

		FOR BHF USE					

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

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

I. IDPH License ID Number: 0052852

Facility Name: Avantara Park Ridge

Address: 1601 N Western Ave Park Ridge 60068
Number City Zip Code

County: Cook

Telephone Number: (847)825-5531 Fax # (847)318-6659

HFS ID Number:

Date of Initial License for Current Owners: 7/25/2014

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

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

Officer or
Administrator
of Provider

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

Paid
Preparer

(Signed) 05/20/2021 (Date)
* Subject to the attached Accountants' Consulting Report
(Print Name Steven N. Lavenda, CPA
and Title Partner
(Firm Name Marcum, LLP
& Address 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Avantara Park Ridge

0052852 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>154</u>	Skilled (SNF)	<u>154</u>	<u>56,364</u>	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	<u>154</u>	TOTALS	<u>154</u>	<u>56,364</u>	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	<u>24,558</u>	<u>9,759</u>	<u>10,276</u>	<u>44,593</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>24,558</u>	<u>9,759</u>	<u>10,276</u>	<u>44,593</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.12%

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

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

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 7/25/2014

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 7/25/2014 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 154 and days of care provided 6,179

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

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

Facility Name & ID Number Avantara Park Ridge # 0052852 Report Period Beginning: 01/01/20 Ending: 12/31/20
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary		12,648	1,004,282	1,016,930		1,016,930	2,642	1,019,572			1
2	Food Purchase		12,904		12,904		12,904	5,006	17,910			2
3	Housekeeping		7,613	360,654	368,267		368,267	1,714	369,981			3
4	Laundry	72,677	21,563	131,635	225,875		225,875	116	225,991			4
5	Heat and Other Utilities			197,448	197,448		197,448	(9,864)	187,584			5
6	Maintenance	128,051	7,104	185,274	320,429		320,429	6,321	326,750			6
7	Other (specify):*											7
8	TOTAL General Services	200,728	61,832	1,879,293	2,141,853		2,141,853	5,935	2,147,788			8
	B. Health Care and Programs											
9	Medical Director			64,894	64,894		64,894		64,894			9
10	Nursing and Medical Records	5,358,664	361,767	49,254	5,769,685		5,769,685	53,667	5,823,352			10
10a	Therapy	207,489		4,082	211,571		211,571		211,571			10a
11	Activities	170,192	8,119	1,045	179,356		179,356	7	179,363			11
12	Social Services	302,235	12,144	2,426	316,805		316,805	4,590	321,395			12
13	CNA Training											13
14	Program Transportation			55,038	55,038		55,038		55,038			14
15	Other (specify):*							4,761	4,761			15
16	TOTAL Health Care and Programs	6,038,580	382,030	176,739	6,597,349		6,597,349	63,025	6,660,374			16
	C. General Administration											
17	Administrative	113,148			113,148		113,148	51,098	164,246			17
18	Directors Fees											18
19	Professional Services			496,250	496,250	(54,306)	441,944	(205,919)	236,025			19
20	Dues, Fees, Subscriptions & Promotions			139,462	139,462		139,462	(84,397)	55,065			20
21	Clerical & General Office Expenses	136,320	1,018	464,117	601,455		601,455	(76,819)	524,636			21
22	Employee Benefits & Payroll Taxes			874,010	874,010		874,010		874,010			22
23	Inservice Training & Education											23
24	Travel and Seminar			805	805		805	114	919			24
25	Other Admin. Staff Transportation			1,328	1,328		1,328	3,820	5,148			25
26	Insurance-Prop.Liab.Malpractice			321,502	321,502		321,502	17,215	338,717			26
27	Other (specify):*							20,480	20,480			27
28	TOTAL General Administration	249,468	1,018	2,297,474	2,547,960	(54,306)	2,493,654	(274,408)	2,219,246			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,488,776	444,880	4,353,506	11,287,162	(54,306)	11,232,856	(205,449)	11,027,407			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							510,331	510,331			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			19,523	19,523		19,523	609,765	629,288			32
33	Real Estate Taxes			380,309	380,309	54,306	434,615	722,637	1,157,252			33
34	Rent-Facility & Grounds			1,593,372	1,593,372		1,593,372	(1,593,292)	80			34
35	Rent-Equipment & Vehicles			29,582	29,582		29,582	2,051	31,633			35
36	Other (specify):*							72,316	72,316			36
37	TOTAL Ownership			2,022,786	2,022,786	54,306	2,077,092	323,808	2,400,900			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	7,402	535,384	1,379,372	1,922,158		1,922,158	(40,127)	1,882,031			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			313,561	313,561		313,561		313,561			42
43	Other (specify):*			747,650	747,650		747,650	(747,650)	0			43
44	TOTAL Special Cost Centers	7,402	535,384	2,440,583	2,983,369		2,983,369	(787,777)	2,195,592			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	6,496,178	980,264	8,816,875	16,293,317		16,293,317	(669,418)	15,623,899			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				4
5	Telephone, TV & Radio in Resident Rooms	(10,758)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	327,213	30		9
10	Interest and Other Investment Income	(5,900)	32		10
11	Discounts, Allowances, Rebates & Refunds	(24,667)	10		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(21)	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	(749)	21		18
19	Entertainment	(5,677)	21		19
20	Contributions	(60,979)	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	(256,695)	21		24
25	Fund Raising, Advertising and Promotional	(9,307)	20		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	(1,112,151)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,159,691)		\$	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)	490,273		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 490,273		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (669,418)		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	Patient Personal Items	\$ (948)	10	1
2	Bank Charges	(132)	21	2
3	Sequestration	(32,929)	21	3
4	Pharmacy Discounts	(5,877)	10	4
5	Misc Income	(2,048)	21	5
6	Capitalized R&M	(3,135)	06	6
7	Non Allowable Auto Lease	(1,660)	35	7
8	Marketing License	(1,344)	43	8
9	Chamber of Commerce Dues	(300)	20	9
10	PAC Dues	(16,157)	20	10
11	Non Allowable Expense	(746,306)	43	11
12	Non Allowable Legal	(36,498)	19	12
13	Prior Period Dues	(519)	20	13
14	Bldg Co - Processing Fee	(1,500)	21	14
15	Bldg Co - Accounting Fee	(15,990)	19	15
16	Bldg Co - Amortization	(246,808)	36	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
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	(1,112,151)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Avantara Park Ridge # 0052852 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			2,642									2,642	1
2	Food Purchase	(21)		5,027									5,006	2
3	Housekeeping			1,714									1,714	3
4	Laundry			116									116	4
5	Heat and Other Utilities	(10,758)				894							(9,864)	5
6	Maintenance	(3,135)		8,590		866							6,321	6
7	Other (specify):*													7
8	TOTAL General Services	(13,914)		18,089		1,760							5,935	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(31,492)		87,872				(2,713)					53,667	10
10a	Therapy													10a
11	Activities			7									7	11
12	Social Services			4,590									4,590	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				4,761								4,761	15
16	TOTAL Health Care and Programs	(31,492)		92,469	4,761			(2,713)					63,025	16
	C. General Administration													
17	Administrative			51,098									51,098	17
18	Directors Fees													18
19	Professional Services	(52,488)	15,990	(163,225)		376	(6,572)						(205,919)	19
20	Fees, Subscriptions & Promotions	(87,262)		2,864		0							(84,397)	20
21	Clerical & General Office Expenses	(299,730)	1,500	221,203		208							(76,819)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			114									114	24
25	Other Admin. Staff Transportation			3,820									3,820	25
26	Insurance-Prop.Liab.Malpractice		16,890	101		224							17,215	26
27	Other (specify):*			20,480									20,480	27
28	TOTAL General Administration	(439,480)	34,380	136,455		809	(6,572)						(274,408)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(484,886)	34,380	247,013	4,761	2,569	(6,572)	(2,713)					(205,449)	29

Summary B

12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	327,213	177,606			5,512							510,331	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(5,900)	612,567			3,098							609,765	32
33	Real Estate Taxes		719,823			2,814							722,637	33
34	Rent-Facility & Grounds		(1,593,372)	25,940		(25,860)							(1,593,292)	34
35	Rent-Equipment & Vehicles	(1,660)			3,711								2,051	35
36	Other (specify):*	(246,808)	319,124										72,316	36
37	TOTAL Ownership	72,845	235,748	25,940	3,711	(14,436)							323,808	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers									(40,127)			(40,127)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(747,650)											(747,650)	43
44	TOTAL Special Cost Centers	(747,650)								(40,127)			(787,777)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,159,691)	270,128	272,952	8,472	(11,867)	(6,572)	(2,713)		(40,127)			(669,418)	45

VII. RELATED PARTIES

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

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

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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	\$ 1,593,372	Park Ridge Property Holdings, LLC		\$	(1,593,372)	1
2	V	32	Interest	1,299	Park Ridge Property Holdings, LLC		613,866	612,567	2
3	V	33	RE Tax Expense		Park Ridge Property Holdings, LLC		719,823	719,823	3
4	V	26	Property Insurance		Park Ridge Property Holdings, LLC		16,890	16,890	4
5	V	36	MIP Expense		Park Ridge Property Holdings, LLC		72,316	72,316	5
6	V	21	Processing Fees		Park Ridge Property Holdings, LLC		1,500	1,500	6
7	V	19	Accounting Fees		Park Ridge Property Holdings, LLC		15,990	15,990	7
8	V	30	Depreciation		Park Ridge Property Holdings, LLC		177,606	177,606	8
9	V	36	Amortization		Park Ridge Property Holdings, LLC		246,808	246,808	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,594,671			\$ 1,864,799	\$ * 270,128	14

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

Facility Name & ID Number

Avantara Park Ridge

0052852

Report Period Beginning:

01/01/20

Ending:

12/31/20

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Chaim Rajchenbach	20.61%	Astoria Place Skilled Nursing Facility LLC	Chicago	Park Ridge Property Holdings, LLC		Building Company	1
2	Menachem Shabat	20.61%	Avantara Arlington	Arlington, SD	Legacy HC & Financial Services	Lincolnwood	Home Office/Bookkeeping	2
3	The Rajchenbach Family Trust	1.33%	Avantara Armour	Armour, SD	CF St. Louis LLC	Skokie	Building Company	3
4	Ronald Shabat	5.48%	Avantara Arrowhead	Rapid City, SD	ML Group Design & Development	Skokie	Asset Management	4
5	Yosef And Naomi Rajchenbach	1.98%	Avantara Aurora	Aurora	ReMED Services LLC	Lincolnwood	Nursing Equipment	5
6	Benjamin Israel	14.40%	Avantara Billings	Billings, MT	Propay HR	Evanston	Payroll Processing	6
7	Berger Family Trust, Trustee	19.20%	Avantara Clark	Clark, SD	Ecobrite Linen	Skokie	Laundry Supplies	7
8	Raphaela Stern	11.40%	Avantara Elgin	Elgin	Aurora Supportive Living	Aurora	Supportive Living	8
9	Whitney Arado	1.00%	Avantara Evergreen Park	Evergreen Park	Terrace Gardens	Morton Grove	Assisted Living	9
10	Sandra Reis	1.00%	Avantara Groton	Groton, SD	Lincolnshire Assisted Living Center	Lincolnshire	Assisted Living	10
11	Gabriel Kroll	1.00%	Avantara Huron	Huron, SD	Wellshire Park Place	Milbank, SD	Assisted Living	11
12	Eitan Schechter	1.00%	Avantara Ipswich	Ipswich, SD	Wellshire Huron	Huron, SD	Assisted Living	12
13	Mark Goldson	1.00%	Avantara Lake Norden	Lake Norden, SD	Lifescan Labs of Illinois	Skokie	Laboratory	13
14			Avantara Long Grove	Long Grove				14
15			Avantara Milbank	Milbank, SD				15
16			Avantara Mountainview	Rapid City, SD				16
17			Avantara North	Rapid City, SD				17
18			Avantara Norton	Sioux Falls, SD				18
19			Avantara Pierre	Pierre, SD				19
20			Avantara Redfield	Redfield, SD				20
21			Avantara Salem	Salem, SD				21
22			Avantara St. Cloud	Rapid City, SD				22
23			Avantara Watertown	Watertown, SD				23
24			Bella Terra Streamwood	Streamwood				24
25			Bella Terra Wheeling	Wheeling				25
26			Bethany Terrace	Morton Grove				26
27			Carlton Skilled Nursing Facility LLC	Chicago				27
28			Chalet Skilled Nursing Facility LLC	Chicago				28
29			Clark Skilled Nursing Facility	Chicago				29
30			Elmbrook Skilled Nursing Facility LLC	Elmhurst				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			Evanston Skilled Nursing Facility LLC	Evanston				1
2			Grove at the Lake Skilled Nursing Facility LLC	Zion				2
3			Grove of Berwyn	Berwyn				3
4			Grove of Fox Valley	Aurora				4
5			Grove of St. Charles	St. Charles				5
6			Lagrange Skilled Nursing Facility LLC	Lagrange Park				6
7			Lakefront Skilled Nursing Facility LLC	Chicago				7
8			Lincoln Park Skilled Nursing Facility LLC	Chicago				8
9			Lincolnshire Living & Rehab Center LLC	Lincolnshire				9
10			Northbrook Skilled Nursing Facility LLC	Northbrook				10
11			Peterson Park Associates Limited Partnership	Chicago				11
12			Skokie Skilled Nursing Facility LLC	Skokie				12
13			Valley Skilled Nursing Facility	Billings, MT				13
14			Warren Barr Living And Rehab	Chicago				14
15			Warren Barr North Shore	Highland Park				15
16			Warren Barr South Loop	Chicago				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 (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	01	Dietician Salary	\$	Legacy Healthcare Financial Services		\$ 2,628	\$ 2,628	15
16	V	01	Dietary Supplies		Legacy Healthcare Financial Services		14	14	16
17	V	02	Food		Legacy Healthcare Financial Services		5,027	5,027	17
18	V	03	Housekeeping		Legacy Healthcare Financial Services		1,714	1,714	18
19	V	04	Linen Replacement		Legacy Healthcare Financial Services		116	116	19
20	V	06	Maintenance Salary		Legacy Healthcare Financial Services		8,109	8,109	20
21	V	06	Repairs & Maintenance		Legacy Healthcare Financial Services		481	481	21
22	V	10	Nursing Salary		Legacy Healthcare Financial Services		67,117	67,117	22
23	V	10	Nurse/Medical Director Consultant		Legacy Healthcare Financial Services		6,335	6,335	23
24	V	10	Medical Supplies		Legacy Healthcare Financial Services		14,420	14,420	24
25	V	12	Social Service Salary		Legacy Healthcare Financial Services		4,572	4,572	25
26	V	11	Activities Program		Legacy Healthcare Financial Services		7	7	26
27	V	12	Social Service Consultant		Legacy Healthcare Financial Services		18	18	27
28	V	17	COO / Administrative Salary		Legacy Healthcare Financial Services		51,098	51,098	28
29	V	19	Professional Fees	180,000	Legacy Healthcare Financial Services		16,775	(163,225)	29
30	V	20	Dues / Licenses / Permits		Legacy Healthcare Financial Services		2,864	2,864	30
31	V	21	Clerical & General Wages		Legacy Healthcare Financial Services		206,169	206,169	31
32	V	21	Clerical & Office Expense		Legacy Healthcare Financial Services		15,034	15,034	32
33	V	24	Education & Seminars		Legacy Healthcare Financial Services		114	114	33
34	V	25	Travel		Legacy Healthcare Financial Services		3,820	3,820	34
35	V	26	Insurance - General		Legacy Healthcare Financial Services		101	101	35
36	V	27	Non-Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		20,480	20,480	36
37	V	34	Rent		Legacy Healthcare Financial Services		25,860	25,860	37
38	V	34	Offsite Storage / Parking		Legacy Healthcare Financial Services		80	80	38
39	Total			\$ 180,000			\$ 452,952	\$ * 272,952	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	35	Equipment Rental		Legacy Healthcare Financial Services		345	\$	345
16	V	35	Auto Rental		Legacy Healthcare Financial Services		3,366		3,366
17	V	15	Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		4,761		4,761
18	V								
19	V								
20	V								
21	V								
22	V								
23	V								
24	V								
25	V								
26	V								
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$			8,472	\$ *	8,472

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	\$	CF St. Louis LLC		\$ 894	\$ 894	15
16	V	6	Repairs & Maintenance		CF St. Louis LLC		866	866	16
17	V	19	Property Valuation Fee		CF St. Louis LLC		306	306	17
18	V	19	Accounting Fees		CF St. Louis LLC		70	70	18
19	V	20	Dues & Subscriptions		CF St. Louis LLC		0	0	19
20	V	21	Office Expense		CF St. Louis LLC		208	208	20
21	V	26	Insurance		CF St. Louis LLC		224	224	21
22	V	30	Depreciation		CF St. Louis LLC		5,512	5,512	22
23	V	32	Interest Expense		CF St. Louis LLC		3,098	3,098	23
24	V	33	Real Estate Taxes		CF St. Louis LLC		2,814	2,814	24
25	V								25
26	V	34	Rent	25,860	CF St. Louis LLC			(25,860)	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			\$ 25,860			\$ 13,993	\$ * (11,867)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	\$ 28,685	ProPay HR		\$ 22,113	\$ (6,572)	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			\$ 28,685			\$ 22,113	\$ * (6,572)	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	10	Medical Supplies	\$ 9,000	ReMED Services		\$ 6,287	\$ (2,713)	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			\$ 9,000			\$ 6,287	\$ * (2,713)	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.

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	04	Laundry Services	\$ 122,397	EcoBrite Linen		\$ 122,397	\$	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			\$ 122,397			\$ 122,397	\$ *	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	39	Laboratory	\$ 98,591	Lifescan Labs of Illinois		\$ 58,464	\$ (40,127)	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			\$ 98,591			\$ 58,464	\$ * (40,127)	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)

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											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.

Ending: 12/31/20

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

IL478-2471

Facility Name & ID Number Avantara Park Ridge# 0052852

Report Period Beginning:

01/01/20Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Legacy Healthcare Financial Services

Street Address

3450 Oakton Street

City / State / Zip Code

Skokie, IL 60076

Phone Number

(847) 679-9797

Fax Number

(847) 683-2900

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e., Days, Direct Cost, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	01	Dietician Salary	Available Bed Days	53	\$ 130,303	\$ 130,303	51,240	\$ 2,628	1
2	01	Dietary Supplies	Available Bed Days	53	697		51,240	14	2
3	02	Food	Available Bed Days	53	249,220		51,240	5,027	3
4	03	Housekeeping	Available Bed Days	53	84,952		51,240	1,714	4
5	04	Linen Replacement	Available Bed Days	53	5,771		51,240	116	5
6	06	Maintenance Salary	Available Bed Days	53	401,986	401,986	51,240	8,109	6
7	06	Repairs & Maintenance	Available Bed Days	53	23,857		51,240	481	7
8	10	Nursing Salary	Available Bed Days	53	3,327,223	3,327,223	51,240	67,117	8
9	10	Nurse/Medical Director Consultant	Available Bed Days	53	314,035		51,240	6,335	9
10	10	Medical Supplies	Available Bed Days	53	714,824		51,240	14,420	10
11	12	Social Service Salary	Available Bed Days	53	226,662	226,662	51,240	4,572	11
12	11	Activities Program	Available Bed Days	53	335		51,240	7	12
13	12	Social Service Consultant	Available Bed Days	53	893		51,240	18	13
14	17	COO / Administrative Salary	Available Bed Days	53	2,533,078	2,533,078	51,240	51,098	14
15	19	Professional Fees	Available Bed Days	53	831,592		51,240	16,775	15
16	20	Dues / Licenses / Permits	Available Bed Days	53	141,983		51,240	2,864	16
17	21	Clerical & General Wages	Available Bed Days	53	10,220,453	10,220,453	51,240	206,169	17
18	21	Clerical & Office Expense	Available Bed Days	53	745,293		51,240	15,034	18
19	24	Education & Seminars	Available Bed Days	53	5,655		51,240	114	19
20	25	Travel	Available Bed Days	53	189,364		51,240	3,820	20
21	26	Insurance - General	Available Bed Days	53	4,997		51,240	101	21
22	27	Non-Nursing Payroll Taxes / Bene	Available Bed Days	53	1,015,274		51,240	20,480	22
23	34	Rent	Available Bed Days	53	1,281,940		51,240	25,860	23
24	34	Offsite Storage / Parking	Available Bed Days	53	3,949		51,240	80	24
25	TOTALS				\$ 22,454,338	\$ 16,839,706		\$ 452,952	25

Ending: 12/31/20

(847) 683-2900

IL478-2471

Ending: 12/31/20

Ending: 12/31/20

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Ending: 12/31/20

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Ending: 12/31/20

IL478-2471

Ending: 12/31/20

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Ending: 12/31/20

Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	The Private Bank		X	Mortgage			\$	14,759,190			\$	613,866	1
2													2
3													3
4													4
5													5
	Working Capital												
6	CIBC		X	Note Payable				1,596,422				19,523	6
7													7
8													8
9	TOTAL Facility Related						\$	16,355,612			\$	633,389	9
	B. Non-Facility Related*												
10	Interest Income		X									(5,900)	10
11	Interest Income - Bldg Co		X									(1,299)	11
12	Allocated from CF St. Louis	X										3,098	12
13													13
14	TOTAL Non-Facility Related						\$				\$	(4,101)	14
15	TOTALS (line 9+line14)						\$	16,355,612			\$	629,288	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 72,316 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 (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.		\$	331,855	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.)				\$	701,344	2
3. Under or (over) accrual (line 2 minus line 1).				\$	369,489	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	733,457	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.)				\$	54,306	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.				\$	1,157,252	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2015	314,741	8		
		2016	300,521	9		
		2017	314,870	10		
		2018	316,052	11		
		2019	698,530	12		
2019 Accrual = \$698,530 x 1.05 = \$733,457						
Allocated from CF St. Louis LLC: \$2,815						

		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.

FACILITY NAME Avantara Park Ridge COUNTY Cook
FACILITY IDPH LICENSE NUMBER 0052852
CONTACT PERSON REGARDING THIS REPORT Steven Lavenda
TELEPHONE (847) 282-6330 FAX #: ()

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.

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

IMPORTANT NOTICE

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

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

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

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Avantara Park Ridge COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0052852

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

A. Square Feet: 82,590

B. General Construction Type: ExteriorMasonryFrameSteel GridsNumber of Stories2

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:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
	1Facility		2014	\$707,443	1
	2Allocated from CF St. Louis, LLC			3,981	2
	3TOTALS			\$711,424	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	154		2014	1959	\$ 8,932,992	\$ 177,606	39	\$ 229,051	\$ 51,445	\$ 1,397,577
5										
6										
7										
8										
	Improvement Type**									
9	Various		2014		76,203		20	3,810	3,810	23,757
10	Various		2015		131,637		20	6,582	6,582	43,323
11	Various		2016		1,004,381		20	50,219	50,219	263,144
12										
13										
14										
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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 Avantara Park Ridge

0052852

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		187,366	5,082		8,909	3,827	39,856	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		\$ 10,332,579	\$ 182,688		\$ 298,571	\$ 115,883	\$ 1,767,657	70

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

Facility Name & ID Number Avantara Park Ridge

0052852

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	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	Totals from Page 12A, Carried Forward		\$ 10,332,579	\$ 182,688		\$ 298,571	\$ 115,883	\$ 1,767,657	1
2	Architect Fees - Pods Conversion	2017	46,000		20	2,300	2,300	9,200	2
3	Replace 8" Drain Line Under Tunnel From Tool Room To Boiler	2017	9,330		20	467	467	1,866	3
4	Resident Rooms/Common Area - Lvp Flooring	2017	60,213		20	3,011	3,011	12,043	4
5	Dining Room - Wallpaper Removal/Prime/Paint	2017	3,795		20	190	190	759	5
6	Electrical & Lighting-Rearrange Life Safety Circuits And Critical	2017	2,900		20	145	145	436	6
7	Window Caulking	2017	8,500		20	425	425	1,204	7
8	Cable Pulls For Patient Rooms	2017	3,615		20	181	181	724	8
9	Replace Condenser Fan Motors And Blades On Chiller	2017	12,000		20	600	600	3,600	9
10	Electrical Work For Mag-Lock Replacement	2017	2,650		20	133	133	795	10
11	Bedrms & Bathrms- Painted Walls, Doors, & Ceilings, & Replaced	2017	65,000		20	3,250	3,250	13,000	11
12	1St Floor Lobby Signage	2017	4,180		20	209	209	836	12
13	Polished Chrome Finish Leverset	2017	4,611		20	231	231	922	13
14	1St Floor Lobby Lighting	2017	5,379		20	269	269	1,883	14
15	2Nd Floor Shades	2017	9,697		20	485	485	3,394	15
16	Lounge Area Roller Shades	2017	12,025		20	601	601	4,209	16
17	Replaced 8" Drain Line Under Tunnel, Installed New Pvc To Boil	2017	7,380		20	369	369	1,476	17
18	1St Flr Lobby Tiling And Carpeting (\$113,017)	2018	104,609		20	5,230	5,230	20,821	18
19	Nursing Station East And West Island Elevation (\$11,524)	2018	10,667		20	533	533	2,219	19
20	Resident Rooms - Flooring (\$59,880)	2018	55,425		20	2,771	2,771	11,530	20
21	Commercial Gas Heater (\$7,992)	2018	7,397		20	370	370	1,339	21
22	Push Button Installation-Reception/1St Floor Nurse Station (\$3,28	2018	3,043		20	152	152	496	22
23	Maglock With Timer For Front Door (\$2,602)	2018	2,408		20	120	120	393	23
24	Replacement Of Fuses And Wiring, Replace Disconnect (\$2,524)	2018	2,336		20	117	117	571	24
25	Excavation, Plumbing, And Jetting - Main Entrance Area (\$2,745)	2018	2,541		20	127	127	529	25
26	Excavation At Main Foundation Crack (\$3,650)	2018	3,378		20	169	169	551	26
27	Install New Asco Ats - Power Transfer Switch (\$4,440)	2018	4,110		20	205	205	675	27
28	Additional Patient Rms Pods Conversion (\$178,053)	2018	164,806		20	8,240	8,240	24,721	28
29	1St Floor Lobby, Pt Gym, 2Nd Floor Pod Conversion (\$503,454)	2018	465,997		20	23,300	23,300	69,900	29
30	Resident Rms Lvp Flooring Installation (\$8,757)	2018	8,105		20	405	405	1,216	30
31	Chimney Work (\$2650)	2019	2,568		20	128	128	393	31
32	Dual Temp Pump (\$8250)	2019	7,995		20	400	400	1,156	32
33	Storm Basin (\$3411)	2019	3,306		20	165	165	393	33
34	TOTAL (lines 1 thru 33)		\$ 11,438,545	\$ 182,688		\$ 353,869	\$ 171,182	\$ 1,960,904	34

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

Facility Name & ID Number Avantara Park Ridge

0052852

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	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	Totals from Page 12B, Carried Forward		\$ 11,438,545	\$ 182,688		\$ 353,869	\$ 171,182	\$ 1,960,904	1
2	Drainage System (\$5292)	2019	5,128		20	256	256	609	2
3	Window Well Pits (\$11070)	2019	10,728		20	536	536	1,274	3
4	Parking Lot Work (\$10490)	2019	10,166		20	508	508	945	4
5	Parking Pole Light (\$2960)	2019	2,869		20	143	143	185	5
6	Bearing Assembly Repair For Heating/Cooling Unit	2019	6,549		20	327	327	468	6
7	Lvp Flooring (\$2580.75)	2019	2,501		20	125	125	154	7
8	Resident Room Carpeting (\$13465)	2019	13,049		20	652	652	1,305	8
9	Lvp Flooring For Resident Rooms (\$6925.95)	2019	6,712		20	336	336	671	9
10	Lvp Flooring For Resident Rooms (\$2747)	2019	2,662		20	133	133	266	10
11	Install Pipe Insulation And Fittings (\$4028)	2019	3,904		20	195	195	397	11
12	Repair Heating Water Leakage (\$3891)	2019	3,771		20	189	189	383	12
13	Boiler And Pump Repair (4,365)	2020	4,258		20	213	213	213	13
14	Install Fire Dock Doors (4,355)	2020	4,248		20	212	212	212	14
15	Resident Rm 19Vinyl Plank Flooring (2,748)	2020	2,680		20	134	134	134	15
16	Water Chiller Navigator (3,100)	2020	3,024		20	151	151	151	16
17	Installation Of Sump Pump Ejectors (4,460)	2020	4,351		20	218	218	218	17
18	Repair Roof & Ceiling Panel Sheets (3,135)	2020	3,058		20	153	153	153	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)		\$ 11,528,203	\$ 182,688		\$ 358,352	\$ 175,664	\$ 1,968,642	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		\$ 11,528,203	\$ 182,688		\$ 358,352	\$ 175,664	\$ 1,968,642	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,528,203	\$ 182,688		\$ 358,352	\$ 175,664	\$ 1,968,642	34

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

Facility Name & ID Number Avantara Park Ridge

0052852

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 11,528,203	\$ 182,688		\$ 358,352	\$ 175,664	\$ 1,968,642	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,528,203	\$ 182,688		\$ 358,352	\$ 175,664	\$ 1,968,642	34

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

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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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 Avantara Park Ridge

0052852

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party								1
2	Buildings:								2
3	Allocated from CF St. Louis, LLC	2016	21,436	995	35	612	(383)	3,062	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	133,090	3,283	20	6,655	3,371	33,273	9
10	Allocated from CF St. Louis, LLC	2017	3,089	76	20	154	78	618	10
11	Allocated from CF St. Louis, LLC	2019	27,998	691	20	1,400	709	2,800	11
12	Allocated from CF St. Louis, LLC	2019	1,473	36	20	74	37	74	12
13									13
14	Allocated from Legacy HC	2018	159		20	8	8	24	14
15	Allocated from Legacy HC	2020	120		20	6	6	6	15
16									16
17									17
18									18
19									19
20									20
21									21
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 187,366	\$ 5,082		\$ 8,909	\$ 3,827	\$ 39,856	34

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

Facility Name & ID Number Avantara Park Ridge

0052852

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 187,366	\$ 5,082		\$ 8,909	\$ 3,827	\$ 39,856	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 187,366	\$ 5,082		\$ 8,909	\$ 3,827	\$ 39,856	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	\$ 1,358,705	\$ 429	\$ 135,871	\$ 135,442	10	\$ 804,180	71
72	Current Year Purchases	122,138	1	16,109	16,107	10	16,109	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,480,844	\$ 430	\$ 151,979	\$ 151,549		\$ 820,289	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

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)			\$	13,720,470
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	183,118
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	510,331
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	327,213
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	2,788,931

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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	Allocated from Legacy Healthcare				80			5
6								6
7	TOTAL				\$80			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?

☐ YES☐ NO
16. Rental Amount for movable equipment: \$19,967Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Toyota	\$830	\$8,300	17
18	Allocated from Legacy Healthcare			3,366	18
19					19
20					20
21	TOTAL		\$830	\$11,666	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 EndingAnnual Rent

12. /2021\$
13. /2022\$
14. /2023\$

* 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

C. CONTRACTUAL INCOME

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)	\$			

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 496,704	\$		\$ 496,704	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			131,587			131,587	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			531,629			531,629	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				357,480		357,480	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached			7,402		219,452	177,904		404,758	13
14	TOTAL			\$ 7,402		\$ 1,379,372	\$ 535,384		\$ 1,922,158	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	\$ 2,416,291	\$ 2,788,011	1
2	Cash-Patient Deposits	1,546	1,546	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,709,040	1,709,040	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,151	5,151	6
7	Other Prepaid Expenses	193,463	227,952	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	216,447	268,374	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,541,938	\$ 5,000,074	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		548,551	13
14	Buildings, at Historical Cost		6,926,641	14
15	Leasehold Improvements, at Historical Cost	2,625,381	2,625,381	15
16	Equipment, at Historical Cost	1,164,604	1,666,940	16
17	Accumulated Depreciation (book methods)	(1,056,428)	(2,691,003)	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): See Attached	2,582,341	4,883,343	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,315,898	\$ 13,959,853	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,857,836	\$ 18,959,927	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,249,855	\$ 1,249,855	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,596,422	1,596,422	29
30	Accrued Salaries Payable	409,588	409,588	30
31	Accrued Taxes Payable (excluding real estate taxes)	301,835	301,835	31
32	Accrued Real Estate Taxes(Sch.IX-B)		733,457	32
33	Accrued Interest Payable		49,197	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,647,735	1,647,735	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,205,435	\$ 5,988,089	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		14,759,190	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	3,662,069	874,271	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,662,069	\$ 15,633,461	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,867,504	\$ 21,621,550	46
47	TOTAL EQUITY(page 18, line 24)	\$ 990,332	\$ (2,661,623)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,857,836	\$ 18,959,927	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 958,680	1
2	Restatements (describe):		2
3	Depreciation	889,589	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,848,269	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	42,070	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	(900,007)	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)	\$ (857,937)	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)	\$ 990,332	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Avantara Park Ridge

0052852

Report Period Beginning:

01/01/20

Ending:

12/31/20

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 16,524,211	1
2	Discounts and Allowances for all Levels	(6,467,983)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,056,228	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,326,870	6
7	Oxygen	77	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,326,947	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	353,979	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	138,127	19
20	Radiology and X-Ray	55	20
21	Other Medical Services	79,344	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 571,505	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,900	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,900	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	1,374,807	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,374,807	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,335,387	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,141,853	31
32	Health Care	6,597,349	32
33	General Administration	2,547,960	33
	B. Capital Expense		
34	Ownership	2,022,786	34
	C. Ancillary Expense		
35	Special Cost Centers	2,669,808	35
36	Provider Participation Fee	313,561	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,293,317	40
41	Income before Income Taxes (line 30 minus line 40)**	42,070	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 42,070	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 5,479,989	44
45	Private Pay - Net Inpatient Revenue	2,305,127	45
46	Medicare - Net Inpatient Revenue	1,601,274	46
47	Other-(specify) Insurance	669,838	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,056,228	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	2,112	2,160	\$ 141,333	\$ 65.43	1
2	Assistant Director of Nursing	2,032	2,160	103,678	48.00	2
3	Registered Nurses	44,290	51,302	1,815,235	35.38	3
4	Licensed Practical Nurses	43,272	50,171	1,580,252	31.50	4
5	CNAs & Orderlies	84,638	96,276	1,673,018	17.38	5
6	CNA Trainees					6
7	Licensed Therapist	185	215	7,402	34.43	7
8	Rehab/Therapy Aides	8,031	9,442	207,489	21.98	8
9	Activity Director	2,112	2,240	51,006	22.77	9
10	Activity Assistants	8,523	9,119	119,186	13.07	10
11	Social Service Workers	9,707	10,362	262,187	25.30	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,942	4,266	128,051	30.02	17
18	Housekeepers					18
19	Laundry	5,306	5,707	72,677	12.74	19
20	Administrator	2,032	2,160	113,148	52.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,084	7,564	136,320	18.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	4,012	4,399	85,197	19.37	33
34	TOTAL (lines 1 - 33)	227,278	257,542	\$ 6,496,179 *	\$ 25.22	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	Monthly	\$ 1,004,282	01-03	35
36	Medical Director	Monthly	64,894	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	33,774	10-03	38
39	Pharmacist Consultant	Monthly	15,480	10-03	39
40	Physical Therapy Consultant	Monthly	3,932	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	150	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,045	11-03	44
45	Social Service Consultant	Monthly	151	12-03	45
46	Other(specify)				46
47	Clergy	Monthly	2,275	12-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 1,125,983		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

Facility Name & ID Number

Avantara Park Ridge

0052852

Report Period Beginning:

01/01/20

Ending:

12/31/20

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Erin B. Levy	Administrator	0	\$ 113,148	Workers' Compensation Insurance	\$ 118,183	IDPH License Fee	\$ 2,819	
				Unemployment Compensation Insurance	21,435	Advertising: Employee Recruitment	768	
				FICA Taxes	496,958	Health Care Worker Background Check	705	
				Employee Health Insurance	170,414	(Indicate # of checks performed 70)		
				Employee Meals		Patient Background Checks	1334 13,340	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	31,824	
				Employee Benefits	24,046	Licenses & Fees	2,744	
				401K Expense	24,173			
				Voluntary Benefit Contributions	18,212			
				Employee Physical Exams	589			
						See Supplemental Schedule	2,865	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 113,148	TOTAL (agree to Schedule V, line 22, col.8)		\$ 874,010	TOTAL (agree to Sch. V, line 20, col. 8)	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense	805
C. Professional Services				TOTAL			\$	
Vendor/Payee	Type		Amount				See Supplemental Schedule	114
Marcum LLP	Accounting		\$ 24,000				Entertainment Expense	()
Achieve Accreditation	Accreditation Services		9,290				(agree to Sch. V,	
Onyx Procurement Solutions	Procurement Services		9,570				line 24, col. 8)	
Compliagent	Compliance Services		3,667				TOTAL	\$ 919
Cortex Health, Inc.	Data Processing		12,295					
Hygieneering, Inc.	Hygiene & Safety Consulting		1,084					
Language Line Services	Interpreter Services		1,226					
MTS Consulting	Tax Consultant		583					
Patient Ping, Inc.	Healthcare Software		5,500					
Personnel Planners	Unemployment Consultant		1,200					
See Attached	Legal		142,802					
See Supplemental Schedule			285,035					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 496,251					

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- | | |
|--|--|
| <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>Yes</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>Yes</u>
If YES, give association name and amount. <u>HCCI \$25,881 ; IHCA \$11,704</u></p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>Yes</u> If YES, have these costs been properly adjusted out of the cost report? <u>Yes</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? <u>N/A</u></p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u>
What was the average life used for new equipment added during this period? <u>10 Years</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>53,268</u> Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u>
If YES, give effective date of lease. <u>N/A</u></p> <p>(9) Are you presently operating under a sublease agreement? YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u> </u> NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. <u>N/A</u></p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>313,561</u>
This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation.</p> | <p>(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? <u>Yes</u></p> <p>(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? <u>No</u> 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.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>N/A</u> Has any meal income been offset against related costs? <u>N/A</u> Indicate the amount. \$ <u> </u></p> <p>(16) Travel and Transportation
a. Are there costs included for out-of-state travel? <u>No</u>
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>N/A</u>
c. What percent of all travel expense relates to transportation of nurses and patients? <u>100% Ln 14</u>
d. Have vehicle usage logs been maintained? <u>No</u>
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>N/A</u>
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u>
g. Does the facility transport residents to and from day training? <u>No</u>
Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u></p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>No</u>
Firm Name: <u>N/A</u></p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u></p> <p>(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. <u>Yes</u>
Attach invoices and a summary of services for all architect and appraisal fees.</p> |
|--|--|