FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0055475

Facility Name: Elevate Care Waukegan

Address: 2222 14th St (Number) Waukegan (City) 60085 (Zip Code)

County: Lake

Telephone Number: (847) 249-2400 **Fax #** (847) 249-9045

HFS ID Number:

Date of Initial License for Current Owners: 2/1/2019

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) (Date)
** Subject to the attached Accountants' Consulting Report*
(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 Waukegan # 0055475 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	183	Skilled (SNF)	183	66,978	1
2		Skilled Pediatric (SNF/PED)			2
3	88	Intermediate (ICF)	88	32,208	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	271	TOTALS	271	99,186	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	13,290	316	5,121	18,727	8
9	SNF/PED					9
10	ICF	39,866	736	1,601	42,203	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	53,156	1,052	6,722	60,930	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.43%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 02/01/2019

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/2019 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 140 and days of care provided 4,510

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

Facility Name & ID Number Elevate Care Waukegan # 0055475 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	507,612	81,032	18,326	606,970		606,970		606,970			1
2	Food Purchase		373,455		373,455		373,455	348	373,803			2
3	Housekeeping	361,943	80,786		442,729		442,729	629	443,358			3
4	Laundry	6,027	18,663	129,718	154,408		154,408		154,408			4
5	Heat and Other Utilities			225,265	225,265		225,265	(19,824)	205,441			5
6	Maintenance	119,260	57,506	175,231	351,997		351,997	33,046	385,043			6
7	Other (specify):*							2,017	2,017			7
8	TOTAL General Services	994,842	611,442	548,540	2,154,824		2,154,824	16,217	2,171,041			8
	B. Health Care and Programs											
9	Medical Director			153,000	153,000		153,000		153,000			9
10	Nursing and Medical Records	4,922,043	820,958	156,399	5,899,400		5,899,400	104,554	6,003,954			10
10a	Therapy	192,979			192,979		192,979		192,979			10a
11	Activities	158,480	19,252	767	178,499		178,499	12,846	191,345			11
12	Social Services	187,234		4,048	191,282		191,282		191,282			12
13	CNA Training											13
14	Program Transportation			11,425	11,425		11,425		11,425			14
15	Other (specify):*							11,303	11,303			15
16	TOTAL Health Care and Programs	5,460,736	840,210	325,639	6,626,585		6,626,585	128,703	6,755,288			16
	C. General Administration											
17	Administrative	128,947		773,480	902,427		902,427	(688,519)	213,908			17
18	Directors Fees											18
19	Professional Services			360,009	360,009		360,009	(347)	359,662			19
20	Dues, Fees, Subscriptions & Promotions			109,322	109,322		109,322	(21,094)	88,228			20
21	Clerical & General Office Expenses	177,738		323,869	501,607		501,607	47,578	549,185			21
22	Employee Benefits & Payroll Taxes			1,072,680	1,072,680		1,072,680		1,072,680			22
23	Inservice Training & Education											23
24	Travel and Seminar			337	337		337	736	1,073			24
25	Other Admin. Staff Transportation			1,347	1,347		1,347	6,261	7,608			25
26	Insurance-Prop.Liab.Malpractice			321,510	321,510		321,510		321,510			26
27	Other (specify):*							41,989	41,989			27
28	TOTAL General Administration	306,685		2,962,554	3,269,239		3,269,239	(613,396)	2,655,843			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,762,263	1,451,652	3,836,733	12,050,648		12,050,648	(468,476)	11,582,172			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 Waukegan #0055475 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			59,206	59,206		59,206	573,969	633,175			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			143,285	143,285		143,285	1,254,812	1,398,097			32
33	Real Estate Taxes			162,939	162,939		162,939	2,942	165,881			33
34	Rent-Facility & Grounds			1,759,286	1,759,286		1,759,286	(1,739,726)	19,560			34
35	Rent-Equipment & Vehicles			11,039	11,039		11,039	5,257	16,296			35
36	Other (specify):*			10,985	10,985		10,985	(10,985)	0			36
37	TOTAL Ownership			2,146,740	2,146,740		2,146,740	86,270	2,233,010			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	421,184	637,515	711,533	1,770,232		1,770,232	(156,307)	1,613,925			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			481,064	481,064		481,064		481,064			42
43	Other (specify):*	78,814		31,201	110,015		110,015	(110,015)	0			43
44	TOTAL Special Cost Centers	499,998	637,515	1,223,798	2,361,311		2,361,311	(266,322)	2,094,989			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,262,261	2,089,167	7,207,271	16,558,699		16,558,699	(648,528)	15,910,171			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 Waukegan # 0055475 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	(20,930)	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	(162,828)	30		9
10	Interest and Other Investment Income	(1,477)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(64)	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	(38,489)	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	(185,548)	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	(357,285)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (766,622)		$	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)	118,093		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 118,093		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (648,529)		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 Waukegan

ID# 0055475

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable Legal	$ (3,787)	19	1
2	Veterans Expense	(4,641)	10	2
3	Supplemental Insurance	(620)	21	3
4	Credit Card Processing	(1,637)	21	4
5	Marketing Salaries	(78,814)	43	5
6	Advertising/Marketing	(21,830)	43	6
7	Promotional Products	(9,371)	43	7
8	Bank Charges	(19,873)	21	8
9	Theft & Damage Loss	(1,273)	21	9
10	Website	(292)	21	10
11	Amortization	(10,985)	36	11
12	Additional R&M	23,192	06	12
13	PAC Dues	(22,818)	20	13
14	Non Allowable Seminar	(67)	24	14
15	Capitalized R&M	(14,463)	06	15
16	Prior Year Professional Fees	(5,420)	19	16
17	Building Company - Professional Fees	(11,135)	19	17
18	Building Company - Amortization	(170,982)	36	18
19	Building Company - Bank Fees	(2,224)	21	19
20	Building Company - Licenses & Permits	(245)	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**	(357,285)		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 Waukegan
IDF 0655475
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 Waukegan # 0055475 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	(64)		412									348	2
3	Housekeeping			112		517							629	3
4	Laundry													4
5	Heat and Other Utilities	(20,930)				1,106							(19,824)	5
6	Maintenance	8,729		22,557		1,760							33,046	6
7	Other (specify):*			2,017									2,017	7
8	**TOTAL General Services**	(12,265)		25,098		3,384							16,217	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(4,641)		109,092		103							104,554	10
10a	Therapy													10a
11	Activities			12,846									12,846	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			11,303									11,303	15
16	**TOTAL Health Care and Programs**	(4,641)		133,241		103							128,703	16
	C. General Administration													
17	Administrative			(688,519)									(688,519)	17
18	Directors Fees													18
19	Professional Services	(20,342)	11,135	12,185	5,271	2,019		(10,454)	(160)				(347)	19
20	Fees, Subscriptions & Promotions	(23,063)	245	931	784	8							(21,094)	20
21	Clerical & General Office Expenses	(249,956)	2,224	117,538	176,160	1,612							47,578	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(67)		725	78								736	24
25	Other Admin. Staff Transportation			6,261									6,261	25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*			20,465	21,524								41,989	27
28	**TOTAL General Administration**	(293,429)	13,604	(530,414)	203,817	3,639		(10,454)	(160)				(613,396)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(310,335)	13,604	(372,075)	203,817	7,126		(10,454)	(160)				(468,476)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elevate Care Waukegan **#** 0055475 **Report Period Beginning:** 01/01/20 **Ending:** 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(162,828)	721,407		331	15,059							573,969	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,477)	1,252,533			3,756							1,254,812	32
33	Real Estate Taxes					2,942							2,942	33
34	Rent-Facility & Grounds		(1,740,000)			274							(1,739,726)	34
35	Rent-Equipment & Vehicles			3,437	444	1,376							5,257	35
36	Other (specify):*	(181,967)	170,982										(10,985)	36
37	TOTAL Ownership	(346,272)	404,922	3,437	775	23,408							86,270	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers									(47,377)	(108,930)		(156,307)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(110,015)											(110,015)	43
44	TOTAL Special Cost Centers	(110,015)								(47,377)	(108,930)		(266,322)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(766,622)	418,526	(368,638)	204,592	30,534		(10,454)	(160)	(47,377)	(108,930)		(648,528)	45

Facility Name & ID Number Elevate Care Waukegan # 0055475 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,740,000	2222 14th Street		$	$ (1,740,000)	1
2	V	33	Real Estate Tax	162,939	2222 14th Street		162,939		2
3	V	19	Professional Fees		2222 14th Street		11,135	11,135	3
4	V	36	Amortization		2222 14th Street		170,982	170,982	4
5	V	21	Bank Charges		2222 14th Street		2,224	2,224	5
6	V	20	Licenses & Permits		2222 14th Street		245	245	6
7	V	30	Depreciation		2222 14th Street		721,407	721,407	7
8	V	32	Interest		2222 14th Street		1,252,533	1,252,533	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,902,939			$ 2,321,465	$ * 418,526	14

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

Facility Name & ID Number Elevate Care Waukegan # 0055475 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	2222 14th Street	Waukegan	Building Co.	1
2			Aperion Care Bridgeport	Bridgeport	Aperion Care Demotte	Demotte, IN	ALF	2
3			Aperion Care Burbank	Burbank	Aperion Care, Inc.	Lincolnwood	Corporate Manager	3
4			Aperion Care Capitol	Capitol	Aperion Consulting, LLC	Lincolnwood	Consulting Co.	4
5			Aperion Care Chicago Heights	Chicago Heights	Aperion Estates Peru	Peru, IN	ALF	5
6			Aperion Care Demotte	Demotte,IN	Aperion Financial, LLC	Lincolnwood	Bookkeeping	6
7			Aperion Care Dolton	Dolton	Aperion Incorporated Cell	Burlington, VT	Insurance	7
8			Aperion Care Elgin	Elgin	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	8
9			Aperion Care Evanston	Evanston	Chase Office, LLC	Lincolnwood	Building Co.	9
10			Aperion Care Fairfield	Fairfield	Concerto Dialysis	Lincolnwood	Dialysis	10
11			Aperion Care Forest Park	Forest Park	Eco-Brite Linen	Skokie	Laundry	11
12			Aperion Care Glenwood	Glenwood	Elevate Care, Inc.	Skokie	Consutling	12
13			Aperion Care Highwood	Highwood	EMSA Purchasing Group	Lincolnwood	Purchasing	13
14			Aperion Care International	Chicago	Interbuild Construction	Chicago	Bldg Improvements	14
15			Aperion Care Jacksonville	Jacksonville	Lifescan Labs of Illinois, LLC	Skokie	Laboratory	15
16			Aperion Care Kokomo	Kokomo, IN	OnTray, LLC	Lincolnwood	Kitchen Management	16
17			Aperion Care Litchfield	Litchfield	Pointe Group Care, LLC	Boston, MA	Bookkeeping	17
18			Aperion Care Marion	Marion, IN	Pointe Property, LLC	Boston, MA	Property Management	18
19			Aperion Care Marseilles	Marseilles	PropayHR	Evanston	Payroll Services	19
20			Aperion Care Mascoutah	Mascoutah	Renewal Rehab, LLC	Lincolnwood	Therapy Services	20
21			Aperion Care Midlothian	Midlothian	San Antonio Property, LLC	San Antonio, TX	Building Co.	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 Waukegan # 0055475 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 Riverwoods	Riverwoods				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 Waukegan # 0055475 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.		$ 112	$ 112	15
16	V	6	Repairs & Maintenance		Elevate Care, Inc.		22,557	22,557	16
17	V	11	Activity Expense		Elevate Care, Inc.		12,846	12,846	17
18	V	2	Food		Elevate Care, Inc.		412	412	18
19	V	17	Administrative		Elevate Care, Inc.		84,961	84,961	19
20	V	19	Professional Fees		Elevate Care, Inc.		12,185	12,185	20
21	V	20	Fees, Subscriptions		Elevate Care, Inc.		931	931	21
22	V	21	Clerical & General		Elevate Care, Inc.		117,538	117,538	22
23	V	24	Seminars		Elevate Care, Inc.		725	725	23
24	V	25	Auto & Travel		Elevate Care, Inc.		6,261	6,261	24
25	V	26	Insurance		Elevate Care, Inc.				25
26	V	35	Equipment Rental		Elevate Care, Inc.		631	631	26
27	V	35	Auto Lease		Elevate Care, Inc.		2,806	2,806	27
28	V	7	Payroll Tax/Group Insurance		Elevate Care, Inc.		2,017	2,017	28
29	V	10	Nursing		Elevate Care, Inc.		109,092	109,092	29
30	V	15	Payroll Tax/Group Insurance		Elevate Care, Inc.		11,303	11,303	30
31	V	27	Emp. Ben. - Gen. Admin.		Elevate Care, Inc.		20,465	20,465	31
32	V	17	Management Fee Income	773,480	Elevate Care, Inc.			(773,480)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 773,480			$ 404,842	$ * (368,638)	39

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

Facility Name & ID Number Elevate Care Waukegan # 0055475 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		5,271	$ 5,271	15
16	V	20	Fees, Subscriptions		Aperion Financial, LLC		784	784	16
17	V	21	Clerical & General		Aperion Financial, LLC		99,452	99,452	17
18	V	24	Seminars		Aperion Financial, LLC		78	78	18
19	V	25	Auto & Travel		Aperion Financial, LLC				19
20	V	27	Emp. Ben. - Gen. Admin.		Aperion Financial, LLC		12,053	12,053	20
21	V	30	Depreciaiton		Aperion Financial, LLC		331	331	21
22	V	32	Interest		Aperion Financial, LLC				22
23	V	35	Equipment Rental		Aperion Financial, LLC		444	444	23
24	V	21	Clerical & General -IL Only		Aperion Financial, LLC		76,708	76,708	24
25	V	27	Emp. Ben. - Gen. Admin.- IL Only		Aperion Financial, LLC		9,471	9,471	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			$			$ 204,592	$ * 204,592	39

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

Facility Name & ID Number Elevate Care Waukegan # 0055475 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		$ 1,106	$ 1,106	15
16	V	6	Repairs & Maintenance		Chase Office, LLC		1,760	1,760	16
17	V	3	Housekeeping		Chase Office, LLC		517	517	17
18	V	10	Medical Supplies		Chase Office, LLC		103	103	18
19	V	19	Professional Fees		Chase Office, LLC		2,019	2,019	19
20	V	20	Dues & Subscriptions		Chase Office, LLC		8	8	20
21	V	21	Office Expense		Chase Office, LLC		1,612	1,612	21
22	V	30	Depreciation		Chase Office, LLC		15,059	15,059	22
23	V	32	Interest Expense		Chase Office, LLC		3,756	3,756	23
24	V	33	Real Estate Taxes		Chase Office, LLC		2,942	2,942	24
25	V	35	Equipment Rental		Chase Office, LLC		1,376	1,376	25
26	V	34	Rent		Chase Office, LLC		274	274	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			$			$ 30,534	$ * 30,534	39

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

Facility Name & ID Number Elevate Care Waukegan # 0055475 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	$ 129,718	EcoBrite Linen		$ 129,718	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V	39	Dialysis	$ 179,085	Concerto Dialysis		179,085		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			$ 308,803			$ 308,803	$ *	39

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

Facility Name & ID Number Elevate Care Waukegan # 0055475 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	$ 45,632	ProPay HR LLC		$ 35,178	$ (10,454)	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			$ 45,632			$ 35,178	$ * (10,454)	39

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

Facility Name & ID Number Elevate Care Waukegan # 0055475 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	Data Processing	$ 1,050	EMSA Purchasing Group		$ 890	$ (160)	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			$ 1,050			$ 890	$ * (160)	39

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

Facility Name & ID Number Elevate Care Waukegan # 0055475 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	$ 83,220	Lifescan Labs of Illinois		$ 35,843	$ (47,377)	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			$ 83,220			$ 35,843	$ * (47,377)	39

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

Facility Name & ID Number Elevate Care Waukegan # 0055475 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	$ 713,250	Renewal Rehab, LLC		$ 604,320	$ (108,930)	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			$ 713,250			$ 604,320	$ * (108,930)	39

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

Facility Name & ID Number Elevate Care Waukegan # 0055475 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	$ 248,591	Aperion Incorporated Cell		$ 248,591	$	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			$ 248,591			$ 248,591	$ *	39

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

Facility Name & ID Number Elevate Care Waukegan # 0055475 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	1.28	3.21%	Alloc Salary	$ 8,017	17-7	1
2	David Berkowitz	Relative	Administrative	0	See Attached	1.28	3.21%	Alloc Salary	3,685	17-7	2
3	Jay Meystel	Relative	Clerical	0	See Attached	1.28	3.21%	Alloc Salary	1,886	21-7	3
4	Elisheva Adest	Relative	Clerical	0	See Attached	0.88	3.21%	Alloc Salary	994	21-7	4
5	Meir Meystel	Relative	Administrative	0	See Attached	6.8	16.99%	Alloc Salary	42,481	17-7	5
6	Aaron Prancer	Relative	Administrative	0	See Attached	6.8	16.99%	Alloc Salary	42,481	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	$ 99,544		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 Waukegan # 0055475 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 Waukegan # 0055475 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	$	60,930	$ 112	1
2	6	Repairs & Maintenance	Census	358,576	7	132,748	127,841	60,930	22,557	2
3	11	Activity Expense	Census	358,576	7	75,597	74,420	60,930	12,846	3
4	2	Food	Census	358,576	7	2,426		60,930	412	4
5	17	Administrative	Census	358,576	7	500,000	500,000	60,930	84,961	5
6	19	Professional Fees	Census	358,576	7	71,707		60,930	12,185	6
7	20	Fees, Subscriptions	Census	358,576	7	5,482		60,930	931	7
8	21	Clerical & General	Census	358,576	7	691,717	662,888	60,930	117,538	8
9	24	Seminars	Census	358,576	7	4,267		60,930	725	9
10	25	Auto & Travel	Census	358,576	7	36,847		60,930	6,261	10
11	26	Insurance	Census	358,576	7			60,930		11
12	35	Equipment Rental	Census	358,576	7	3,714		60,930	631	12
13	35	Auto Lease	Census	358,576	7	16,511		60,930	2,806	13
14	7	Payroll Tax/Group Insurance	Census	358,576	7	11,870		60,930	2,017	14
15	10	Nursing	Census	358,576	7	642,014	642,014	60,930	109,092	15
16	15	Payroll Tax/Group Insurance	Census	358,576	7	66,518		60,930	11,303	16
17	27	Emp. Ben. - Gen. Admin.	Census	358,576	7	120,438		60,930	20,465	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,382,516	$ 2,007,163		$ 404,842	25

Facility Name & ID Number Elevate Care Waukegan # 0055475 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		60,930	5,271	1
2	20	Fees, Subscriptions	Census	1,899,996	65	24,450		60,930	784	2
3	21	Clerical & General	Census	1,899,996	65	3,101,245	3,044,021	60,930	99,452	3
4	24	Seminars	Census	1,899,996	65	2,428		60,930	78	4
5	25	Auto & Travel	Census	1,899,996	65			60,930		5
6	27	Emp. Ben. - Gen. Admin.	Census	1,899,996	65	375,858		60,930	12,053	6
7	30	Depreciaiton	Census	1,899,996	65	10,323		60,930	331	7
8	32	Interest	Census	1,899,996	65			60,930		8
9	35	Equipment Rental	Census	1,899,996	65	13,849		60,930	444	9
10	21	Clerical & General -IL Only	Census/Direct Alloc	1,208,651	46	1,767,260	1,767,260	60,930	76,708	10
11	27	Emp. Ben. - Gen. Admin.- IL Only	Census/Direct Alloc	1,208,651	46	218,211		60,930	9,471	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		$ 204,592	25

Facility Name & ID Number Elevate Care Waukegan # 0055475 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	$	60,930	$ 1,106	1
2	6	Repairs & Maintenance	Actual Census	1,899,996	65	54,886		60,930	1,760	2
3	3	Housekeeping	Actual Census	1,899,996	65	16,134		60,930	517	3
4	10	Medical Supplies	Actual Census	1,899,996	65	3,211		60,930	103	4
5	19	Professional Fees	Actual Census	1,899,996	65	62,958		60,930	2,019	5
6	20	Dues & Subscriptions	Actual Census	1,899,996	65	256		60,930	8	6
7	21	Office Expense	Actual Census	1,899,996	65	50,267		60,930	1,612	7
8	30	Depreciation	Actual Census	1,899,996	65	469,583		60,930	15,059	8
9	32	Interest Expense	Actual Census	1,899,996	65	117,136		60,930	3,756	9
10	33	Real Estate Taxes	Actual Census	1,899,996	65	91,748		60,930	2,942	10
11	35	Equipment Rental	Actual Census	1,899,996	65	8,550		60,930	1,376	11
12	34	Rent	Actual Census	1,899,996	65	42,922		60,930	274	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	$		$ 30,534	25

Facility Name & ID Number Elevate Care Waukegan # 0055475 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 / Concerto Dialysis
Street Address: 3712 Jarvis Avenue / 4600 W. Touhy
City / State / Zip Code: Skokie, IL 60076 / Lincolnwood, IL 60712
Phone Number: (847) 582-4000 / (847) 233-1202
Fax Number: ( )

	1 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			$	$		$ 129,718	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11	39	Dialysis	Direct						179,085	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					$	$		$ 308,803	25

Facility Name & ID Number Elevate Care Waukegan # 0055475 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			$	$		$ 35,178	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					$	$		$ 35,178	25

Facility Name & ID Number Elevate Care Waukegan # 0055475 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: EMSA Purchasing Group
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	Data Processing	Direct			$	$		$ 890	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 890	25

Facility Name & ID Number Elevate Care Waukegan # 0055475 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			$	$		$ 35,843	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					$	$		$ 35,843	25

Facility Name & ID Number Elevate Care Waukegan # 0055475 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	$	$		$ 604,320	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					$	$		$ 604,320	25

Facility Name & ID Number Elevate Care Waukegan # 0055475 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			$	$		$ 248,591	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					$	$		$ 248,591	25

Facility Name & ID Number Elevate Care Waukegan # 0055475 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	Oxford Finance LLC		X	Mortgage			$	$ 15,400,000			$ 1,252,533	1
2							$	$			$	2
3							$	$			$	3
4							$	$			$	4
5							$	$			$	5
	Working Capital											
6	Oxford Finance LLC		X					1,116,280			143,285	6
7								-			-	7
8												8
9	TOTAL Facility Related						$	$ 16,516,280			$ 1,395,818	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,477)	10
11	Alloc from Chase Office	X									3,756	11
12											-	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 2,279	14
15	TOTALS (line 9+line14)						$	$ 16,516,280			$ 1,398,096	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 Waukegan # 0055475 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.**	$ 126,819	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.)		$ 147,821	2
3. Under or (over) accrual (line 2 minus line 1).		$ 21,002	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 144,879	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.		$ 165,881	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	179,691	8
	2016	144,920	9
	2017	135,658	10
	2018	126,819	11
	2019	144,879	12

2020 Accrual = 2019 Real Estate Tax
Allocated from Chase Office $2,942

	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 Waukegan COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0055475

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.	08-32-109-020	Long Term Care Property	$ 2,766	$ 2,766
2.	08-32-109-021	Long Term Care Property	$ 142,113	$ 142,113
3.	10-27-307-027-0000	Allocated from Chase Office	$ 72,111	$ 2,197
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 216,989	$ 147,076

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

IMPORTANT NOTICE

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

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

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

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Elevate Care Waukegan COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0055475

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

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

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

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Elevate Care Waukegan # 0055475 Report Period Beginning: 01/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 48,925 B. General Construction Type: Exterior Brick Frame Concrete & Steel Number of Stories 4

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

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

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

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

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

None

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2019	$ 1,483,429	1
2	Allocated from Chase Office LLC			1,892	2
3	TOTALS			$ 1,485,321	3

Facility Name & ID Number Elevate Care Waukegan # 0055475 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	271		2019	1975	$ 14,123,000	$ 721,407	35	$ 403,514	$ (317,893)	$ 807,029	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 Waukegan # 0055475 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
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63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		119,052	8,115		5,538	(2,577)	22,845	68
69	Financial Statement Depreciation			59,206			(59,206)		69
70	TOTAL (lines 4 thru 69)		$ 14,242,052	$ 788,728		$ 409,053	$ (379,675)	$ 829,873	70

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

Facility Name & ID Number Elevate Care Waukegan # 0055475 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		$ 14,242,052	$ 788,728		$ 409,053	$ (379,675)	$ 829,873	1
2	Outdoor Camera, Dome Camera, Dvr & Cabling	2019	18,126		20	906	906	1,812	2
3	Replace Vct Flooring & Install Vinyl Base Cove	2019	4,895		20	245	245	490	3
4	Install Cat 6 Cabling & Jacks With Ladder Rack & Wires	2019	10,547		20	527	527	1,054	4
5	Installation Of Internet In Various Areas Of Facility	2019	4,263		20	213	213	426	5
6	Crock Filing, Patching, Sealcoating & Striping Of Parking Lot	2019	7,880		20	394	394	788	6
7	Plumbing Work On Drain Line & Water Lines	2019	4,350		20	218	218	436	7
8	Delay Magnetic Locks With Keypads & Staff Alert Panel	2019	11,365		20	568	568	1,136	8
9	Cast Iron Pipes For Pumps With Check & Float Valves	2019	6,800		20	340	340	680	9
10	Patio Sewer Line To Catch Basin, Through Concrete Wall/Rocks	2019	17,220		20	861	861	1,722	10
11	Replace Concrete Patio & Install 50 Foot Drain	2019	15,000		20	750	750	1,500	11
12	3 Doors With Hardware	2019	3,352		20	168	168	336	12
13	New Fence	2019	2,700		20	135	135	270	13
14	New Freezer Door	2019	5,900		20	295	295	590	14
15	Dialysis Room-Permit/Architectural/Plumbing/Electrical/Walls/Fl	2019	161,400		20	8,070	8,070	16,140	15
16	Hot Water Heater	2019	3,524		20	176	176	352	16
17	Delayed Egress Door Release	2019	5,215		20	261	261	522	17
18	Chiller - Repaired Leaks, Changed Circuits	2019	3,605		20	180	180	360	18
19	New Signage - Front Lit With Channel Letters	2020	9,587		20	479	479	479	19
20	8 Keypads For Exit Doors/2 Locks For Basement Doors/Connect T	2020	7,296		20	365	365	365	20
21	Install Custom Iron Fence	2020	8,810		20	441	441	441	21
22	Termpering Valve Installation	2020	12,200		20	610	610	610	22
23	Magnetic Lock At Back Gate Patio Exit To Parking Lot	2020	3,257		20	163	163	163	23
24	Hallway Makeup Air Unit - Replace Dampers, Valve, Control Syst	2020	25,700		20	1,285	1,285	1,285	24
25	Installed Groove Check Valve On Fire Alarm	2020	3,200		20	160	160	160	25
26	Replacement Pump For Boiler Room Fan	2020	3,275		20	164	164	164	26
27	Hvac New Honeywell 7890 Controller	2020	2,685		20	134	134	134	27
28	Phone System	2020	9,042		20	452	452	452	28
29	Replaced Light Pole Lamps With Ballast Bypass Lamps	2020	3,260		20	163	163	163	29
30	Repaired Compressor And Chiller A/C - Contactors, Fuses, Switch	2020	3,992		20	200	200	200	30
31	Repaired Chiller A/C	2020	3,936		20	197	197	197	31
32	2 Pump Replacements On Air Handler	2020	3,275		20	164	164	164	32
33									33
34	TOTAL (lines 1 thru 33)		$ 14,627,710	$ 788,728		$ 428,335	$ (360,393)	$ 863,463	34

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

Facility Name & ID Number Elevate Care Waukegan # 0055475 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		$ 14,627,710	$ 788,728		$ 428,335	$ (360,393)	$ 863,463	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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10									10
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 14,627,710	$ 788,728		$ 428,335	$ (360,393)	$ 863,463	34

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

Facility Name & ID Number Elevate Care Waukegan # 0055475 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		$ 14,627,710	$ 788,728		$ 428,335	$ (360,393)	$ 863,463	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 14,627,710	$ 788,728		$ 428,335	$ (360,393)	$ 863,463	34

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

Facility Name & ID Number Elevate Care Waukegan # 0055475 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		$ 14,627,710	$ 788,728		$ 428,335	$ (360,393)	$ 863,463	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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19									19
20									20
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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)		$ 14,627,710	$ 788,728		$ 428,335	$ (360,393)	$ 863,463	34

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

Facility Name & ID Number Elevate Care Waukegan # 0055475 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
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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 Waukegan # 0055475 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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 Waukegan # 0055475 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	17,025	437	20	437		1,928	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Chase Office LLC	2020	340		20	17	17	17	9
10	Allocated from Chase Office LLC	2019	8,671	394	20	434	40	867	10
11	Allocated from Chase Office LLC	2018	77	4	20	4	(0)	12	11
12	Allocated from Chase Office LLC	2017	3,941	964	20	197	(766)	788	12
13	Allocated from Chase Office LLC	2016	86,286	6,317	20	4,314	(2,003)	19,055	13
14									14
15	Allocated From Elevate Care Inc.	2019	839		20	42	42	84	15
16	Allocated From Elevate Care Inc.	2020	1,873		20	94	94	94	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)		$ 119,052	$ 8,115		$ 5,538	$ (2,577)	$ 22,845	34

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

Facility Name & ID Number Elevate Care Waukegan # 0055475 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		$ 119,052	$ 8,115		$ 5,538	$ (2,577)	$ 22,845	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 119,052	$ 8,115		$ 5,538	$ (2,577)	$ 22,845	34

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

Facility Name & ID Number Elevate Care Waukegan # 0055475 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,035,983	$ 7,275	$ 203,600	$ 196,325	10	$ 416,623	71
72	Current Year Purchases	12,403		1,240	1,240	10	1,240	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,048,387	$ 7,275	$ 204,840	$ 197,565		$ 417,863	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 18,161,417	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 796,003	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 633,175	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (162,828)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,281,326	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	New Tektone	$ 16,000	92
93	Remodeling	984,159	93
94			94
95		$ 1,000,159	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 Waukegan # 0055475 Report Period Beginning: 01/01/20 Ending: 12/31/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Elevate Care (Fargo Office)				19,285			5
6	Allocated from Chase Office				274			6
7	TOTAL				$ 19,559 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

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

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

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

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 13,104 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	$ 386	$ 386	17
18	Allocated from Elevate Care			2,806	18
19					19
20					20
21	TOTAL		$ 386	$ 3,192	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 Waukegan # 0055475 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	$		$ 268,550	$		$ 268,550	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			140,449			140,449	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			302,297			302,297	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				323,719		323,719	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):			421,184		237	313,796		735,217	13
14	TOTAL			$ 421,184		$ 711,533	$ 637,515		$ 1,770,232	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 Waukegan # 0055475 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	$ 823,554	$ 1,200,956	1
2	Cash-Patient Deposits	2,789	2,789	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,561,680	1,561,680	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,570	23,570	6
7	Other Prepaid Expenses	25,412	25,412	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	1,036,741	1,251,274	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,473,746	$ 4,065,681	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,483,429	13
14	Buildings, at Historical Cost		13,350,857	14
15	Leasehold Improvements, at Historical Cost	376,164	376,164	15
16	Equipment, at Historical Cost	133,221	2,028,606	16
17	Accumulated Depreciation (book methods)	(87,830)	(1,500,585)	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):	2,946,884	3,271,199	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,368,439	$ 19,009,670	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,842,185	$ 23,075,351	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 499,133	$ 605,222	26
27	Officer's Accounts Payable		1	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,116,280	1,116,280	29
30	Accrued Salaries Payable	271,798	271,798	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,134	6,134	31
32	Accrued Real Estate Taxes(Sch.IX-B)	144,879	144,879	32
33	Accrued Interest Payable	11,862	11,862	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		1,630,666	1,630,666	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,680,752	$ 3,786,842	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		15,400,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43		3,083,390	4,600,144	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,083,390	$ 20,000,144	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,764,142	$ 23,786,986	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 78,043	$ (711,635)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,842,185	$ 23,075,351	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,262,794	1
2	Restatements (describe):		2
3	Member Contributions	(4,600,000)	3
4	Bad Debts	(52,200)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (389,406)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	467,449	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)**	$ 467,449	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)**	$ 78,043	24 *

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 16,640,427	1
2	Discounts and Allowances for all Levels	(1,504,104)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 15,136,323	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	271,201	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 271,201	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	10,925	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,123	19
20	Radiology and X-Ray	1,448	20
21	Other Medical Services	39,692	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 53,188	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,477	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,477	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	1,563,959	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,563,959	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,026,148	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,154,824	31
32	Health Care	6,626,585	32
33	General Administration	3,269,239	33
	B. Capital Expense		
34	Ownership	2,146,740	34
	C. Ancillary Expense		
35	Special Cost Centers	1,880,247	35
36	Provider Participation Fee	481,064	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,558,699	40
41	**Income before Income Taxes (line 30 minus line 40)****	467,449	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 467,449	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,974,418	44
45	Private Pay - Net Inpatient Revenue	250,058	45
46	Medicare - Net Inpatient Revenue	3,243,051	46
47	Other-(specify) Insurance	1,320,955	47
48	Other-(specify) Managed Care	8,347,841	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 15,136,323	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

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

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

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,112	2,272	$ 142,922	$ 62.91	1
2	Assistant Director of Nursing	1,540	1,636	74,926	45.80	2
3	Registered Nurses	43,702	49,313	1,714,895	34.78	3
4	Licensed Practical Nurses	37,528	41,201	1,266,194	30.73	4
5	CNAs & Orderlies	92,278	100,145	1,686,103	16.84	5
6	CNA Trainees					6
7	Licensed Therapist	10,997	11,897	421,184	35.40	7
8	Rehab/Therapy Aides	6,100	7,335	192,979	26.31	8
9	Activity Director	1,584	1,831	31,400	17.15	9
10	Activity Assistants	9,771	10,248	127,080	12.40	10
11	Social Service Workers	7,684	8,340	187,234	22.45	11
12	Dietician					12
13	Food Service Supervisor	2,286	2,493	67,346	27.01	13
14	Head Cook	6,675	7,372	104,838	14.22	14
15	Cook Helpers/Assistants	23,770	25,536	335,428	13.14	15
16	Dishwashers					16
17	Maintenance Workers	6,358	6,670	119,260	17.88	17
18	Housekeepers	26,446	28,123	361,943	12.87	18
19	Laundry	398	413	6,027	14.59	19
20	Administrator	1,749	2,216	128,947	58.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,348	1,467	28,363	19.33	23
24	Clerical	6,962	7,613	149,375	19.62	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	31	31	733	23.65	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	3,159	3,587	115,084	32.08	33
34	TOTAL (lines 1 - 33)	292,478	319,739	$ 7,262,261 *	$ 22.71	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	366	$ 18,326	01-03	35
36	Medical Director	Monthly	153,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	323	16,157	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	767	11-03	44
45	Social Service Consultant	81	4,048	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	770	$ 192,298		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	9	$ 530	10-03	50
51	Licensed Practical Nurses	952	67,155	10-03	51
52	Certified Nurse Assistants/Aides	1,854	72,557	10-03	52
53	TOTAL (lines 50 - 52)	2,815	$ 140,242		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Shmuel Follman	Administrator		$ 9,174
Michale Jacobson	Administrator		16,859
Hina Rehman	Administrator		102,915
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 128,947

B. Administrative - Other

Description	Amount
Management Fees - Elevate Care Inc.	$ 773,480
TOTAL (agree to Schedule V, line 17, col. 3)	$ 773,480
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
National Datacare Center	Resident Trust Fund Service	$ 4,342
Aperion Care	Data Processing	361
Creative Technology Solutions	IT Consulting	48,850
Dgtell LLC	Data Processing	535
Earlysense INC	Data Processing	54,297
Elevate Care	Data Processing	30,233
Emsa Purchasing Group	Procurement Solutions	1,050
PointClickCare Technologies	Data Processing	86,360
Reside Admissions LLC	Data Processing	4,635
Telemedicine Solutions	Data Processing	6,300
See Attached	Legal	5,123
See Supplemental Schedule		117,925
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 360,011

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 140,390
Unemployment Compensation Insurance	7,295
FICA Taxes	555,563
Employee Health Insurance	146,007
Employee Meals	25,005
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	22,205
Employee Benefits - Other	32,503
401K Expense	835
Union Pension Fund	142,878
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,072,680

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	8,375
Health Care Worker Background Check	
(Indicate # of checks performed 303)	3,030
Patient Background Checks 306	3,055
Dues & Subscriptions	40,818
Licenses & Fees	29,236
See Supplemental Schedule	1,724
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 88,228

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	270
See Supplemental Schedule	803
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,073

* 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 $45,636**

(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. $ **56,207** 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. $ **481,064**
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. $ **25,005** 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? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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