FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0055483

Facility Name: Elevate Care Riverwoods

Address: 3705 Deerfield Road (Number) Riverwoods (City) 60015 (Zip Code)

County: Lake

Telephone Number: (847) 947-9000 **Fax #** (847) 947-9005

HFS ID Number:

Date of Initial License for Current Owners: 8/1/2019

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed)
** Subject to the attached Accountants' Consulting Report* (Date)
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	240	Skilled (SNF)	240	87,840	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	240	TOTALS	240	87,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,811	1,679	11,379	19,869	8
9	SNF/PED					9
10	ICF	20,432	5,037		25,469	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,243	6,716	11,379	45,338	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 51.61%

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 [X] NO [ ]

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

I. On what date did you start providing long term care at this location?
Date started 8/1/2019

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/1/2019 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 240 and days of care provided 6,747

Medicare Intermediary Wisconsin Physicans Service Insurance Corporation

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] 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 Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	439,825	56,689	17,603	514,117		514,117		514,117			1
2	Food Purchase		305,672		305,672		305,672	(146)	305,526			2
3	Housekeeping	266,510	76,390		342,900		342,900	468	343,368			3
4	Laundry	82,428	16,585	36,665	135,678		135,678		135,678			4
5	Heat and Other Utilities			217,081	217,081		217,081	(14,832)	202,249			5
6	Maintenance	107,691	26,372	162,751	296,814		296,814	13,133	309,947			6
7	Other (specify):*							1,501	1,501			7
8	**TOTAL General Services**	896,454	481,708	434,100	1,812,262		1,812,262	123	1,812,385			8
	B. Health Care and Programs											
9	Medical Director			44,750	44,750		44,750		44,750			9
10	Nursing and Medical Records	4,750,642	675,399	455,025	5,881,066		5,881,066	(93,977)	5,787,089			10
10a	Therapy	229,272			229,272		229,272		229,272			10a
11	Activities	207,783	13,780	390	221,953		221,953	9,558	231,511			11
12	Social Services	157,354		2,112	159,466		159,466		159,466			12
13	CNA Training											13
14	Program Transportation			43,501	43,501		43,501		43,501			14
15	Other (specify):*			32,912	32,912		32,912	8,411	41,323			15
16	**TOTAL Health Care and Programs**	5,345,051	689,179	578,690	6,612,920		6,612,920	(76,008)	6,536,912			16
	C. General Administration											
17	Administrative	134,984		718,995	853,979		853,979	(655,775)	198,204			17
18	Directors Fees											18
19	Professional Services			330,094	330,094		330,094	6,724	336,818			19
20	Dues, Fees, Subscriptions & Promotions			71,577	71,577		71,577	(20,431)	51,146			20
21	Clerical & General Office Expenses	214,957		222,387	437,344		437,344	83,234	520,578			21
22	Employee Benefits & Payroll Taxes			928,107	928,107		928,107		928,107			22
23	Inservice Training & Education											23
24	Travel and Seminar			928	928		928	160	1,088			24
25	Other Admin. Staff Transportation			351	351		351	4,659	5,010			25
26	Insurance-Prop.Liab.Malpractice			318,435	318,435		318,435		318,435			26
27	Other (specify):*							31,245	31,245			27
28	**TOTAL General Administration**	349,941		2,590,874	2,940,815		2,940,815	(550,184)	2,390,631			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,591,446	1,170,887	3,603,664	11,365,997		11,365,997	(626,068)	10,739,929			29

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

Facility Name & ID Number Elevate Care Riverwoods #0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			31,653	31,653		31,653	(810)	30,843			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			70,206	70,206		70,206	1,573	71,779			32
33	Real Estate Taxes			138,097	138,097		138,097	2,189	140,286			33
34	Rent-Facility & Grounds			1,677,835	1,677,835		1,677,835	204	1,678,039			34
35	Rent-Equipment & Vehicles			18,322	18,322		18,322	3,912	22,234			35
36	Other (specify):*			32,242	32,242		32,242	(32,242)	(0)			36
37	TOTAL Ownership			1,968,355	1,968,355		1,968,355	(25,174)	1,943,181			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		633,855	1,035,250	1,669,105		1,669,105	(211,538)	1,457,567			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			356,318	356,318		356,318		356,318			42
43	Other (specify):*	107,911		34,873	142,784		142,784	(142,784)	(0)			43
44	TOTAL Special Cost Centers	107,911	633,855	1,426,441	2,168,207		2,168,207	(354,322)	1,813,885			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,699,357	1,804,742	6,998,460	15,502,559		15,502,559	(1,005,564)	14,496,995			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 Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(15,655)	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	(12,261)	30		9
10	Interest and Other Investment Income	(1,222)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(453)	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	(189)	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	(120,493)	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	(318,267)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (468,540)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(537,024)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (537,024)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,005,564)		37

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

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

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

Elevate Care Riverwoods

ID# 0055483

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable Legal	$ (75)	19	1
2	Veterans Expense	(100,229)	10	2
3	Supplement Insurance	(393)	21	3
4	Credit Card Processing	(11,447)	21	4
5	Marketing Salaries	(107,911)	43	5
6	Marketing/Advertising	(25,771)	43	6
7	Promotional Products	(9,102)	43	7
8	Bank Charges	(918)	21	8
9	Theft & Damage Loss	(378)	21	9
10	Website Costs	(286)	21	10
11	Amortization	(32,242)	36	11
12	Other Unclassified Income	(677)	21	12
13	Non Allowable Seminar	(437)	24	13
14	PAC Dues	(21,713)	20	14
15	Additional R&M	14,588	06	15
16	Capitalized R&M	(19,550)	06	16
17	Prior Year Expense	(1,725)	21	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(318,267)		49

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

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

STATE OF ILLINOIS **Page 5B**

Elevate Care Riverwoods

IDF **0055483**

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

Ending: **12/31/20**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		b		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(453)		307									(146)	2
3	Housekeeping			83		385							468	3
4	Laundry													4
5	Heat and Other Utilities	(15,655)				823							(14,832)	5
6	Maintenance	(4,962)		16,785		1,310							13,133	6
7	Other (specify):*			1,501									1,501	7
8	**TOTAL General Services**	(21,070)		18,676		2,518							123	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(100,229)		6,176		77							(93,977)	10
10a	Therapy													10a
11	Activities			9,558									9,558	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			8,411									8,411	15
16	**TOTAL Health Care and Programs**	(100,229)		24,145		77							(76,008)	16
	C. General Administration													
17	Administrative			(655,775)									(655,775)	17
18	Directors Fees													18
19	Professional Services	(75)		9,067	3,922	1,502		(7,692)					6,724	19
20	Fees, Subscriptions & Promotions	(21,713)		693	583	6							(20,431)	20
21	Clerical & General Office Expenses	(136,507)		87,460	131,081	1,199							83,234	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(437)		539	58								160	24
25	Other Admin. Staff Transportation			4,659									4,659	25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*			15,228	16,017								31,245	27
28	**TOTAL General Administration**	(158,732)		(538,129)	151,661	2,708		(7,692)					(550,184)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(280,031)		(495,309)	151,661	5,302		(7,692)					(626,068)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elevate Care Riverwoods # 0055483 **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 D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(12,261)			246	11,205							(810)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,222)				2,795							1,573	32
33	Real Estate Taxes					2,189							2,189	33
34	Rent-Facility & Grounds					204							204	34
35	Rent-Equipment & Vehicles			2,557	330	1,024							3,912	35
36	Other (specify):*	(32,242)											(32,242)	36
37	**TOTAL Ownership**	(45,725)		2,557	576	17,418							(25,174)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(51,578)	(159,960)			(211,538)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(142,784)											(142,784)	43
44	**TOTAL Special Cost Centers**	(142,784)							(51,578)	(159,960)			(354,322)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(468,540)		(492,751)	152,237	22,720		(7,692)	(51,578)	(159,960)			(1,005,564)	45

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	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 Riverwoods # 0055483 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	Consutling	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 Riverwoods # 0055483 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 Northbrook	Northbrook				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

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping	$	Elevate Care, Inc.		$ 83	$ 83	15
16	V	6	Repairs & Maintenance		Elevate Care, Inc.		16,785	16,785	16
17	V	11	Activity Expense		Elevate Care, Inc.		9,558	9,558	17
18	V	2	Food		Elevate Care, Inc.		307	307	18
19	V	17	Administrative		Elevate Care, Inc.		63,220	63,220	19
20	V	19	Professional Fees		Elevate Care, Inc.		9,067	9,067	20
21	V	20	Fees, Subscriptions		Elevate Care, Inc.		693	693	21
22	V	21	Clerical & General		Elevate Care, Inc.		87,460	87,460	22
23	V	24	Seminars		Elevate Care, Inc.		539	539	23
24	V	25	Auto & Travel		Elevate Care, Inc.		4,659	4,659	24
25	V	26	Insurance		Elevate Care, Inc.				25
26	V	35	Equipment Rental		Elevate Care, Inc.		470	470	26
27	V	35	Auto Lease		Elevate Care, Inc.		2,088	2,088	27
28	V	7	Payroll Tax/Group Insurance		Elevate Care, Inc.		1,501	1,501	28
29	V	10	Nursing		Elevate Care, Inc.		81,176	81,176	29
30	V	15	Payroll Tax/Group Insurance		Elevate Care, Inc.		8,411	8,411	30
31	V	27	Emp. Ben. - Gen. Admin.		Elevate Care, Inc.		15,228	15,228	31
32	V	17	Management Fee Income	718,995	Elevate Care, Inc.			(718,995)	32
33	V	10	Consulting Income	75,000	Elevate Care, Inc.			(75,000)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 793,995			$ 301,243	$ * (492,751)	39

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

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees		Aperion Financial, LLC		3,922	$ 3,922	15
16	V	20	Fees, Subscriptions		Aperion Financial, LLC		583	583	16
17	V	21	Clerical & General		Aperion Financial, LLC		74,002	74,002	17
18	V	24	Seminars		Aperion Financial, LLC		58	58	18
19	V	25	Auto & Travel		Aperion Financial, LLC				19
20	V	27	Emp. Ben. - Gen. Admin.		Aperion Financial, LLC		8,969	8,969	20
21	V	30	Depreciaiton		Aperion Financial, LLC		246	246	21
22	V	32	Interest		Aperion Financial, LLC				22
23	V	35	Equipment Rental		Aperion Financial, LLC		330	330	23
24	V	21	Clerical & General -IL Only		Aperion Financial, LLC		57,079	57,079	24
25	V	27	Emp. Ben. - Gen. Admin.- IL Only		Aperion Financial, LLC		7,048	7,048	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			$			$ 152,237	$ * 152,237	39

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

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Chase Office, LLC		$ 823	$ 823	15
16	V	6	Repairs & Maintenance		Chase Office, LLC		1,310	1,310	16
17	V	3	Housekeeping		Chase Office, LLC		385	385	17
18	V	10	Medical Supplies		Chase Office, LLC		77	77	18
19	V	19	Professional Fees		Chase Office, LLC		1,502	1,502	19
20	V	20	Dues & Subscriptions		Chase Office, LLC		6	6	20
21	V	21	Office Expense		Chase Office, LLC		1,199	1,199	21
22	V	30	Depreciation		Chase Office, LLC		11,205	11,205	22
23	V	32	Interest Expense		Chase Office, LLC		2,795	2,795	23
24	V	33	Real Estate Taxes		Chase Office, LLC		2,189	2,189	24
25	V	35	Equipment Rental		Chase Office, LLC		1,024	1,024	25
26	V	34	Rent		Chase Office, LLC		204	204	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			$			$ 22,720	$ * 22,720	39

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

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	04	Laundry Services	$ 36,665	EcoBrite Linen		$ 36,665	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 36,665			$ 36,665	$ *	39

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

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	$ 33,577	ProPay HR LLC		$ 25,885	$ (7,692)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 33,577			$ 25,885	$ * (7,692)	39

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

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Laboratory	$ 90,599	Lifescan Labs of Illinois		$ 39,021	$ (51,578)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 90,599			$ 39,021	$ * (51,578)	39

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

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy Services	$ 1,047,389	Renewal Rehab, LLC		$ 887,429	$ (159,960)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,047,389			$ 887,429	$ * (159,960)	39

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

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	Insurance	$ 244,716	Aperion Incorporated Cell		$ 244,716	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 244,716			$ 244,716	$ *	39

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

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Dialysis	$ 163,680	Concerto Dialysis		$ 163,680	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 163,680			$ 163,680	$ *	39

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

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Relative	Administrative	0	See Attached	0.95	2.39%	Alloc Salary	$ 5,966	17-7	1
2	David Berkowitz	Relative	Administrative	0	See Attached	0.95	2.39%	Alloc Salary	2,742	17-7	2
3	Jay Meystel	Relative	Clerical	0	See Attached	0.95	2.39%	Alloc Salary	1,404	21-7	3
4	Elisheva Adest	Relative	Clerical	0	See Attached	0.65	2.39%	Alloc Salary	740	21-7	4
5	Meir Meystel	Relative	Administrative	0	See Attached	5.06	12.64%	Alloc Salary	31,610	17-7	5
6	Aaron Prancer	Relative	Administrative	0	See Attached	5.06	12.64%	Alloc Salary	31,610	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	$ 74,072		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 Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Elevate Care, Inc.
Street Address: 5454 Fargo Ave.
City / State / Zip Code: Skokie, IL 60077
Phone Number: ((847) 674-5454
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Census	358,576	7	$ 660	$	45,338	$ 83	1
2	6	Repairs & Maintenance	Census	358,576	7	132,748	127,841	45,338	16,785	2
3	11	Activity Expense	Census	358,576	7	75,597	74,420	45,338	9,558	3
4	2	Food	Census	358,576	7	2,426		45,338	307	4
5	17	Administrative	Census	358,576	7	500,000	500,000	45,338	63,220	5
6	19	Professional Fees	Census	358,576	7	71,707		45,338	9,067	6
7	20	Fees, Subscriptions	Census	358,576	7	5,482		45,338	693	7
8	21	Clerical & General	Census	358,576	7	691,717	662,888	45,338	87,460	8
9	24	Seminars	Census	358,576	7	4,267		45,338	539	9
10	25	Auto & Travel	Census	358,576	7	36,847		45,338	4,659	10
11	26	Insurance	Census	358,576	7			45,338		11
12	35	Equipment Rental	Census	358,576	7	3,714		45,338	470	12
13	35	Auto Lease	Census	358,576	7	16,511		45,338	2,088	13
14	7	Payroll Tax/Group Insurance	Census	358,576	7	11,870		45,338	1,501	14
15	10	Nursing	Census	358,576	7	642,014	642,014	45,338	81,176	15
16	15	Payroll Tax/Group Insurance	Census	358,576	7	66,518		45,338	8,411	16
17	27	Emp. Ben. - Gen. Admin.	Census	358,576	7	120,438		45,338	15,228	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,382,516	$ 2,007,163		$ 301,243	25

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Fees	Census	1,899,996	65	164,380		45,338	3,922	1
2	20	Fees, Subscriptions	Census	1,899,996	65	24,450		45,338	583	2
3	21	Clerical & General	Census	1,899,996	65	3,101,245	3,044,021	45,338	74,002	3
4	24	Seminars	Census	1,899,996	65	2,428		45,338	58	4
5	25	Auto & Travel	Census	1,899,996	65			45,338		5
6	27	Emp. Ben. - Gen. Admin.	Census	1,899,996	65	375,858		45,338	8,969	6
7	30	Depreciaiton	Census	1,899,996	65	10,323		45,338	246	7
8	32	Interest	Census	1,899,996	65			45,338		8
9	35	Equipment Rental	Census	1,899,996	65	13,849		45,338	330	9
10	21	Clerical & General -IL Only	Census/Direct Alloc	1,208,651	46	1,767,260	1,767,260	45,338	57,079	10
11	27	Emp. Ben. - Gen. Admin.- IL Only	Census/Direct Alloc	1,208,651	46	218,211		45,338	7,048	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		$ 152,237	25

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Actual Census	1,899,996	65	$ 34,497	$	45,338	$ 823	1
2	6	Repairs & Maintenance	Actual Census	1,899,996	65	54,886		45,338	1,310	2
3	3	Housekeeping	Actual Census	1,899,996	65	16,134		45,338	385	3
4	10	Medical Supplies	Actual Census	1,899,996	65	3,211		45,338	77	4
5	19	Professional Fees	Actual Census	1,899,996	65	62,958		45,338	1,502	5
6	20	Dues & Subscriptions	Actual Census	1,899,996	65	256		45,338	6	6
7	21	Office Expense	Actual Census	1,899,996	65	50,267		45,338	1,199	7
8	30	Depreciation	Actual Census	1,899,996	65	469,583		45,338	11,205	8
9	32	Interest Expense	Actual Census	1,899,996	65	117,136		45,338	2,795	9
10	33	Real Estate Taxes	Actual Census	1,899,996	65	91,748		45,338	2,189	10
11	35	Equipment Rental	Actual Census	1,899,996	65	8,550		45,338	1,024	11
12	34	Rent	Actual Census	1,899,996	65	42,922		45,338	204	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	$		$ 22,720	25

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	4	Laundry Services	Direct			$	$		$ 36,665	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					$	$		$ 36,665	25

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct			$	$		$ 25,885	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					$	$		$ 25,885	25

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Laboratory	Direct			$	$		$ 39,021	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					$	$		$ 39,021	25

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Therapy Services	Direct		59	$	$		$ 887,429	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					$	$		$ 887,429	25

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Aperion Incorporated Cell
Street Address: 30 Main Street, Suite 330
City / State / Zip Code: Burlington, Vermont 05401
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	26	Insurance	Direct Allocation			$	$		$ 244,716	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					$	$		$ 244,716	25

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Concerto Dialysis
Street Address: 4600 W. Touhy
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: ((847) 233-1202
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Dialysis	Direct			$	$		$ 163,680	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					$	$		$ 163,680	25

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2							$	$			$	2
3							$	$			$	3
4							$	$			$	4
5							$	$			$	5
	Working Capital											
6	Congressional Bank		X	Line of Credit				1,004,842			70,206	6
7								-			-	7
8												8
9	TOTAL Facility Related						$	$ 1,004,842			$ 70,206	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,222)	10
11	Alloc from Chase Office	X									2,795	11
12											-	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 1,573	14
15	TOTALS (line 9+line14)						$	$ 1,004,842			$ 71,779	15

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

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

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

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 134,623	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.)		$ 138,549	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,926	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 136,360	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.		$ 140,286	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	138,942	8
	2016	136,351	9
	2017	135,234	10
	2018	133,012	11
	2019	136,360	12

2020 Accrual = 2019 Real Estate Tax
Allocated from Chase Office $2,189

	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 Riverwoods COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0055483

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

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

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-35-200-001	3705 Deerfield Rd, Riverwoods, IL	$ 127,940	$ 127,940
2.	15-35-200-002	3705 Deerfield Rd, Riverwoods, IL	$ 5,548	$ 5,548
3.	15-35-100-003	3705 Deerfield Rd, Riverwoods, IL	$ 2,872	$ 2,872
4.	10-27-307-027-0000	Allocated from Chase Office	$ 72,111	$ 1,635
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 208,471	$ 137,995

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach 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 Riverwoods COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0055483

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

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

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

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

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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 Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 90,758 B. General Construction Type: Exterior Brick/Masonry Frame Metal Number of Stories One

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

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

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

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

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

None

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2	Allocated from Chase Office LLC			1,408	2
3	TOTALS			$ 1,408	3

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	240				$	$		$	$	$	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

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		88,586	6,038		4,121	(1,918)	16,998	68
69	Financial Statement Depreciation			31,653			(31,653)		69
70	TOTAL (lines 4 thru 69)		$ 88,586	$ 37,692		$ 4,121	$ (33,571)	$ 16,998	70

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

Facility Name & ID Number Elevate Care Riverwoods # 0055483 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		$ 88,586	$ 37,692		$ 4,121	$ (33,571)	$ 16,998	1
2	Replace All Existing Walls; Plumbing&New Outlets In Water Rm	2019	81,300		20	4,065	4,065	4,065	2
3	Outdoor Turret Camera Lens	2019	7,172		20	359	359	359	3
4	Nurses Stations/Hallways - Rooftop Heating/Cooling Unit	2019	16,640		20	832	832	832	4
5	Hot Water Heater / Hot Water Circulating Pump	2019	4,406		20	220	220	220	5
6	Install Interior Drain Tile System	2020	5,900		20	295	295	295	6
7	Cooling Rooftop Replacement	2020	11,200		20	560	560	560	7
8	New Tektone Nc120 System	2020	54,000		20	2,700	2,700	2,700	8
9	Resurfacing Pavement And Sealing	2020	68,783		20	3,439	3,439	3,439	9
10	Replace 20 Ton Package Rooftop Unit	2020	24,000		20	1,200	1,200	1,200	10
11	Sidewalks, Electric Valve Fittings, Rotaries, And Other	2020	11,380		20	569	569	569	11
12	Exterior Sign	2020	4,522		20	226	226	226	12
13	Hot Water Heater Burner & Control Board	2020	3,043		20	152	152	152	13
14	7.5 Ton Carrier Rooftop Unit	2020	10,500		20	525	525	525	14
15	Delayed Egress Mag Lock System	2020	12,336		20	617	617	617	15
16	Phone System	2020	13,763		20	688	688	688	16
17	Sewer Line Root Cutting	2020	3,030		20	303	303	303	17
18	Installed Door Alarms At Nurse Station	2020	4,800		20	480	480	480	18
19	Sewer Line Work	2020	5,500		20	550	550	550	19
20	Elevator Repair	2020	2,719		20	272	272	272	20
21	Fixed The Boiler	2020	3,501		20	350	350	350	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)		$ 437,081	$ 37,692		$ 22,523	$ (15,169)	$ 35,401	34

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

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 437,081	$ 37,692		$ 22,523	$ (15,169)	$ 35,401	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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19									19
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 437,081	$ 37,692		$ 22,523	$ (15,169)	$ 35,401	34

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

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 437,081	$ 37,692		$ 22,523	$ (15,169)	$ 35,401	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)		$ 437,081	$ 37,692		$ 22,523	$ (15,169)	$ 35,401	34

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

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 437,081	$ 37,692		$ 22,523	$ (15,169)	$ 35,401	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)		$ 437,081	$ 37,692		$ 22,523	$ (15,169)	$ 35,401	34

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

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Chase Office LLC	2016	12,668	325	20	325		1,435	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Chase Office LLC	2020	253		20	13	13	13	9
10	Allocated from Chase Office LLC	2019	6,452	293	20	323	30	645	10
11	Allocated from Chase Office LLC	2018	58	3	20	3	(0)	9	11
12	Allocated from Chase Office LLC	2017	2,932	717	20	147	(570)	586	12
13	Allocated from Chase Office LLC	2016	64,206	4,701	20	3,210	(1,490)	14,179	13
14									14
15	Allocated from Elevate Care Inc.	2019	625		20	31	31	62	15
16	Allocated from Elevate Care Inc.	2020	1,393		20	70	70	70	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)		$ 88,586	$ 6,038		$ 4,121	$ (1,918)	$ 16,998	34

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

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 88,586	$ 6,038		$ 4,121	$ (1,918)	$ 16,998	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 88,586	$ 6,038		$ 4,121	$ (1,918)	$ 16,998	34

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

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 59,406	$ 5,413	$ 5,940	$ 527	10	$ 15,996	71
72	Current Year Purchases	23,805		2,381	2,381	10	2,381	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 83,211	$ 5,413	$ 8,321	$ 2,908		$ 18,376	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)	$ 521,699	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 43,105	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 30,844	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (12,261)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 53,777	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	Remodel	$ 1,208,775	92
93			93
94			94
95		$ 1,208,775	95

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

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

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Brentwood Healthcare Real Estate, LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] 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:				$ 1,658,549			3
4	Additions							4
5	Allocated from Chase Office				204			5
6	Elevate Care (Fargo Office)				19,286			6
7	TOTAL				$ 1,678,039 **			7

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

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

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

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

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 9,563 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	Facility	GM	$ 779	$ 10,583	17
18	Allocated from Elevate Care			2,088	18
19					19
20					20
21	TOTAL		$ 779	$ 12,671	21

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

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

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 416,377	$		$ 416,377	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			137,798			137,798	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			481,075			481,075	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				404,270		404,270	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):						229,585		229,585	13
14	TOTAL			$		$ 1,035,250	$ 633,855		$ 1,669,105	14

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

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/20 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 525,879	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,599,295		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,358		6
7	Other Prepaid Expenses	35,380		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	600,544		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,781,456	$	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	286,397		15
16	Equipment, at Historical Cost	113,791		16
17	Accumulated Depreciation (book methods)	(37,322)		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):	2,187,586		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,550,452	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,331,908	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 523,300	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,004,842		29
30	Accrued Salaries Payable	428,536		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,769		31
32	Accrued Real Estate Taxes(Sch.IX-B)	136,360		32
33	Accrued Interest Payable	7,423		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		1,335,788		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,453,018	$	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		1,425,000		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,425,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,878,018	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 453,890	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,331,908	$	48

***(See instructions.)**

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (33,493)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (33,493)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	487,383	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)**	$ 487,383	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)**	$ 453,890	24 *

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

Facility Name & ID Number Elevate Care Riverwoods # 0055483 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 15,395,244	1
2	Discounts and Allowances for all Levels	(1,602,801)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,792,443	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	555,978	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 555,978	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	7,929	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	660	19
20	Radiology and X-Ray	8,154	20
21	Other Medical Services	19,912	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 36,655	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,222	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,222	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		1,603,644	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,603,644	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,989,942	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,812,262	31
32	Health Care	6,612,920	32
33	General Administration	2,940,815	33
	B. Capital Expense		
34	Ownership	1,968,355	34
	C. Ancillary Expense		
35	Special Cost Centers	1,811,889	35
36	Provider Participation Fee	356,318	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,502,559	40
41	**Income before Income Taxes (line 30 minus line 40)****	487,383	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 487,383	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,192,617	44
45	Private Pay - Net Inpatient Revenue	2,262,516	45
46	Medicare - Net Inpatient Revenue	4,258,333	46
47	Other-(specify) Insurance	944,500	47
48	Other-(specify) Managed Care/Veterans	4,134,477	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 13,792,443	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,960	2,104	$ 129,393	$ 61.50	1
2	Assistant Director of Nursing	1,696	1,989	79,911	40.18	2
3	Registered Nurses	36,949	41,466	1,520,720	36.67	3
4	Licensed Practical Nurses	28,626	31,233	1,036,523	33.19	4
5	CNAs & Orderlies	91,894	101,548	1,895,320	18.66	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,421	9,478	229,272	24.19	8
9	Activity Director	1,928	2,065	46,517	22.53	9
10	Activity Assistants	8,541	9,229	161,266	17.47	10
11	Social Service Workers	5,412	5,928	157,354	26.54	11
12	Dietician					12
13	Food Service Supervisor	1,964	2,430	59,710	24.57	13
14	Head Cook	8,023	9,107	160,421	17.62	14
15	Cook Helpers/Assistants	15,386	17,019	219,694	12.91	15
16	Dishwashers					16
17	Maintenance Workers	3,797	4,381	107,691	24.58	17
18	Housekeepers	14,872	16,016	266,510	16.64	18
19	Laundry	6,685	7,266	82,428	11.34	19
20	Administrator	2,133	2,192	134,984	61.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,928	2,080	63,477	30.52	23
24	Clerical	5,819	6,589	151,480	22.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,839	2,142	38,363	17.91	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	3,648	4,152	158,323	38.13	33
34	TOTAL (lines 1 - 33)	251,521	278,414	$ 6,699,357 *	$ 24.06	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 17,603	01-03	35
36	Medical Director	Monthly	44,750	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	75,000	10-03	38
39	Pharmacist Consultant	Per Visit	9,856	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	390	11-03	44
45	Social Service Consultant	34	2,112	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	42	$ 149,711		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,346	$ 256,953	10-03	50
51	Licensed Practical Nurses	1,004	76,661	10-03	51
52	Certified Nurse Assistants/Aides	740	36,555	10-03	52
53	TOTAL (lines 50 - 52)	3,090	$ 370,169		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Marcus Shaw	Administrator		$ 66,719
Michael Jacobson	Administrator		41,347
Elimelech S Ray	Administrator		26,918
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 134,984

B. Administrative - Other

Description	Amount
Management Fees - Elevate Care, Inc.	$ 718,995
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 718,995

C. Professional Services

Vendor/Payee	Type	Amount
National Datacare Center	Data Processing	$ 2,682
Aperion Care	Data Processing	308
Creative Technology Solutions	IT Consulting	40,447
EarlySense Inc	Data Processing	63,335
Elevate Care	Data Processing	28,899
PointClickCare Technolgies	Data Processing	70,386
Reside Admissions LLC	Data Processing	4,635
Telemedicine Solutions	Data Processing	10,500
ProPay HR	Payroll Processing	33,577
Marcum LLC	Accounting Fees	13,648
See Attached	Legal	6,978
See Supplemental Schedule		54,699
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 330,094

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 116,308
Unemployment Compensation Insurance	11,247
FICA Taxes	512,501
Employee Health Insurance	232,246
Employee Meals	18,242
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits - Other	33,494
Employee Physicals	1,572
401K Expense	2,497
TOTAL (agree to Schedule V, line 22, col.8)	$ 928,107

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,252
Advertising: Employee Recruitment	3,464
Health Care Worker Background Check	
(Indicate # of checks performed 80)	795
Patient Background Checks 248	2,480
Dues & Subscriptions	39,348
Licenses & Fees	1,525
See Supplemental Schedule	1,282
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 51,147

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	491
See Supplemental Schedule	597
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,089

* Attach copy of IMRF notifications

**See instructions.

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI $43,426**

(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. $ **46,119** 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. $ **356,318**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **18,242** 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? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **No**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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