

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0045534

Facility Name: Avanti Wellness & Rehab

Address: 6840 West Touhy Ave Niles 60714
Number City Zip Code

County: Cook

Telephone Number: (847) 647-8994 Fax # (847) 647-0500

HFS ID Number:

Date of Initial License for Current Owners: 12/1/2001

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ 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 01/01/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

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

Paid Preparer

(Signed) *
* Subject to the attached Accountants Consulting Report (Date)
(Print Name and Title)
(Firm Name & Address) Marcum, LLP
111 Pfingsten Road, Suite 300 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

Avanti Wellness & Rehab

#

0045534

Report Period Beginning:

01/01/16

Ending:

12/31/16

III. STATISTICAL DATA

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

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	212	Skilled (SNF)	212	77,592	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	212	TOTALS	212	77,592	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	26,501	9,813	11,594	47,908	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,501	9,813	11,594	47,908	14

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

61.74%

D. How many bed-hold days during this year were paid by the Department?

None

(Do not include bed-hold 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

12/01/2001

J. Was the facility purchased or leased after January 1, 1978?

YES

X

Date

12/01/2001

NO

K. Was the facility certified for Medicare during the reporting year?

YES

X

NO

If YES, enter number of beds certified

212

and days of care provided

6,832

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:

12/31/16

Fiscal Year:

12/31/16

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

Facility Name & ID Number Avanti Wellness & Rehab # 0045534 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	337,019	33,764	18,025	388,808		388,808		388,808			1
2	Food Purchase		414,245		414,245	(103,249)	310,996	(882)	310,114			2
3	Housekeeping	252,408	68,452		320,860		320,860		320,860			3
4	Laundry	73,727	17,258	5,900	96,885		96,885		96,885			4
5	Heat and Other Utilities			176,137	176,137		176,137		176,137			5
6	Maintenance	38,520	44,774	96,916	180,210		180,210	9,595	189,805			6
7	Other (specify):*											7
8	TOTAL General Services	701,674	578,493	296,978	1,577,145	(103,249)	1,473,896	8,713	1,482,610			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	3,469,253	440,976	148,138	4,058,367		4,058,367	(12,574)	4,045,793			10
10a	Therapy	173,732			173,732		173,732		173,732			10a
11	Activities	257,319	18,591	1,320	277,230		277,230		277,230			11
12	Social Services	178,158		1,811	179,969		179,969		179,969			12
13	CNA Training											13
14	Program Transportation			65,935	65,935		65,935	(1,390)	64,545			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,078,462	459,567	241,204	4,779,233		4,779,233	(13,964)	4,765,269			16
	C. General Administration											
17	Administrative	116,493		176,400	292,893		292,893		292,893			17
18	Directors Fees											18
19	Professional Services			281,181	281,181	(55,888)	225,293	(28,911)	196,382			19
20	Dues, Fees, Subscriptions & Promotions			30,739	30,739		30,739	(4,350)	26,389			20
21	Clerical & General Office Expenses	338,736	46,168	244,490	629,394		629,394	(95,304)	534,090			21
22	Employee Benefits & Payroll Taxes			866,899	866,899	103,249	970,148		970,148			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,070	4,070		4,070	(250)	3,820			24
25	Other Admin. Staff Transportation			37,343	37,343		37,343	(29,844)	7,499			25
26	Insurance-Prop.Liab.Malpractice			348,097	348,097		348,097	13,261	361,358			26
27	Other (specify):*											27
28	TOTAL General Administration	455,229	46,168	1,989,219	2,490,616	47,361	2,537,977	(145,397)	2,392,579			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,235,365	1,084,228	2,527,401	8,846,994	(55,888)	8,791,106	(150,648)	8,640,458			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			101,050	101,050		101,050	528,174	629,224			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			159,038	159,038		159,038	628,640	787,678			32
33	Real Estate Taxes					55,888	55,888	567,369	623,257			33
34	Rent-Facility & Grounds			1,771,671	1,771,671		1,771,671	(1,771,671)				34
35	Rent-Equipment & Vehicles			30,240	30,240		30,240		30,240			35
36	Other (specify):*							91,648	91,648			36
37	TOTAL Ownership			2,061,999	2,061,999	55,888	2,117,887	44,160	2,162,047			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,378,431	719,892	184,666	2,282,989		2,282,989		2,282,989			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			373,076	373,076		373,076		373,076			42
43	Other (specify):*	673,270		115,908	789,178		789,178	(789,178)	0			43
44	TOTAL Special Cost Centers	2,051,701	719,892	673,650	3,445,243		3,445,243	(789,178)	2,656,065			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	7,287,066	1,804,120	5,263,050	14,354,236		14,354,236	(895,666)	13,458,570			45

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

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 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(34)	02		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				8
9	Non-Straightline Depreciation	3,753	30		9
10	Interest and Other Investment Income	(365)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(848)	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	(9,885)	21		18
19	Entertainment	(3,498)	21		19
20	Contributions	(4,600)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,000)	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	(1,003,253)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,078,730)		\$	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)	183,064		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 183,064		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (895,666)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (491)	21	1
2	Medical Records	(1,338)	10	2
3	Resident Missing Items	(11,236)	10	3
4	Bank Fees	(21,430)	21	4
5	Marketing/Advertising	(112,908)	43	5
6	Non-allowable Interest	(58,500)	32	6
7	Non-allowable Travel	(5,373)	25	7
8	Non-allowable Auto Lease	(24,471)	25	8
9	Non-allowable Seminar	(250)	24	9
10	Promotional	(3,000)	43	10
11	Additional R&M	6,097	06	11
12	Non-allowable Legal	(84,799)	19	12
13	Non-allowable Salary	(599,997)	43	13
14	Marketing Salary	(73,273)	43	14
15	Building Company - Legal Fees	(1,155)	19	15
16	Building Company - Amortization	(3,578)	36	16
17	Additional R&M - Building Company	538	06	17
18	2016 Membership Fee	250	20	18
19	Capitalized R&M - Building Company	(8,340)	06	19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,003,253)		49

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
50		\$		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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Avanti Wellness & Rehab # 0045534 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(882)											(882)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(1,705)	11,300										9,595	6
7	Other (specify):*													7
8	TOTAL General Services	(2,587)	11,300										8,713	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(12,574)											(12,574)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation			(1,390)									(1,390)	14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(12,574)		(1,390)									(13,964)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(85,954)	57,043										(28,911)	19
20	Fees, Subscriptions & Promotions	(4,350)											(4,350)	20
21	Clerical & General Office Expenses	(95,304)											(95,304)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(250)											(250)	24
25	Other Admin. Staff Transportation	(29,844)											(29,844)	25
26	Insurance-Prop.Liab.Malpractice		13,261										13,261	26
27	Other (specify):*													27
28	TOTAL General Administration	(215,701)	70,304										(145,397)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(230,862)	81,604	(1,390)									(150,648)	29

Summary B

12/31/16

[illegible]

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 1,771,671	Forest Villa Property, LLC		\$	(1,771,671)	1
2	V	32	Interest	197	Forest Villa Property, LLC		687,702	687,505	2
3	V	36	MIP Expense		Forest Villa Property, LLC		91,648	91,648	3
4	V	26	Insurance		Forest Villa Property, LLC		13,261	13,261	4
5	V	19	Property Valuation		Forest Villa Property, LLC		3,500	3,500	5
6	V	06	Building Décor		Forest Villa Property, LLC		8,340	8,340	6
7	V	30	Depreciation		Forest Villa Property, LLC		524,421	524,421	7
8	V	36	Amortization		Forest Villa Property, LLC		3,578	3,578	8
9	V	33	Real Estate Taxes		Forest Villa Property, LLC		567,369	567,369	9
10	V	19	Tax Assessment		Forest Villa Property, LLC		52,388	52,388	10
11	V	06	Repairs and Maintenace		Forest Villa Property, LLC		2,960	2,960	11
12	V	19	Legal Fees				1,155	1,155	12
13	V								13
14	Total			\$ 1,771,868			\$ 1,956,322	\$ * 184,454	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	14	Ambulance	\$ 10,539	Lifeline Ambulance	100.00%	\$ 9,149	\$ (1,390)	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			\$ 10,539			\$ 9,149	\$ * (1,390)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

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

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	BARRY CARR	42.00%			FOREST VILLA PROPERTY, LL	LINCOLNWOOD	BUILDING CO	1
2	JANET HARRIS	4.75%			LIFELINE AMBULANCE, LLC	CHICAGO	AMBULANCE	2
3	MICHAEL HARRIS	17.63%						3
4	ROBERT HARTMAN FAMILY TRUST	10.00%						4
5	THE ROBERT & DEBRA HARTMAN FOUNDATION	3.00%						5
6	JUDY HARRIS TRUST	12.63%						6
7	DAVID HARTMAN	10.00%						7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Avanti Wellness & Rehab # 0045534 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											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	\$		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 Avanti Wellness & Rehab # 0045534 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

Ending: 12/31/16

((312) 949-9262

IL478-2471

Facility Name & ID Number	Avanti Wellness & Rehab
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0045534

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

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 Avanti Wellness & Rehab # 0045534 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			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 Avanti Wellness & Rehab # 0045534 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			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 Avanti Wellness & Rehab # 0045534 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			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 Avanti Wellness & Rehab # 0045534 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			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 Avanti Wellness & Rehab # 0045534 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

Ending: 12/31/16

Facility Name & ID Number	Avanti Wellness & Rehab
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0045534

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

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

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	HUD		X	Mortgage			\$	16,573,152			\$	687,702	1	
2													2	
3													3	
4													4	
5					-								5	
	Working Capital													
6	Bank of America		X	Line of Credit				2,326,106				100,538	6	
7	Private Bank		X	Loan Payable				550,000					7	
8	See Supplemental Schedule				-			812,804					8	
9	TOTAL Facility Related						\$	20,262,062				\$	788,240	9
	B. Non-Facility Related*													
10	Interest Income		X									(365)	10	
11	Judy Harris Trust	X										58,500	11	
12	Non Allowable Interest											(58,500)	12	
13	Interest Income - Bldg Co.		X		-							(197)	13	
14	TOTAL Non-Facility Related						\$					\$	(562)	14
15	TOTALS (line 9+line14)						\$	20,262,062				\$	787,678	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 91,648 Line # 36

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term												7
	Working Capital												
8	Lincoln		X	Auto Loan			\$		\$ 12,804			\$	8
9	Loan Advance		X	Loan Advance					800,000				9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital								812,804				14
	B. Non-Facility Related*												
15							\$					\$	15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related												20

* 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

FACILITY NAME	Avanti Wellness & Rehab	COUNTY	Cook
---------------	-------------------------	--------	------

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Avanti Wellness & Rehab

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0045534

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-6300

FAX #:

(847) 236-6301

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

A. Square Feet: 31,000

B. General Construction Type: Exterior Brick Frame Steel Number of Stories

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	Facility			2009		\$ 2,330,768	1
2							2
3	TOTALS					\$ 2,330,768	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	212		2009	1964	\$ 9,756,249	\$ 524,421	35	\$ 325,994	\$ (198,427)	\$ 2,369,373
5										
6										
7										
8										
	Improvement Type**									
9	Various		2002		258,372		20	10,879	10,879	210,435
10	Various		2003		125,406		20	2,489	2,489	110,408
11	Various		2004		63,667		20	2,166	2,166	48,664
12	Various		2005		70,739		20	1,888	1,888	54,844
13	Various		2006		32,275		20	1,253	1,253	25,009
14	Various		2007		33,549		20	2,359	2,359	26,014
15	Various		2008		34,393		20	2,336	2,336	20,483
16	Various		2009		95,565		20	8,102	8,102	63,448
17	Various		2010		36,676		20	2,572	2,572	16,599
18	Various		2011		48,999		20	4,562	4,562	25,023
19	Various		2012		60,727		20	3,600	3,600	16,702
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
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 Avanti Wellness & Rehab

0045534

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		3,019,339			152,578	152,578	773,391	67
68	Related Party Allocations (Pages 12H & 12I)								68
69	Financial Statement Depreciation			101,050			(101,050)		69
70	TOTAL (lines 4 thru 69)		\$ 13,635,956	\$ 625,471		\$ 520,778	\$ (104,693)	\$ 3,760,392	70

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

Facility Name & ID Number Avanti Wellness & Rehab

0045534

Report Period Beginning:

01/01/16

Ending:

12/31/16

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		\$ 13,635,956	\$ 625,471		\$ 520,778	\$ (104,693)	\$ 3,760,392	1
2	Door Hardware	2013	4,915		20	246	246	983	2
3	Remove & Replace Kitchen Exhaust Duct	2013	3,500		20	175	175	700	3
4	Elevator Work - Installed 2 Mechanical Door Restrictors	2014	3,800		20	190	190	523	4
5	Reprogrammed Alarm	2014	2,746		20	392	392	1,046	5
6	Removed 2 Big Honey Locust On West Side Of Building	2014	2,800		20	140	140	338	6
7	Water Meter Replacement	2015	2,797		20	140	140	245	7
8	Installed 2 Pit Access Ladders In Elevator	2016	3,980		20	199	199	199	8
9	Hot Water Heater	2016	4,950		20	248	248	248	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 13,665,444	\$ 625,471		\$ 522,508	\$ (102,964)	\$ 3,764,674	34

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

Facility Name & ID Number Avanti Wellness & Rehab

0045534

Report Period Beginning:

01/01/16

Ending:

12/31/16

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		\$ 13,665,444	\$ 625,471		\$ 522,508	\$ (102,964)	\$ 3,764,674	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 13,665,444	\$ 625,471		\$ 522,508	\$ (102,964)	\$ 3,764,674	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$13,665,444	\$625,471		\$522,508	\$(102,964)	\$3,764,674	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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22									22
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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)		\$13,665,444	\$625,471		\$522,508	\$(102,964)	\$3,764,674	34

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

Facility Name & ID Number Avanti Wellness & Rehab

0045534

Report Period Beginning:

01/01/16

Ending:

12/31/16

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		\$ 13,665,444	\$ 625,471		\$ 522,508	\$ (102,964)	\$ 3,764,674	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 13,665,444	\$ 625,471		\$ 522,508	\$ (102,964)	\$ 3,764,674	34

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

Facility Name & ID Number Avanti Wellness & Rehab

0045534

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Millwork/Railings	2011	47,926		20	2,396	2,396	14,377	9
10	Flooring	2011	459,687		20	22,984	22,984	137,905	10
11	Sprinklers	2011	10,280		20	514	514	3,084	11
12	Ceramic Tile	2011	322,430		20	16,122	16,122	96,731	12
13	Michael Raymond Project-carpentry,acoustic ceiling, electric,plun	2011	912,684		20	45,634	45,634	273,805	13
14	Building Professional fees-design consulting services,construction	2011	35,189		20	3,370	3,370	20,219	14
15	Schematic Design and Architect consulting related to the facility r	2011	21,414		20	1,071	1,071	6,425	15
16	Window Treatments-Renovated areas	2011	126,650		20	6,333	6,333	37,997	16
17	Generator	2012	52,332		20	2,617	2,617	13,084	17
18	Replace Water Heater-Laundry Room	2012	7,928		20	396	396	1,981	18
19	Boiler Repairs	2012	4,600		20	230	230	1,150	19
20	Door handles, Smoke Alarms	2012	5,760		20	288	288	1,440	20
21	Roof Repairs	2012	22,298		20	1,115	1,115	5,575	21
22	Chiller Replacement Work	2012	88,200		20	4,410	4,410	22,050	22
23	Cooling Tower	2013	23,262		20	1,163	1,163	4,652	23
24	Roof Repairs	2013	119,000		20	5,950	5,950	23,800	24
25	Roof Repairs	2013	26,050		20	1,303	1,303	5,212	25
26	Installed Sod Near Sidewalk and Entrance	2014	4,785		20	239	239	717	26
27	Installed Dawrf Burning Bushes on Either Side of Entrance	2014	7,862		20	393	393	1,179	27
28	Install Low Voltage LED Lighting on Front of Building and 10 Sh	2014	7,955		20	398	398	1,194	28
29	Installed 60 Mil Fully Adhered TPO Roof System	2014	172,155		20	8,608	8,608	25,824	29
30	Demo of Canopy/Paving/Concrete/Masonry/Roofing/Carpentry	2014	433,141		20	21,657	21,657	64,971	30
31	Bathroom Demo/Carpentry/Plumbing/Electric/Cabinetry	2015	39,506		20	1,975	1,975	3,950	31
32	Dining Room Wall Protection/Painting/Lighting/Window Art	2015	36,635		20	1,832	1,832	3,664	32
33	Construction Drawings of Entrance Canopy/ New Vestibule	2015	16,500		20	825	825	1,650	33
34	TOTAL (lines 1 thru 33)		\$ 3,004,229	\$		\$ 151,823	\$ 151,823	\$ 772,636	34

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

Facility Name & ID Number Avanti Wellness & Rehab

0045534

Report Period Beginning:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12F, Carried Forward		\$ 3,004,229	\$		\$ 151,823	\$ 151,823	\$ 772,636	1
2								2
3 Install 8" of 4000 PSI Concrete and Finish With Tampico Brush	2016	8,000		20	400	400	400	3
4 Bedded New Sewer Pipe On Southwest Corner of Building	2016	7,110		20	355	355	355	4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,019,339	\$		\$ 152,578	\$ 152,578	\$ 773,391	34

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

Facility Name & ID Number Avanti Wellness & Rehab

0045534

Report Period Beginning:

01/01/16

Ending:

12/31/16

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									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Avanti Wellness & Rehab

0045534

Report Period Beginning:

01/01/16

Ending:

12/31/16

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		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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	\$873,860	\$	\$96,670	\$96,670	10	\$752,839	71
72	Current Year Purchases	18,092		1,809	1,809	10	1,809	72
73	Fully Depreciated Assets	794,720				10	794,720	73
74								74
75	TOTALS	\$1,686,671	\$	\$98,479	\$98,479		\$1,549,368	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		Conversion Van	2007	\$7,200	\$	\$	\$	5	\$7,200	76
77		Used 2013 Lincoln Auto SD/MKT	2015	32,304		8,238	8,238	5	13,083	77
78										78
79										79
80	TOTALS			\$39,504	\$	\$8,238	\$8,238		\$20,283	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$17,722,387	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$625,471	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$629,224	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$3,753	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$5,334,325	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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:
-
- *

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ 25,859
- Description: See Attached Schedule
- (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	Ford F-150	\$ 548	\$ 4,382	17
18					18
19					19
20					20
21	TOTAL		\$ 548	\$ 4,382	21

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. /2017 \$
13. /2018 \$
14. /2019 \$

* 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.

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

☒ 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 - 01	hrs	\$ 533,325		\$	\$		\$ 533,325	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	174,537		17,212			191,749	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	670,569					670,569	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				559,245		559,245	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					167,454	160,647		328,101	13
14	TOTAL			\$ 1,378,431		\$ 184,666	\$ 719,892		\$ 2,282,989	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 10,381	\$ 24,217	1
2	Cash-Patient Deposits	26,414	26,414	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,260,859	5,260,859	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		55,848	6
7	Other Prepaid Expenses	78,298	2,015	7
8	Accounts Receivable (owners or related parties)	1,549,807	2,894,482	8
9	Other(specify): <u>See Attached Schedule</u>	11,493	386,991	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,937,252	\$ 8,650,826	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		2,330,768	13
14	Buildings, at Historical Cost		9,709,136	14
15	Leasehold Improvements, at Historical Cost	917,139	3,873,051	15
16	Equipment, at Historical Cost	1,226,524	2,774,586	16
17	Accumulated Depreciation (book methods)	(1,857,758)	(7,441,004)	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):		(720,985)	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 285,905	\$ 10,525,552	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,223,157	\$ 19,176,378	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,987,100	\$ 2,046,516	26
27	Officer's Accounts Payable	1,312,804	1,312,804	27
28	Accounts Payable-Patient Deposits	29,711	29,711	28
29	Short-Term Notes Payable	2,626,106	2,878,279	29
30	Accrued Salaries Payable	622,235	622,235	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		577,095	32
33	Accrued Interest Payable		59,111	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	2,027,942	2,052,942	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 8,605,898	\$ 9,578,693	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		16,320,979	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)	\$	\$ 16,320,979	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,605,898	\$ 25,899,672	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,382,741)	\$ (6,723,294)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,223,157	\$ 19,176,378	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (790,986)	1
2	Restatements (describe):		2
3	Depreciation	4,796	3
4	Bad Debts	(125,873)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (912,063)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(470,678)	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)	\$ (470,678)	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)	\$ (1,382,741)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Avanti Wellness & Rehab

0045534

Report Period Beginning: 01/01/16

Ending: 12/31/16

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 13,690,438	1
2	Discounts and Allowances for all Levels	(2,610,387)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,080,051	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,203,226	6
7	Oxygen	3,840	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,207,066	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	34	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	435,313	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	60,626	19
20	Radiology and X-Ray		20
21	Other Medical Services	98,274	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 594,247	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	365	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 365	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,829	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,829	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,883,558	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,577,145	31
32	Health Care	4,779,233	32
33	General Administration	2,490,616	33
	B. Capital Expense		
34	Ownership	2,061,999	34
	C. Ancillary Expense		
35	Special Cost Centers	3,072,167	35
36	Provider Participation Fee	373,076	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,354,236	40
41	Income before Income Taxes (line 30 minus line 40)**	(470,678)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (470,678)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 5,342,582	44
45	Private Pay - Net Inpatient Revenue	1,611,591	45
46	Medicare - Net Inpatient Revenue	2,985,412	46
47	Other-(specify) <u>HMO</u>	918,266	47
48	Other-(specify) <u>Hospice</u>	222,200	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,080,051	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.

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,984	2,080	\$ 100,509	\$ 48.32	1
2	Assistant Director of Nursing	1,304	1,648	77,868	47.25	2
3	Registered Nurses	31,572	34,593	1,079,463	31.20	3
4	Licensed Practical Nurses	32,187	35,665	930,376	26.09	4
5	CNAs & Orderlies	86,104	93,904	1,233,518	13.14	5
6	CNA Trainees					6
7	Licensed Therapist	30,631	33,661	1,378,431	40.95	7
8	Rehab/Therapy Aides	8,020	9,002	173,732	19.30	8
9	Activity Director	8,771	9,422	114,869	12.19	9
10	Activity Assistants	10,603	11,409	142,450	12.49	10
11	Social Service Workers	7,444	7,784	178,158	22.89	11
12	Dietician					12
13	Food Service Supervisor	1,832	2,080	59,912	28.80	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,450	24,913	277,107	11.12	15
16	Dishwashers					16
17	Maintenance Workers	2,098	2,526	38,520	15.25	17
18	Housekeepers	18,374	21,039	252,408	12.00	18
19	Laundry	7,081	7,710	73,727	9.56	19
20	Administrator	2,032	2,080	116,493	56.01	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,230	17,652	338,736	19.19	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	1,749	1,845	22,655	12.28	31
32	Other Health Care(specify)					32
33	Other(specify)	5,857	6,185	698,134	112.88	33
34	TOTAL (lines 1 - 33)	296,323	325,198	\$ 7,287,066 *	\$ 22.41	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	383	\$ 18,025	01-03	35
36	Medical Director	Monthly	24,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	81,212	10-03	38
39	Pharmacist Consultant	359	16,536	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	24	1,320	11-03	44
45	Social Service Consultant	29	1,811	12-03	45
46	Other(specify)				46
47	Geriatric Consulting	Monthly	50,040	10-03	47
48	Cardiologist	Visit	350	10-03	48
49	TOTAL (lines 35 - 48)	795	\$ 193,294		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

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

** See instructions.

STATE OF ILLINOIS

Page 21

Facility Name & ID Number

Avanti Wellness & Rehab

0045534

Report Period Beginning:

01/01/16

Ending:

12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Amanda Andrews	Administrator	0	\$ 116,493
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 116,493

B. Administrative - Other

Description	Amount
LTC Consulting Services - Management Fees	\$ 176,400
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 176,400

C. Professional Services

Vendor/Payee	Type	Amount
Marcum	Accounting	\$ 25,970
Achieve Accreditation	Survey Consulting	9,778
Documentation Solutions	HC Consulting	6,253
Language Line	Interpetation Services	1,200
Marilyn Torres	Public Aid Consultant	300
Metro Infectious Disease	Infectious Disease Consulting	20,000
Terrill Consulting	MDS Consulting	28,797
HDSI Health Systems	Payroll Processing	44,573
Matrixcare	E.H.R	33,360
eHeath Data Solutions	Risk Management Software	2,130
Optima Healthcare Solutions	Point of Care	5,369
See Supplemental Schedule		103,453
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 281,182

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 123,713
Unemployment Compensation Insurance	82,652
FICA Taxes	353,548
Employee Health Insurance	243,686
Employee Meals	103,249
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	63,302
TOTAL (agree to Schedule V, line 22, col.8)	\$ 970,149

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	
Health Care Worker Background Check (Indicate # of checks performed 1,604)	16,038
Patient Background Checks	
Licenses	2,537
Dues & Subscriptions	5,594
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 26,160

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	3,821
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 3,821

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number		Avanti Wellness & Rehab		STATE OF ILLINOIS	#	0045534	Report Period Beginning:	01/01/16	Ending:	12/31/16	Page 22
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?			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.			\$		None		Line		N/A	
(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.			\$		373,076					
	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? 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.			\$		103,249		Has any meal income been offset against related costs?		Yes	
								Indicate the amount.		\$ 34	
(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 of Schedule V?			Yes							
(19)	Has a schedule for the legal fees reported on the cost report been provided by the facility?			Yes		See page 39 of the instructions for details.					
	Attach invoices and a summary of services for all architect and appraisal fees.										