835,782)
33	V	10 <u>Consulting Income</u>	90,000	<u>Elevate Care, Inc.</u>			(90,000)
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 925,782			\$ 478,369	\$ * (447,413)

* 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		6,229	\$	6,229	15
16	V	20 Fees, Subscriptions		Aperion Financial, LLC		926		926	16
17	V	21 Clerical & General		Aperion Financial, LLC		117,515		117,515	17
18	V	24 Seminars		Aperion Financial, LLC		92		92	18
19	V	25 Auto & Travel		Aperion Financial, LLC					19
20	V	27 Emp. Ben. - Gen. Admin.		Aperion Financial, LLC		14,242		14,242	20
21	V	30 Depreciaton		Aperion Financial, LLC		391		391	21
22	V	32 Interest		Aperion Financial, LLC					22
23	V	35 Equipment Rental		Aperion Financial, LLC		525		525	23
24	V	21 Clerical & General -IL Only		Aperion Financial, LLC		90,640		90,640	24
25	V	27 Emp. Ben. - Gen. Admin.- IL Only		Aperion Financial, LLC		11,192		11,192	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		\$			241,752	\$ *	241,752	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		\$ 1,307	\$	1,307	15
16	V	6 Repairs & Maintenance		Chase Office, LLC		2,080		2,080	16
17	V	3 Housekeeping		Chase Office, LLC		611		611	17
18	V	10 Medical Supplies		Chase Office, LLC		122		122	18
19	V	19 Professional Fees		Chase Office, LLC		2,386		2,386	19
20	V	20 Dues & Subscriptions		Chase Office, LLC		10		10	20
21	V	21 Office Expense		Chase Office, LLC		1,905		1,905	21
22	V	30 Depreciation		Chase Office, LLC		17,794		17,794	22
23	V	32 Interest Expense		Chase Office, LLC		4,439		4,439	23
24	V	33 Real Estate Taxes		Chase Office, LLC		3,477		3,477	24
25	V	35 Equipment Rental		Chase Office, LLC		1,626		1,626	25
26	V	34 Rent		Chase Office, LLC		324		324	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		\$			\$ 36,080	\$ *	36,080	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	04 Laundry Services	\$ 170,507	EcoBrite Linen		\$ 170,507	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V	39 Dialysis	\$ 110,670	Concerto Dialysis		110,670		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		\$ 281,177			\$ 281,177	\$ *	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	\$ 35,641	ProPay HR LLC		\$ 27,476	\$ (8,165)
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		\$ 35,641			\$ 27,476	\$ * (8,165)

* 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.

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	\$ 53,117	Lifescan Labs of Illinois		\$ 22,878	\$ (30,239)
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		\$ 53,117			\$ 22,878	\$ * (30,239)

* 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	\$ 423,545	Renewal Rehab, LLC		\$ 358,860	\$ (64,685)
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		\$ 423,545			\$ 358,860	\$ * (64,685)

* 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	\$ 257,437	Aperion Incorporated Cell		\$ 257,437	\$
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		\$ 257,437			\$ 257,437	\$ *

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

Facility Name & ID Number

Elevate Care Northbrook

0055558

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	1.52	3.79%	Alloc Salary	\$ 9,473	17-7	1	
2	David Berkowitz	Relative	Administrative	0	See Attached	1.52	3.79%	Alloc Salary	4,354	17-7	2	
3	Jay Meystel	Relative	Clerical	0	See Attached	1.52	3.79%	Alloc Salary	2,229	21-7	3	
4	Elisheva Adest	Relative	Clerical	0	See Attached	1.03	3.79%	Alloc Salary	1,175	21-7	4	
5	Meir Meystel	Relative	Administrative	0	See Attached	8.03	20.08%	Alloc Salary	50,196	17-7	5	
6	Aaron Prancer	Relative	Administrative	0	See Attached	8.03	20.08%	Alloc Salary	50,196	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	\$ 117,623		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 Northbrook

005558

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 Northbrook

0055558

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	\$ 71,996	\$ 132	1	
2	6	Repairs & Maintenance	Census	358,576	7	132,748	127,841	71,996	26,654	2
3	11	Activity Expense	Census	358,576	7	75,597	74,420	71,996	15,179	3
4	2	Food	Census	358,576	7	2,426	71,996	487	4	
5	17	Administrative	Census	358,576	7	500,000	500,000	71,996	100,392	5
6	19	Professional Fees	Census	358,576	7	71,707	71,996	14,397	6	
7	20	Fees, Subscriptions	Census	358,576	7	5,482	71,996	1,101	7	
8	21	Clerical & General	Census	358,576	7	691,717	662,888	71,996	138,885	8
9	24	Seminars	Census	358,576	7	4,267	71,996	857	9	
10	25	Auto & Travel	Census	358,576	7	36,847	71,996	7,398	10	
11	26	Insurance	Census	358,576	7		71,996		11	
12	35	Equipment Rental	Census	358,576	7	3,714	71,996	746	12	
13	35	Auto Lease	Census	358,576	7	16,511	71,996	3,315	13	
14	7	Payroll Tax/Group Insurance	Census	358,576	7	11,870	71,996	2,383	14	
15	10	Nursing	Census	358,576	7	642,014	642,014	71,996	128,906	15
16	15	Payroll Tax/Group Insurance	Census	358,576	7	66,518	71,996	13,356	16	
17	27	Emp. Ben. - Gen. Admin.	Census	358,576	7	120,438	71,996	24,182	17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 2,382,516	\$ 2,007,163	\$ 478,369	25	

Facility Name & ID Number Elevate Care Northbrook

0055558

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 Aperion Financial, 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	19	Professional Fees	Census	1,899,996	65	164,380	71,996	6,229	1
2	20	Fees, Subscriptions	Census	1,899,996	65	24,450	71,996	926	2
3	21	Clerical & General	Census	1,899,996	65	3,101,245	3,044,021	117,515	3
4	24	Seminars	Census	1,899,996	65	2,428	71,996	92	4
5	25	Auto & Travel	Census	1,899,996	65		71,996		5
6	27	Emp. Ben. - Gen. Admin.	Census	1,899,996	65	375,858	71,996	14,242	6
7	30	Depreciaton	Census	1,899,996	65	10,323	71,996	391	7
8	32	Interest	Census	1,899,996	65		71,996		8
9	35	Equipment Rental	Census	1,899,996	65	13,849	71,996	525	9
10	21	Clerical & General -IL Only	Census/Direct Alloc	1,208,651	46	1,767,260	1,767,260	90,640	10
11	27	Emp. Ben. - Gen. Admin.- IL Only	Census/Direct Alloc	1,208,651	46	218,211	71,996	11,192	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	\$ 241,752	25

Facility Name & ID Number Elevate Care Northbrook

0055558

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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	5	Utilities	Actual Census	1,899,996	65	\$ 34,497	\$ 71,996	\$ 1,307	1
2	6	Repairs & Maintenance	Actual Census	1,899,996	65	54,886	71,996	2,080	2
3	3	Housekeeping	Actual Census	1,899,996	65	16,134	71,996	611	3
4	10	Medical Supplies	Actual Census	1,899,996	65	3,211	71,996	122	4
5	19	Professional Fees	Actual Census	1,899,996	65	62,958	71,996	2,386	5
6	20	Dues & Subscriptions	Actual Census	1,899,996	65	256	71,996	10	6
7	21	Office Expense	Actual Census	1,899,996	65	50,267	71,996	1,905	7
8	30	Depreciation	Actual Census	1,899,996	65	469,583	71,996	17,794	8
9	32	Interest Expense	Actual Census	1,899,996	65	117,136	71,996	4,439	9
10	33	Real Estate Taxes	Actual Census	1,899,996	65	91,748	71,996	3,477	10
11	35	Equipment Rental	Actual Census	1,899,996	65	8,550	71,996	1,626	11
12	34	Rent	Actual Census	1,899,996	65	42,922	71,996	324	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	\$	\$ 36,080	25

Facility Name & ID Number Elevate Care Northbrook

005558

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 EcoBrite Linen / Concerto Dialysis
 Street Address 3712 Jarvis Avenue / 4600 W. Touhy
 City / State / Zip Code Skokie, IL 60076 / Lincolnwood, IL 60712
 Phone Number (847) 582-4000 / (847) 233-1202
 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	4	Laundry Services	Direct		\$	\$		\$ 170,507	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10	39	Dialysis	Direct					110,670	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				\$	\$		\$ 281,177	25

Facility Name & ID Number Elevate Care Northbrook

005558

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		\$	\$		\$ 27,476	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 27,476	25

Facility Name & ID Number Elevate Care Northbrook

005558

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 Northbrook

005558

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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 ()

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	39	Laboratory	Direct		\$	\$		\$ 22,878	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				\$	\$		\$ 22,878	25

Facility Name & ID Number Elevate Care Northbrook

005558

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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	39	Therapy Services	Direct	59	\$	\$		\$ 358,860	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				\$	\$		\$ 358,860	25

Facility Name & ID Number Elevate Care Northbrook

0055558

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		\$	\$		\$ 257,437	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				\$	\$		\$ 257,437	25

Facility Name & ID Number

Elevate Care Northbrook

0055558

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		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	Congressional Bank	X						-		93,029								
7								-		-								
8																		
9	TOTAL Facility Related					\$	\$		\$	93,029								
B. Non-Facility Related*																		
10	Interest Income	X								(16,394)								
11	Allocated from Chase Office									4,439								
12										-								
13																		
14	TOTAL Non-Facility Related					\$	\$		\$	(11,955)								
15	TOTALS (line 9+line14)					\$	\$		\$	81,074								

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.	\$	545,543	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.)	\$	547,838	2
3. Under or (over) accrual (line 2 minus line 1).	\$	2,295	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	544,361	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.	\$	546,656	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	590,122	8
	2016	505,072	9
	2017	554,279	10
	2018	568,989	11
	2019	544,361	12

2020 Accrual = 2020 Tax

Allocated from Chase Office \$3,477

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

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Elevate Care Northbrook COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0055558

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>04-02-202-033-0000</u>	<u>270 Skokie Highway</u>	\$ <u>123,827</u>	\$ <u>123,827</u>
2. <u>04-02-202-038-0000</u>	<u>270 Skokie Highway</u>	\$ <u>420,534</u>	\$ <u>420,534</u>
3. <u>10-27-307-027-0000</u>	<u>Allocated from Chase Office</u>	\$ <u>72,111</u>	\$ <u>2,596</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>616,472</u></u>	\$ <u><u>546,957</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 Northbrook COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0055558

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 X 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 Northbrook

0055558

Report Period Beginning:

01/01/20

Ending:

12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 72,000 B. General Construction Type: Exterior Brick Frame 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

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 a final column for counts. Row 1: 1, Use, Square Feet, Year Acquired, \$, 1. Row 2: 2, Allocated from Chase Office LLC, 2,235, 2. Row 3: 3, TOTALS, \$, 2,235, 3.

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			140,674	9,589		6,544	(3,044)	26,993				
69				8,768			(8,768)					
70		\$	140,674	\$	18,357	\$	6,544	\$	(11,812)	\$	26,993	70

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

Facility Name & ID Number Elevate Care Northbrook

0055558

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		\$ 140,674	\$ 18,357		\$ 6,544	\$ (11,812)	\$ 26,993	1
2	New Concrete Floor	2020	2,800		20	140	140	140	2
3	Plumbing Work On Pipes, New Tempering Valve	2020	11,500		20	575	575	575	3
4	Delay Egress Single Lock	2020	2,715		20	136	136	136	4
5	Refinsh The Outdoor Signs	2020	2,700		20	135	135	135	5
6	Update Sign With Polycarbonate Face And Led'S	2020	6,023		20	301	301	301	6
7	Rbld Dura 1000, Motor, Sensor, Gear Reducer (For Doors)	2020	3,842		20	192	192	192	7
8	Break Up 25 Ft Floor Of Concrete Up To Wall & Install Pipe	2020	14,200		20	710	710	710	8
9	6 Fabric Roller Shades In Dining Room (3,350)	2020	1,961		20	98	98	98	9
10	Radiator Replacement, Alternator And Fan Belt Replacement	2020	4,611		20	231	231	231	10
11	Repaired The Elevator	2020	4,263		20	426	426	426	11
12	Plumbing Rpz Installation	2020	2,743		20	274	274	274	12
13	Elevator Repair	2020	4,263		20	426	426	426	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)		\$ 202,294	\$ 18,357		\$ 10,188	\$ (8,169)	\$ 30,637	34

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

Facility Name & ID Number Elevate Care Northbrook

0055558

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		\$ 202,294	\$ 18,357		\$ 10,188	\$ (8,169)	\$ 30,637	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		\$ 202,294	\$ 18,357		\$ 10,188	\$ (8,169)	\$ 30,637	34

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

Facility Name & ID Number Elevate Care Northbrook

0055558

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		\$ 202,294	\$ 18,357		\$ 10,188	\$ (8,169)	\$ 30,637	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		\$ 202,294	\$ 18,357		\$ 10,188	\$ (8,169)	\$ 30,637	34

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

Facility Name & ID Number Elevate Care Northbrook

0055558

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		\$ 202,294	\$ 18,357		\$ 10,188	\$ (8,169)	\$ 30,637	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)	\$ 202,294	\$ 18,357		\$ 10,188	\$ (8,169)	\$ 30,637	34

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

Facility Name & ID Number Elevate Care Northbrook

0055558

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 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	20,117	516	20	516		2,278	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Chase Office LLC	2020	401		20	20	20	20	9
10	Allocated from Chase Office LLC	2019	10,246	465	20	512	47	1,025	10
11	Allocated from Chase Office LLC	2018	91	5	20	5	(0)	14	11
12	Allocated from Chase Office LLC	2017	4,657	1,139	20	233	(906)	931	12
13	Allocated from Chase Office LLC	2016	101,957	7,464	20	5,098	(2,367)	22,516	13
14									14
15	Allocated from Elevate Care Inc.	2019	992		20	50	50	99	15
16	Allocated from Elevate Care Inc.	2020	2,213		20	111	111	111	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)		\$ 140,674	\$ 9,589		\$ 6,544	\$ (3,044)	\$ 26,993	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 140,674	\$ 9,589		\$ 6,544	\$ (3,044)	\$ 26,993	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
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 140,674	\$ 9,589		\$ 6,544	\$ (3,044)	\$ 26,993	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	\$ 48,328	\$ 8,596	\$ 4,833	\$ (3,764)	10	\$ 20,801	71
72	Current Year Purchases	36,747		3,054	3,054	10	3,054	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 85,075	\$ 8,596	\$ 7,887	\$ (709)		\$ 23,855	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)	\$ 289,605	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 26,953	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 18,075	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (8,878)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 54,492	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	Electrical Upgrade &	\$ 388,780	92
93	Architect Fees		93
94			94
95		\$ 388,780	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: Glen Oaks Real Estate & Development, LLP

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>1961</u>	<u>298</u>		\$ <u>2,384,960</u>			3
4	Additions	<u>Elevate Care (Fargo Office)</u>			<u>19,286</u>			4
5	Storage Rental				<u>801</u>			5
6	Allocated from Chase Office				<u>324</u>			6
7	TOTAL		<u>298</u>		\$ <u>2,405,371</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: \$ 12,296 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>Allocated from Elevate Care</u>		\$ _____	\$ <u>3,315</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>3,315</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	\$		\$ 146,177	\$		\$ 146,177	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			73,578			73,578	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			203,914			203,914	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				164,187		164,187	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):			428,095			203,430		631,525	13
14	TOTAL			\$ 428,095		\$ 423,669	\$ 367,617		\$ 1,219,381	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.

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	\$ 1,292,151	\$	1
2	Cash-Patient Deposits	2,752		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,761,622		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,179		6
7	Other Prepaid Expenses	20,692		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	1,025,726		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,109,122	\$	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	48,693		15
16	Equipment, at Historical Cost	43,353		16
17	Accumulated Depreciation (book methods)	(8,781)		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):	1,929,245		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,012,510	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,121,632	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 120,947	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	387,599		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,663		31
32	Accrued Real Estate Taxes(Sch.IX-B)	544,361		32
33	Accrued Interest Payable	1,938		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		1,363,414		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,427,922	\$	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		2,656,969		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,656,969	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,084,891	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,036,741	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,121,632	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 26,168	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 26,168	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,010,573	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,010,573	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)	\$ 1,036,741	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Elevate Care Northbrook

0055558

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	\$ 17,490,945	1
2	Discounts and Allowances for all Levels	(1,040,687)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 16,450,258	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	220,097	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 220,097	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	22,986	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,584	19
20	Radiology and X-Ray	4,153	20
21	Other Medical Services	17,668	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 49,391	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	16,394	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 16,394	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28		1,942,976	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,942,976	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 18,679,116	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,321,899	31
32	Health Care	7,037,104	32
33	General Administration	3,380,259	33
B. Capital Expense			
34	Ownership	3,082,792	34
C. Ancillary Expense			
35	Special Cost Centers	1,335,949	35
36	Provider Participation Fee	510,540	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 17,668,543	40
41	Income before Income Taxes (line 30 minus line 40)**	1,010,573	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,010,573	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,811,227	44
45	Private Pay - Net Inpatient Revenue	383,252	45
46	Medicare - Net Inpatient Revenue	1,803,864	46
47	Other-(specify) <u>Insurance</u>	628,411	47
48	Other-(specify) <u>Managed Care</u>	11,823,504	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 16,450,258	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 Northbrook

0055558

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	2,096	2,240	\$ 159,139	\$ 71.04	1
2	Assistant Director of Nursing	2,032	2,176	92,650	42.58	2
3	Registered Nurses	42,615	47,018	1,620,549	34.47	3
4	Licensed Practical Nurses	27,075	29,657	975,226	32.88	4
5	CNAs & Orderlies	107,673	120,728	2,124,660	17.60	5
6	CNA Trainees					6
7	Licensed Therapist	12,020	13,367	428,095	32.03	7
8	Rehab/Therapy Aides	16	16	272	17.00	8
9	Activity Director	2,850	3,223	56,590	17.56	9
10	Activity Assistants	8,259	9,124	133,531	14.64	10
11	Social Service Workers	7,803	10,287	273,635	26.60	11
12	Dietician					12
13	Food Service Supervisor	1,968	2,160	63,221	29.27	13
14	Head Cook	6,706	7,336	113,541	15.48	14
15	Cook Helpers/Assistants	19,501	21,075	305,353	14.49	15
16	Dishwashers					16
17	Maintenance Workers	6,205	6,888	176,592	25.64	17
18	Housekeepers	24,889	27,719	389,651	14.06	18
19	Laundry	2,154	2,402	32,190	13.40	19
20	Administrator	1,872	2,038	95,302	46.76	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	80	80	3,027	37.84	23
24	Clerical	13,237	15,036	241,131	16.04	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	4,758	5,017	52,275	10.42	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	3,986	4,595	126,005	27.42	33
34	TOTAL (lines 1 - 33)	297,795	332,182	\$ 7,462,635 *	\$ 22.47	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	\$ 19,490	01-03	35
36	Medical Director	Monthly	65,125	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	90,000	10-03	38
39	Pharmacist Consultant	Monthly	15,725	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	8	416	11-03	44
45	Social Service Consultant	17	861	12-03	45
46	Other(specify)				46
47	<u>Psychiatric MD</u>	Monthly	12,000	10-03	47
48					48
49	TOTAL (lines 35 - 48)	25	\$ 203,617		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,904	\$ 188,417	10-03	50
51	Licensed Practical Nurses	790	68,717	10-03	51
52	Certified Nurse Assistants/Aides	6,271	346,079	10-03	52
53	TOTAL (lines 50 - 52)	8,965	\$ 603,213		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount				
Yaniv Zuckerman	Administrator		\$ 72,908	Workers' Compensation Insurance	\$ 123,525	IDPH License Fee	\$ 1,811				
Mary Angeline Sales	Administrator		22,394	Unemployment Compensation Insurance	21,447	Advertising: Employee Recruitment	3,464				
				FICA Taxes	570,892	Health Care Worker Background Check (Indicate # of checks performed 74)	738				
				Employee Health Insurance	252,823	Patient Background Checks	1,290				
				Employee Meals	23,246	Dues & Subscriptions	44,288				
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Fees	2,619				
				Employee Benefits - Other	51,747						
				Employee Physicals	25,205						
				401K Expense	2,601						
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 95,302	Union Pension Fund	56,280	See Supplemental Schedule	2,036				
B. Administrative - Other						Less: Public Relations Expense	()				
Description			Amount			Non-allowable advertising	()				
Management Fees - Elevate Care			\$ 835,782			Yellow page advertising	()				
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 835,782	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,127,766	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 56,246				
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount			
National Datacare Corporation	Resident Trust Fund Service		\$ 4,747				Out-of-State Travel	\$			
Aperion Care	Data Processing		286								
Creative Technology Solutions	IT Consulting		42,045				In-State Travel				
DGTell LLC	Data Processing		604								
Early Sense Inc.	Remote Patient Monitoring		47,649				Seminar Expense	8,861			
Elevate Care	Data Processing		32,499								
EMSA Purchasing Group	Procurement Solutions		1,050				See Supplemental Schedule	949			
Point Click Care Technologies	Data Processing		102,883				Entertainment Expense	()			
Reside Admissions	Data Processing		3,085								
Telemedicine Solutions	Data Processing		6,300								
See Attached	Legal		58,104								
See Supplemental Schedule			105,154								
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 404,407	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 9,809			

* 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 - \$52,627
- (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. \$ 38,386 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. \$ 510,540
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. \$ 23,246 Has any meal income been offset against related costs? No 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.