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: 0055582

Facility Name: ELEVATE ST ANDREW LVING COMM

Address: 7000 N NEWARK AVENUE (Number) NILES (City) 60714 (Zip Code)

County: COOK

Telephone Number: (847) 647-8332 **Fax #** (847) 647-7073

HFS ID Number:

Date of Initial License for Current Owners: 04/02/2019

Type of Ownership:

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

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: DANIEL S. GAAFAR **Telephone Number:** (317) 237-5500
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 01/01/2020 to 12/31/2020 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) Dan Feinstein
(Title) Manager / CEO

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) DANIEL S. GAAFAR, PARTNER
(Firm Name & Address) BRADLEY ASSOCIATES, 201 S Capitol Ave, Suite 700, Indianapolis, IN 46225
(Telephone) (317) 237-5500 Fax # (317) 237-5503

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 ST ANDREW LVING COMM # 0055582 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	55	Skilled (SNF)	55	20,130	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	55	TOTALS	55	20,130	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	10,208	3,586	2,716	16,510	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,208	3,586	2,716	16,510	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.02%

D. How many bed reserve days during this year were paid by the Department?
0 (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)
N/A

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

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

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

I. On what date did you start providing long term care at this location?
Date started 12/08/2014

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/02/2019 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 55 and days of care provided 2,350

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 ST ANDREW LVING COMM # 0055582 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	566,964	51,533	9,142	627,639		627,639	(267,925)	359,714			1
2	Food Purchase		310,894		310,894		310,894	(165,945)	144,949			2
3	Housekeeping	180,701	25,129		205,830		205,830	(135,107)	70,723			3
4	Laundry	53,147	15,330		68,477		68,477	(30,538)	37,939			4
5	Heat and Other Utilities			393,998	393,998		393,998	(255,098)	138,900			5
6	Maintenance	213,706	11,772	50,912	276,390		276,390	(181,422)	94,968			6
7	Other (specify):*											7
8	TOTAL General Services	1,014,518	414,658	454,052	1,883,228		1,883,228	(1,036,035)	847,193			8
	B. Health Care and Programs											
9	Medical Director			16,875	16,875		16,875	(11,077)	5,798			9
10	Nursing and Medical Records	2,333,901	85,013	55,201	2,474,115		2,474,115	(139,676)	2,334,439			10
10a	Therapy	308,171	944	42,000	351,115		351,115		351,115			10a
11	Activities	106,018	197		106,215		106,215	(69,719)	36,496			11
12	Social Services	66,750		2,896	69,646		69,646	(28,790)	40,856			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX CONSULTANT			6,630	6,630		6,630	(374)	6,256			15
16	TOTAL Health Care and Programs	2,814,840	86,154	123,602	3,024,596		3,024,596	(249,636)	2,774,960			16
	C. General Administration											
17	Administrative	124,922			124,922		124,922	(42,733)	82,189			17
18	Directors Fees											18
19	Professional Services			467,766	467,766		467,766	(555,528)	(87,762)			19
20	Dues, Fees, Subscriptions & Promotions			55,079	55,079		55,079	(9,455)	45,624			20
21	Clerical & General Office Expenses	173,881	4,334	334,057	512,272		512,272	(191,043)	321,229			21
22	Employee Benefits & Payroll Taxes			499,242	499,242		499,242	(77,561)	421,681			22
23	Inservice Training & Education											23
24	Travel and Seminar							1,740	1,740			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			108,586	108,586		108,586	(52,404)	56,182			26
27	Other (specify):*											27
28	TOTAL General Administration	298,803	4,334	1,464,730	1,767,867		1,767,867	(926,984)	840,883			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,128,161	505,146	2,042,384	6,675,691		6,675,691	(2,212,655)	4,463,036			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 ST ANDREW LVING COMM #0055582 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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			50,830	50,830		50,830	308,590	359,420			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,080	12,080		12,080	620,170	632,250			32
33	Real Estate Taxes			776,004	776,004		776,004	(509,369)	266,635			33
34	Rent-Facility & Grounds			900,000	900,000		900,000	(1,468,635)	(568,635)			34
35	Rent-Equipment & Vehicles			12,185	12,185		12,185	(7,998)	4,187			35
36	Other (specify):*											36
37	TOTAL Ownership			1,751,099	1,751,099		1,751,099	(1,057,242)	693,857			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			7,368	7,368		7,368	(4,836)	2,532			38
39	Ancillary Service Centers		93,146		93,146		93,146		93,146			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			119,207	119,207		119,207		119,207			42
43	Other (specify):* Non-Allowable			161,253	161,253		161,253	(161,253)				43
44	TOTAL Special Cost Centers		93,146	287,828	380,974		380,974	(166,089)	214,885			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,128,161	598,292	4,081,311	8,807,764		8,807,764	(3,435,986)	5,371,778			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 ST ANDREW LVING COMM # 0055582 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	(33,424)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(2,231)	4		8
9	Non-Straightline Depreciation	(27,878)	30		9
10	Interest and Other Investment Income	(973)	32		10
11	Discounts, Allowances, Rebates & Refunds	522	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(390)	1		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	(2,285)	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	(161,253)	43		24
25	Fund Raising, Advertising and Promotional	(5,840)	21		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	(2,992,748)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (3,226,500)		$	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)	(209,486)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (209,486)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (3,435,986)		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.		X	$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44			X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

ELEVATE ST ANDREW LVING COMM

ID# 0055582

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-allowable Rent Income	$ (2,400)	34	1
2	Non-allowable Dietary - ILF/ALF	(267,535)	1	2
3	Non-allowable Food Pur. - ILF/ALF	(132,521)	2	3
4	Non-allowable Housekeeping - ILF/ALF	(135,107)	3	4
5	Non-allowable Laundry - ILF/ALF	(28,307)	4	5
6	Non-allowable Utilities - ILF/ALF	(258,620)	5	6
7	Non-allowable Maintenance - ILF/ALF	(181,422)	6	7
8	Non-allowable Medical Dir. - ILF/ALF	(11,077)	9	8
9	Non-allowable Nursing, Medical Records - ILF/ALF	(139,676)	10	9
10	Non-allowable Activities - ILF/ALF	(69,719)	11	10
11	Non-allowable Social Ser. - ILF/ALF	(28,790)	12	11
12	Non-allowable Rx Consult - ILF/ALF	(374)	15	12
13	Non-allowable Admin. - ILF/ALF	(42,733)	17	13
14	Non-allowable Prof. Ser. - ILF/ALF	(160,011)	19	14
15	Non-allowable Fees & Subs - ILF/ALF	(18,841)	20	15
16	Non-allowable Clerical - ILF/ALF	(175,235)	21	16
17	Non-allowable Benef/Taxes - ILF/ALF	(110,307)	22	17
18	Non-allowable Travel and Seminar - ILF/ALF	0	24	18
19	Non-allowable Insurance - ILF/ALF	(71,276)	26	19
20	Non-allowable Interest - ILF/ALF	(7,929)	32	20
21	Non-allowable Real Est Taxes - ILF/ALF	(509,369)	33	21
22	Non-allowable Rent - ILF/ALF	(590,760)	34	22
23	Non-allowable Equipment - ILF/ALF	(7,998)	35	23
24	Non-allowable Medical Tran - ILF/ALF	(4,836)	38	24
25	Non-allowable Marketing Coordinator	(37,905)	21	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**	(2,992,748)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ELEVATE ST ANDREW LVING COMM # 0055582 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	(267,925)	0	0	0	0	0	0	0	0	0	0	(267,925)	1
2	Food Purchase	(165,945)	0	0	0	0	0	0	0	0	0	0	(165,945)	2
3	Housekeeping	(135,107)	0	0	0	0	0	0	0	0	0	0	(135,107)	3
4	Laundry	(30,538)	0	0	0	0	0	0	0	0	0	0	(30,538)	4
5	Heat and Other Utilities	(258,620)	3,522	0	0	0	0	0	0	0	0	0	(255,098)	5
6	Maintenance	(181,422)	0	0	0	0	0	0	0	0	0	0	(181,422)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,039,557)	3,522	0	0	0	0	0	0	0	0	0	(1,036,035)	8
	B. Health Care and Programs													
9	Medical Director	(11,077)	0	0	0	0	0	0	0	0	0	0	(11,077)	9
10	Nursing and Medical Records	(139,676)	0	0	0	0	0	0	0	0	0	0	(139,676)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(69,719)	0	0	0	0	0	0	0	0	0	0	(69,719)	11
12	Social Services	(28,790)	0	0	0	0	0	0	0	0	0	0	(28,790)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(374)	0	0	0	0	0	0	0	0	0	0	(374)	15
16	**TOTAL Health Care and Programs**	(249,636)	0	0	0	0	0	0	0	0	0	0	(249,636)	16
	C. General Administration													
17	Administrative	(42,733)	0	0	0	0	0	0	0	0	0	0	(42,733)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(160,011)	(395,517)	0	0	0	0	0	0	0	0	0	(555,528)	19
20	Fees, Subscriptions & Promotions	(18,841)	9,386	0	0	0	0	0	0	0	0	0	(9,455)	20
21	Clerical & General Office Expenses	(220,743)	29,700	0	0	0	0	0	0	0	0	0	(191,043)	21
22	Employee Benefits & Payroll Taxes	(110,307)	32,746	0	0	0	0	0	0	0	0	0	(77,561)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,740	0	0	0	0	0	0	0	0	0	1,740	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(71,276)	18,872	0	0	0	0	0	0	0	0	0	(52,404)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(623,911)	(303,073)	0	0	0	0	0	0	0	0	0	(926,984)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,913,104)	(299,551)	0	0	0	0	0	0	0	0	0	(2,212,655)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ELEVATE ST ANDREW LVING COMM # 0055582 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	(27,878)	336,468	0	0	0	0	0	0	0	0	0	308,590	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,902)	629,072	0	0	0	0	0	0	0	0	0	620,170	32
33	Real Estate Taxes	(509,369)	0	0	0	0	0	0	0	0	0	0	(509,369)	33
34	Rent-Facility & Grounds	(593,160)	(875,475)	0	0	0	0	0	0	0	0	0	(1,468,635)	34
35	Rent-Equipment & Vehicles	(7,998)	0	0	0	0	0	0	0	0	0	0	(7,998)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,147,307)	90,065	0	0	0	0	0	0	0	0	0	(1,057,242)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(4,836)	0	0	0	0	0	0	0	0	0	0	(4,836)	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(161,253)	0	0	0	0	0	0	0	0	0	0	(161,253)	43
44	**TOTAL Special Cost Centers**	(166,089)	0	0	0	0	0	0	0	0	0	0	(166,089)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(3,226,500)	(209,486)	0	0	0	0	0	0	0	0	0	(3,435,986)	45

Facility Name & ID Number ELEVATE ST ANDREW LVING COMM # 0055582 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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
Elevate Housing Foundation	100%	Woodview, A Caring Community	Fort Wayne, IN	NONE		
		Blackhawk Nursing and Rehabilitation	Waterloo, IA			

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	5	Utilities	$	GS Management		$ 3,522	$ 3,522	1
2	V	19	Professional Services	403,131	GS Management		7,614	(395,517)	2
3	V	20	Dues, Fees, Subscriptions & Promotions		GS Management		9,386	9,386	3
4	V	21	Clerical and General Office Expenses		GS Management		29,700	29,700	4
5	V	22	Employee Benefits & Payroll Taxes		GS Management		32,746	32,746	5
6	V	24	Travel and Seminar		GS Management		1,740	1,740	6
7	V	26	Insurance - Prop. Liab. Malpractice		GS Management		18,872	18,872	7
8	V	34	Rent - Facility & Grounds		GS Management		24,525	24,525	8
9	V	34	Rent - Facility & Grounds	900,000	Elevate Saint Andrew, LLC			(900,000)	9
10	V	30	Depreciation		Elevate Saint Andrew, LLC		336,468	336,468	10
11	V	32	Interest		Elevate Saint Andrew, LLC		629,072	629,072	11
12	V								12
13	V								13
14	Total			$ 1,303,131			$ 1,093,645	$ * (209,486)	14

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

Facility Name & ID Number ELEVATE ST ANDREW LVING COMM # 0055582 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number ELEVATE ST ANDREW LVING COMM # 0055582 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

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: GS Healthcare Management
Street Address: 8140 McCormick Blvd., Suite 124
City / State / Zip Code: Skokie, IL 60076
Phone Number: (206) 484-3120
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				$	$		$ 3,522	1
2	19	Professional Services							7,614	2
3	20	Dues, Fees, Subscriptions & Promotions							9,386	3
4	21	Clerical and General Office Expenses							29,700	4
5	22	Employee Benefits & Payroll Taxes							32,746	5
6	24	Travel and Seminar							1,740	6
7	26	Insurance - Prop. Liab. Malpractice							18,872	7
8	34	Rent - Facility & Grounds							24,525	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					$	$		$ 128,105	25

Facility Name & ID Number ELEVATE ST ANDREW LVING COMM # 0055582 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	Elevate Housing Foundation		X	Mortgage		3/31/19	$ 9,500,000	$ 9,500,000	12/15/2048	0.0712	$ 629,072	1
2	SBA - PPP Loan		X	PPP Loan			758,057	758,057				2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 10,258,057	$ 10,258,057			$ 629,072	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 10,258,057	$ 10,258,057			$ 629,072	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A 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 ST ANDREW LVING COMM # 0055582 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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.**	$ (140,083)	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.)		$ 631,231	2
3. Under or (over) accrual (line 2 minus line 1).		$ 771,314	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 4,690	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.		$ 776,004	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	473,875	8
	2016	674,427	9
	2017	738,695	10
	2018	722,086	11
	2019	631,231	12

	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 ST ANDREW LVING COMM COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0055582

CONTACT PERSON REGARDING THIS REPORT DANIEL S. GAAFAR

TELEPHONE (317) 237-5500 FAX #: (317) 237-5503

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.	10-31-100-023-0000	7063 W. Touhy Ave, Niles, IL 60714	$ 601,136.94	$ 601,136.94
2.	10-31-100-004-0000	7000 Newark Ave, Nile, IL 60714	$ 30,093.81	$ 30,093.81
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 631,230.75	$ 631,230.75

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach 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.

Facility Name & ID Number ELEVATE ST ANDREW LVING COMM # 0055582 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 155,990 B. General Construction Type: Exterior Brick Frame Masonry Number of Stories 6

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).

Elevate Saint Andrew Living Community Assisted Living - 47 regular units & 12 Alzheimer units

Elevate Saint Andrew Living Community Independent Living Facilities - 95 units

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	Patient Care		2019	$ 1,192,559	1
2					2
3	TOTALS			$ 1,192,559	3

Facility Name & ID Number ELEVATE ST ANDREW LVING COMM # 0055582 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	55		2019	1952	$ 7,349,216	$ 183,732	40	$ 183,730	$ (2)	$ 321,531	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Renovated Visitor Bathroom, Floor 1 - Lighting,			2019	2,189	404	39	56	(348)	998	9
10	Exhaust Vent, Electric & Plumbing										10
11	Dishwasher / Overflowing Gray Tank Boiler			2019	1,957	361	39	50	(311)	892	11
12	116 Shower Conversion, Mulch, Dishwasher Leaking Pipes			2019	3,474	642	39	89	(553)	1,584	12
13	Lighting for Exit Doors, Keypads for 5th Floor Storage,										13
14	2 Grinders, Rental Concrete Saw & Braker										14
15	Plumbing - Main Valves Leaking Steam			2019	2,864	529	39	73	(456)	1,306	15
16	New AC Units			2019	4,274	790	39	110	(680)	1,948	16
17	Modernization of Elevator #1 - 3rd Payment			2019	33,000	6,097	39	846	(5,251)	15,045	17
18	Modernization of Elevator #1 - 4th Payment			2019	19,100	3,529	39	490	(3,039)	8,709	18
19	New Floor Rm 450, Timer Sprinklers outside,			2019	2,619	484	39	67	(417)	1,194	19
20	& Pipes for new grease trap installed										20
21	Modernization of Elevator			2019	9,390	1,735	39	241	(1,494)	4,280	21
22	Supplies for Tile to Front Stairs to Chapel, Repair			2019	1,326	245	39	34	(211)	605	22
23	Stone On Stairs to Chapel										23
24	Test Boiler Low Water Cutoffs, Check Pilot			2019	780	144	39	20	(124)	356	24
25	Check Boiler & Pipework, Drain Boiler			2019	2,860	528	39	73	(455)	1,304	25
26	Garden - Porcelain Tile & Stone Tile			2019	2,592	479	39	66	(413)	1,182	26
27	Re-Installed Intercooler			2019	2,978	550	39	76	(474)	1,358	27
28	Modernization of Elevator			2019	6,369	1,177	39	163	(1,014)	2,904	28
29	Sign for building			2019	7,858	1,452	39	201	(1,251)	3,583	29
30	Deposit of Checked Boiler			2019	1,472	272	39	38	(234)	671	30
31	Engineering Survey for purchase			2019	6,500	1,201	39	167	(1,034)	2,964	31
32	New Sign Deposit			2019	4,100	757	39	105	(652)	1,869	32
33	Annual Fire Alarm System Services			2019	7,799	1,441	39	200	(1,241)	3,556	33
34	Annual Fire Alarm System Services			2019	4,310	796	39	111	(685)	1,965	34
35	Elevator Pump			2019	3,720	687	39	95	(592)	1,696	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 ST ANDREW LVING COMM # 0055582 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	New Dishwasher	2019	$ 846	$ 156	39	$ 22	$ (134)	$ 385	37
38									38
39	Sherwin Williams - paint throughout facility	2020	1,088	201	39	28	(173)	201	39
40	115V 12K BTU for corridor AC Unit	2020	418	77	39	11	(66)	77	40
41	Deposit for Hot Water System Repairs	2020	34,500	6,374	39	885	(5,489)	6,374	41
42	Concrete/ limestone tubs	2020	173	32	39	4	(28)	32	42
43	2nd installment for Hot Water System Repairs	2020	17,250	3,187	39	442	(2,745)	3,187	43
44	Replaced feed valve on make-up feed tank	2020	1,044	193	39	27	(166)	193	44
45	Boiler repairs / additional tubes	2020	2,500	462	39	64	(398)	462	45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,538,566	$ 218,714		$ 188,586	$ (30,128)	$ 392,411	70

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

Facility Name & ID Number ELEVATE ST ANDREW LVING COMM # 0055582 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	$ 510,033	$ 167,819	$ 170,011	$ 2,192	3	$ 308,629	71
72	Current Year Purchases	2,470	765	823	58	3	765	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 512,503	$ 168,584	$ 170,834	$ 2,250		$ 309,394	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)	$ 9,243,628	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 387,298	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 359,420	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (27,878)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 701,805	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number ELEVATE ST ANDREW LVING COMM # 0055582 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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								5
6								6
7	TOTAL				$ **			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: $ Description:
(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			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	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 ST ANDREW LVING COMM # 0055582 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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.

Facility Name & ID Number ELEVATE ST ANDREW LVING COMM # 0055582 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		525	42,000	944	525	42,944	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescrpts				93,146		93,146	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	525	$ 42,000	$ 94,090	525	$ 136,090	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 ST ANDREW LVING COMM # 0055582 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (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	$ 354,001	$ 354,001	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,706,121	1,706,121	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	57,471	57,471	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	377,466	377,466	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,495,059	$ 2,495,059	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	190,130	190,130	15
16	Equipment, at Historical Cost	54,278	54,278	16
17	Accumulated Depreciation (book methods)	(56,681)	(56,681)	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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 187,727	$ 187,727	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,682,786	$ 2,682,786	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,104,465	$ 3,104,465	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	130,673	130,673	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,904	9,904	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,245,042	$ 3,245,042	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	758,057	758,057	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 758,057	$ 758,057	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,003,099	$ 4,003,099	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,320,313)	$ (1,320,313)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,682,786	$ 2,682,786	48

***(See instructions.)**

Facility Name & ID Number ELEVATE ST ANDREW LVING COMM # 0055582 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (698,357)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (698,357)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(686,296)	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) **Correction Adjustments**	64,340	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (621,956)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,320,313)	24 *

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

Facility Name & ID Number ELEVATE ST ANDREW LVING COMM # 0055582 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	$ 7,339,885	1
2	Discounts and Allowances for all Levels	(824,513)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,515,372	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	993,590	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 993,590	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	(2,179)	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	59,579	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	1,045	20
21	Other Medical Services		21
22	Laundry	2,231	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 60,676	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	973	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 973	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	HHS Stimulus Funds	515,032	28
28a	Misc. Income	35,824	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 550,856	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,121,467	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,883,228	31
32	Health Care	3,024,596	32
33	General Administration	1,767,867	33
	B. Capital Expense		
34	Ownership	1,751,099	34
	C. Ancillary Expense		
35	Special Cost Centers	93,146	35
36	Provider Participation Fee	119,207	36
	D. Other Expenses (specify):		
37	Bad Debt Expense	161,253	37
38	Medically Necessary Transportation	7,368	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,807,764	40
41	**Income before Income Taxes (line 30 minus line 40)****	(686,297)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (686,297)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,974,596	44
45	Private Pay - Net Inpatient Revenue	1,980,186	45
46	Medicare - Net Inpatient Revenue	602,349	46
47	Other-(specify) Managed Care	(775,906)	47
48	Other-(specify) ALF/ILF Income	2,734,147	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,515,372	49

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

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

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

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

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,893	2,045	$ 119,315	$ 58.34	1
2	Assistant Director of Nursing	2,022	2,136	93,846	43.94	2
3	Registered Nurses	17,637	19,956	742,017	37.18	3
4	Licensed Practical Nurses	9,577	10,778	307,237	28.51	4
5	CNAs & Orderlies	46,335	51,427	882,767	17.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,493	11,327	407,863	36.01	8
9	Activity Director	3,491	4,857	106,018	21.83	9
10	Activity Assistants					10
11	Social Service Workers	1,735	2,176	64,771	29.77	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	35,110	37,912	566,964	14.95	15
16	Dishwashers					16
17	Maintenance Workers	7,683	9,461	213,706	22.59	17
18	Housekeepers	12,655	13,892	180,701	13.01	18
19	Laundry	3,751	4,151	53,147	12.80	19
20	Administrator	2,459	2,540	124,922	49.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,695	7,439	175,859	23.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,360	1,893	36,696	19.39	31
32	Other Health Care(specify)					32
33	Other(specify) Admissions Coord	1,531	1,637	52,332	31.97	33
34	TOTAL (lines 1 - 33)	164,427	183,627	$ 4,128,161 *	$ 22.48	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	261	$ 9,142	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	19	663	10-3	38
39	Pharmacist Consultant	133	6,630	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	32	1,121	12-3	45
46	Other(specify) MDS Consultant	708	35,420	10-3	46
47	Purchasing Consultant	763	26,708	20-3	47
48	HR Consultant	2,513	125,631	21-3	48
49	TOTAL (lines 35 - 48)	4,429	$ 205,315		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	58	3,289	10-3	51
52	Certified Nurse Assistants/Aides	592	15,686	10-3	52
53	TOTAL (lines 50 - 52)	650	$ 18,975		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lyudmila Tur	Administrator		$ 124,922
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 124,922

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
GS Management	Mgmt/Professional Fees	$ 403,131
Bradley Associates	Accounting Fees	12,987
Touch Support	Accounting Fees	2,910
Personnel Planners, Inc	Legal & Professional Fees	1,770
Bock and Clark Corporation	Legal & Professional Fees	3,133
Skidelsky & Associates	Legal & Professional Fees	17,320
Proactive Risk	Legal & Professional Fees	6,118
OpX Advisory Group	Legal & Professional Fees	3,750
O'Hagan Meyer	Legal & Professional Fees	14,983
Polsinelli	Legal & Professional Fees	1,664
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 467,766

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 104,604
Unemployment Compensation Insurance	46,466
FICA Taxes	316,898
Employee Health Insurance	38,838
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	(9,424)
Other Employee Benefits	1,860
Non-allowable ILF/ALF Expenses	(110,307)
GS Management Allocation	32,746
TOTAL (agree to Schedule V, line 22, col.8)	$ 421,681

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	$ 5,170
Advertising: Employee Recruitment	
Health Care Worker Background Check	1,892
(Indicate # of checks performed 51)	
Merville J. Chavez Duarte	18,000
PointClickCare Technologies	10,070
RAR Purchasing	6,440
Other License, Fees & Dues	13,507
GS Management Allocation	9,386
Non-allowable ILF/ALF Expense	(18,841)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 45,624

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
GS Management Allocation	1,740
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,740

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ELEVATE ST ANDREW LVING COMM # 0055582 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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? **NO**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(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? **5,10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **24,850** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **119,207**
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? **YES - ALF/ILF** 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. $ **NONE** Has any meal income been offset against related costs? **YES** 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? **N/A**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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