

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: 0057851

Facility Name: Avantara Libertyville

Address: 1500 S Milwaukee Ave Libertyville 60048
Number City Zip Code

County: Lake

Telephone Number: (847) 816-3200 Fax # (847) 816-1371

HFS ID Number:

Date of Initial License for Current Owners: 01/01/2023

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: John Epperson Telephone Number: (312) 344-2883
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 01/01/2025 to 12/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

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

Paid Preparer

(Signed) (Date)
(Print Name and Title) John Epperson Principal
(Firm Name & Address) Miller Cooper & Co., Ltd. 3 Parkway North, Suite 200, Deerfield IL 60015
(Telephone) (312) 344-2883 Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number Avantara Libertyville # 0057851 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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 <u>N/A</u>					
	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>150</u>	Skilled (SNF)	<u>150</u>	<u>54,750</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>150</u>	TOTALS	<u>150</u>	<u>54,750</u>	7

B. Census-For the entire report period.										
	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF				774		7,952	4,130	12,856	8
9	SNF/PED									9
10	ICF	7,518	10,320	4,149		3,190			25,177	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	7,518	10,320	4,149	774	3,190	7,952	4,130	38,033	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 69.47%

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 01/01/2023

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 01/01/2023 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter certified beds.
number of certified beds 150

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2025 Fiscal Year: 12/31/2025
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Avantara Libertyville # 0057851 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	515,224	65,547	42,577	623,348		623,348	188	623,536			1
2	Food Purchase		257,068		257,068		257,068	(1,937)	255,131			2
3	Housekeeping	214,180	33,781		247,961		247,961	425	248,386			3
4	Laundry	64,174	20,270		84,444		84,444		84,444			4
5	Heat and Other Utilities			304,821	304,821		304,821	(37,074)	267,747			5
6	Maintenance	136,553	21,850	158,790	317,193		317,193	8,419	325,612			6
7	Other (specify):*			169	169		169	684	853			7
8	TOTAL General Services	930,131	398,516	506,357	1,835,004		1,835,004	(29,295)	1,805,709			8
	B. Health Care and Programs											
9	Medical Director			36,300	36,300		36,300	4,210	40,510			9
10	Nursing and Medical Records	5,178,987	87,623	425,651	5,692,261		5,692,261	71,163	5,763,424			10
10a	Therapy	1,094,376		58,325	1,152,701		1,152,701	1,910	1,154,611			10a
11	Activities	107,613	4,625	2,441	114,679		114,679	80	114,759			11
12	Social Services	103,510		7,582	111,092		111,092	1,560	112,652			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							11,946	11,946			15
16	TOTAL Health Care and Programs	6,484,486	92,248	530,299	7,107,033		7,107,033	90,869	7,197,902			16
	C. General Administration											
17	Administrative	179,646			179,646		179,646	35,695	215,341			17
18	Directors Fees											18
19	Professional Services			174,261	174,261		174,261	22,337	196,598			19
20	Dues, Fees, Subscriptions & Promotions			80,865	80,865		80,865	(45,575)	35,290			20
21	Clerical & General Office Expenses	458,793	2,589	708,208	1,169,590		1,169,590	(236,803)	932,787			21
22	Employee Benefits & Payroll Taxes			1,151,853	1,151,853		1,151,853		1,151,853			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,230	5,230		5,230	632	5,862			24
25	Other Admin. Staff Transportation							2,400	2,400			25
26	Insurance-Prop.Liab.Malpractice			316,878	316,878		316,878	5,393	322,271			26
27	Other (specify):*							21,891	21,891			27
28	TOTAL General Administration	638,439	2,589	2,437,295	3,078,323		3,078,323	(194,030)	2,884,293			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,053,056	493,353	3,473,951	12,020,360		12,020,360	(132,456)	11,887,904			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			67,926	67,926		67,926	27,213	95,139			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			77,081	77,081		77,081	(33,803)	43,278			32
33	Real Estate Taxes			254,263	254,263		254,263	1,116	255,379			33
34	Rent-Facility & Grounds			1,394,773	1,394,773		1,394,773	11,914	1,406,687			34
35	Rent-Equipment & Vehicles			25,785	25,785		25,785	1,119	26,904			35
36	Other (specify):*											36
37	TOTAL Ownership			1,819,828	1,819,828		1,819,828	7,559	1,827,387			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		686,292	204,116	890,408		890,408		890,408			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*			828,873	828,873		828,873	(828,873)				43
44	TOTAL Special Cost Centers		686,292	1,032,989	1,719,281		1,719,281	(828,873)	890,408			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	8,053,056	1,179,645	6,326,768	15,559,469		15,559,469	(953,770)	14,605,699			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	(37,855)	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	25,715	30		9
10	Interest and Other Investment Income	(27,538)	32		10
11	Discounts, Allowances, Rebates & Refunds	(5,314)	32		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,937)	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	737	21		18
19	Entertainment	(11,148)	21		19
20	Contributions	(24,700)	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	(277,348)	21		24
25	Fund Raising, Advertising and Promotional	(9,080)	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 Page 5a	(1,002,664)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,371,132)		\$	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)	417,362		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 417,362		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (953,770)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$(13,050)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Non-Allowable Expense	(828,873)	43	3
4	Bank Charges	(10,952)	21	4
5	Misc Income	(175)	21	5
6	Patient Personal Items	0	10	6
7	Sequestration Expense	(128,699)	21	7
8	Non-Allowable Legal	(20,915)	19	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				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	(1,002,664)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Avantara Libertyville # 0057851 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	0	0	188	0	0	0	0	0	0	0	0	188	1
2	Food Purchase	(1,937)	0	0	0	0	0	0	0	0	0	0	(1,937)	2
3	Housekeeping	0	0	425	0	0	0	0	0	0	0	0	425	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(37,855)	0	440	341	0	0	0	0	0	0	0	(37,074)	5
6	Maintenance	0	0	8,072	429	(82)	0	0	0	0	0	0	8,419	6
7	Other (specify):*	0	0	684	0	0	0	0	0	0	0	0	684	7
8	TOTAL General Services	(39,792)	0	9,809	770	(82)	0	0	0	0	0	0	(29,295)	8
	B. Health Care and Programs													
9	Medical Director	0	0	4,210	0	0	0	0	0	0	0	0	4,210	9
10	Nursing and Medical Records	0	0	72,731	0	0	0	(1,568)	0	0	0	0	71,163	10
10a	Therapy	0	0	1,910	0	0	0	0	0	0	0	0	1,910	10a
11	Activities	0	0	80	0	0	0	0	0	0	0	0	80	11
12	Social Services	0	0	1,560	0	0	0	0	0	0	0	0	1,560	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	11,946	0	0	0	0	0	0	0	0	11,946	15
16	TOTAL Health Care and Programs	0	0	92,437	0	0	0	(1,568)	0	0	0	0	90,869	16
	C. General Administration													
17	Administrative	0	0	35,695	0	0	0	0	0	0	0	0	35,695	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(20,915)	0	50,718	34	0	(7,500)	0	0	0	0	0	22,337	19
20	Fees, Subscriptions & Promotions	(46,830)	0	1,255	0	0	0	0	0	0	0	0	(45,575)	20
21	Clerical & General Office Expenses	(427,585)	0	190,752	30	0	0	0	0	0	0	0	(236,803)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	632	0	0	0	0	0	0	0	0	632	24
25	Other Admin. Staff Transportation	0	0	2,400	0	0	0	0	0	0	0	0	2,400	25
26	Insurance-Prop.Liab.Malpractice	0	0	5,291	102	0	0	0	0	0	0	0	5,393	26
27	Other (specify):*	0	0	21,891	0	0	0	0	0	0	0	0	21,891	27
28	TOTAL General Administration	(495,330)	0	308,634	166	0	(7,500)	0	0	0	0	0	(194,030)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(535,122)	0	410,880	936	(82)	(7,500)	(1,568)	0	0	0	0	(132,456)	29

Summary B

12/31/2025

	Capital Expense	PAGES	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)
	Depreciation	25,715	0	0	1,498	0	0	0	0	0	0	0	27,213 30
	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
	Interest	(32,852)	0	(1,892)	941	0	0	0	0	0	0	0	(33,803) 32
	Real Estate Taxes	0	0	0	1,116	0	0	0	0	0	0	0	1,116 33
	Rent-Facility & Grounds	0	0	11,914	0	0	0	0	0	0	0	0	11,914 34
	Rent-Equipment & Vehicles	0	0	1,119	0	0	0	0	0	0	0	0	1,119 35
	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
	TOTAL Ownership	(7,137)	0	11,141	3,555	0	0	0	0	0	0	0	7,559 37
	Ancillary Expense												
	E. Special Cost Centers												
	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
	Other (specify):*	(828,873)	0	0	0	0	0	0	0	0	0	0	(828,873) 43
	TOTAL Special Cost Centers	(828,873)	0	0	0	0	0	0	0	0	0	0	(828,873) 44
	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,371,132)	0	422,021	4,491	(82)	(7,500)	(1,568)	0	0	0	0	(953,770) 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 Ownership Listing-1		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			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

Facility Name & ID Number

Avantara Libertyville

0057851

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

VII. RELATED PARTIES

A. (Continued)

Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Astoria Place Living and Rehab	Chicago, IL	Bella Terra Streamwood	Streamwood, IL	Gross Point Property I	Skokie	Building Company	1
2	Avantara Arrowhead	Rapid City, SD	Bella Terra Wheeling	Wheeling, IL	Legacy HC & Financial	Skokie	Home Office/Book	2
3	Avantara Aurora	Aurora, IL	Carlton at the Lake	Chicago, IL	CF St. Louis LLC	Skokie	Building Company	3
4	Avantara Chicago Ridge	Chicago Ridge, IL	Chalet Living and Rehab	Chicago, IL	ML Group Design & I	Skokie	Asset Management	4
5	Avantara Clark City	Clark, SD	Cardinal Grove Independent & Assisted Living	Garner, IA	ReMED Services LLC	Skokie	Nursing Equipment	5
6	Avantara of Elgin	Elgin, IL	Glenview Terrace	Glenview, IL	Propay HR	Evanston	Payroll Processing	6
7	Avantara Evergreen Park	Evergreen Park, IL	Harmony Cedar Rapids	Cedar Rapids, IA				7
8	Avantara Groton	Groton, SD	Harmony Davenport	Davenport, IA				8
9	Avantara Huron	Huron, SD	Harmony Dubuque	Dubuque, IA				9
10	Avantara Lake Norden	Lake Norden, SD	Harmony Marshalltown	Marshalltown, IA				10
11	Avantara Lake Zurich	Lake Zurich, IL	Harmony Healthcare & Rehabilitation Center	Chicago, IL				11
12	Avantara Libertyville	Libertyville, IL	Harmony Palos	Palos Heights, IL				12
13	Avantara Lincoln Park	Chicago, IL	Harmony Utica Ridge	Davenport, IA				13
14	Avantara Long Grove	Long Grove, IL	Harmony Waterloo	Waterloo, IA				14
15	Avantara Milbank	Milbank, SD	Harmony West Des Moines	West Des Moines, IA				15
16	Avantara Mountain View	Rapid City, SD	Lakefront	Chicago, IL				16
17	Avantara North	Rapid City, SD	Peterson Park Health Care Center	Chicago, IL				17
18	Avantara Norton	Rapid City, SD	Grove at the Lake	Zion, IL				18
19	Avantara Palos Heights	Palos Heights, IL	Harmony House Care Center ICF	Waterloo, IA				19
20	Avantara Park Ridge	Park Ridge, IL	The Grove of Elmhurst	Elmhurst, IL				20
21	Avantara Pierre	Pierre, SD	The Grove of Evanston	Evanston, IL				21
22	Avantara Redfield	Redfield, SD	The Grove of Fox Valley	Aurora, IL				22
23	Avantara Saint Cloud	St. Cloud, MN	The Grove of La Grange Park	La Grange Park, IL				23
24	Avantara Watertown	Watertown, SD	The Grove of Northbrook	Northbrook, IL				24
25	Bella Terra Bloomingdale	Bloomingdale, IL	The Grove of Skokie	Skokie, IL				25
26	Bella Terra Elmhurst	Elmhurst, IL	Grove of St. Charles	St. Charles, IL				26
27	Bella Terra La Grange	La Grange, IL	Vistas Fox Valley	Aurora, IL				27
28	Bella Terra Lombard	Lombard, IL	Vistas of Lincoln Park	Chicago, IL				28
29	Bella Terra Morton Grove	Morton Grove, IL	Wellshire Morton Grove	Morton Grove, IL				29
30	Bella Terra Schaumburg	Schaumburg, IL	Warren Barr Buffalo Grove	Buffalo Grove, IL				30

Facility Name & ID Number

Avantara Libertyville

0057851

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

VII. RELATED PARTIES

A. (Continued)

Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Warren Barr Gold Coast	Chicago, IL	Nora Springs Care Center	Nora Springs, IA				1
2	Warren Barr Lieberman	Skokie, IL	Grandview Care Center	Oelwein, IA				2
3	Warren Barr Lincoln Park	Chicago, IL	Oelwein Healthcare Center	Oelwein, IA				3
4	Warren Barr North Shore	Highland Park, IL	Park View Care Center	Sac City, IA				4
5	Whitehall	Deerfield, IL	Manor House Care Center	Sigourney, IA				5
6	Warren Barr Orland Park	Orland Park, IL	Main Street Manor	Swea City, IA				6
7	Warren Barr South Loop	Chicago, IL	Harmony House Care Center SNF	Waterloo, IA				7
8	Wellshire Huron	Huron, SD	Northgate Care Center	Waukon, IA				8
9	Wellshire Park Place	Milbank, SD	Southfield Wellness Community	Webster City, IA				9
10	Warren Barr Oak Lawn	Oak Lawn, IL	Avantara Joliet	Joliet, IL				10
11	Rehab Center Of Allison	Allison, IA	Harmony Park Ridge	Park Ridge, IL				11
12	Maple Manor Village	Aplington, IA	Mulberry Place Independent & Assisted Living	Bloomfield, IA				12
13	Valley Vue Care Center	Armstrong, IA	Afton Oaks Independent & Assisted Living	Elma, IA				13
14	Willow Dale Wellness Village	Battle Creek, IA	Southfield Wellness Community Independent &	Webster City, IA				14
15	Rehab Center Of Belmond	Belmond, IA	Emerald Oaks Independent & Assisted Living	Emmetsburg, IA				15
16	Bloomfield Care Center	Bloomfield, IA	Eagle Ridge Assisted Living Apartments	Guttenberg, IA				16
17	Westview Care Center	Britt, IA	Cherry Ridge Independent & Assisted Living	Mount Vernon, IA				17
18	Oakwood Care Center	Clear Lake, IA	Mills Harbor Assisted Living Lake	Lake Mills, IA				18
19	Colonial Manor Of Elma	Elma, IA	Deer View Manor Independent & Assisted Living	Sigourney, IA				19
20	Emmetsburg Care Center	Emmetsburg, IA	Maple Manor Village Independent & Assisted Living	Aplington, IA				20
21	Concord Care Center	Garner, IA	Summit Heights	Nora Springs, IA				21
22	Guttenberg Care Center	Guttenberg, IA	Southercrest Manor II Assisted Living	Waukon, IA				22
23	Rehab Center Of Hampton	Hampton, IA	The Courtyard	West Des Moines, IA				23
24	Rehab Center Of Independence-West	Independence, IA	Park Place Independent & Assisted Living	Sac City, IA				24
25	Westview Of Indianola	Indianola, IA	Elm Springs	Arkansas, IA				25
26	Rehab Center Of Lisbon	Lisbon, IA	Belle Haven Independent & Assisted Living	Blemond, IA				26
27	Lake Mills Care Center	Lake Mills, IA	Leahy Grove Independent & Assisted Living	Hampton, IA				27
28	Heritage Health & Rehab Center	Cedar Rapids, IA	Indian Creek Independent & Assisted Living	Nevada, IA				28
29	Hallmark Care Center	Mt Vernon, IA	Spring Creek Independent & Assisted Living	Armstrong, IA				29
30	Rolling Green Village	Nevada, IA	Clark SNF	Clark St, IL				30

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Elmbrook SNF	Elmhurst, IL						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

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	1	Dietary	\$	Legacy Healthcare Financial Services		\$ 188	\$ 188	15
16	V	3	Housekeeping		Legacy Healthcare Financial Services		425	425	16
17	V	5	Heat and other Utilities		Legacy Healthcare Financial Services		440	440	17
18	V	6	Maintenece		Legacy Healthcare Financial Services		8,072	8,072	18
19	V	7	Other (specify):*Employee Benefits		Legacy Healthcare Financial Services		684	684	19
20	V	9	Medical Director		Legacy Healthcare Financial Services		4,210	4,210	20
21	V	10	Nursing and Medical Records		Legacy Healthcare Financial Services		72,731	72,731	21
22	V	10A	Therapy		Legacy Healthcare Financial Services		1,910	1,910	22
23	V	11	Activities		Legacy Healthcare Financial Services		80	80	23
24	V	12	Social Services		Legacy Healthcare Financial Services		1,560	1,560	24
25	V	15	Other (specify):*Employee Benefits		Legacy Healthcare Financial Services		11,946	11,946	25
26	V	17	Administrative		Legacy Healthcare Financial Services		35,695	35,695	26
27	V	19	Professional Services		Legacy Healthcare Financial Services		50,718	50,718	27
28	V	20	Dues, Fees, Subscriptions & Promotions		Legacy Healthcare Financial Services		1,255	1,255	28
29	V	21	Clerical & General Office Expenses		Legacy Healthcare Financial Services		190,752	190,752	29
30	V	24	Travel and Seminar		Legacy Healthcare Financial Services		632	632	30
31	V	25	Other Admin. Staff Transportation		Legacy Healthcare Financial Services		2,400	2,400	31
32	V	26	Insurance-Prop.Liab.Malpractice		Legacy Healthcare Financial Services		5,291	5,291	32
33	V	27	Other (specify):* Employee Benefits		Legacy Healthcare Financial Services		21,891	21,891	33
34	V	32	Interest		Legacy Healthcare Financial Services		(1,892)	(1,892)	34
35	V	34	Rent-Facility & Grounds		Legacy Healthcare Financial Services		11,914	11,914	35
36	V	35	Equipment Rental		Legacy Healthcare Financial Services		137	137	36
37	V	35	Auto Rental		Legacy Healthcare Financial Services		982	982	37
38	V								38
39	Total			\$			\$ 422,021	\$ * 422,021	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	5	Utilities	\$	CF St. Louis LLC		\$ 341	\$ 341	15
16	V	6	Repairs and Maintenance		CF St. Louis LLC		429	429	16
17	V	19	Real Estate Appraisal Fee		CF St. Louis LLC		34	34	17
18	V	20	Professional Fees		CF St. Louis LLC		0		18
19	V	21	Office Expense		CF St. Louis LLC		30	30	19
20	V	26	Insurance		CF St. Louis LLC		102	102	20
21	V	30	Depreciation		CF St. Louis LLC		1,498	1,498	21
22	V	32	Interest Expense		CF St. Louis LLC		941	941	22
23	V	33	Real Estate Taxes		CF St. Louis LLC		1,116	1,116	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			\$			\$ 4,491	\$ * 4,491	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	6	Maintenance	\$ 6,000	ML Group Design & Development		\$ 5,918	\$ (82)	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			\$ 6,000			\$ 5,918	\$ * (82)	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 Service	\$ 32,922	ProPay HR LLC		\$ 25,422	\$ (7,500)	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			\$ 32,922			\$ 25,422	\$ * (7,500)	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	\$ 23,164	ReMED Services		\$ 21,596	\$ (1,568)	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			\$ 23,164			\$ 21,596	\$ * (1,568)	39

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

STATE OF ILLINOIS					Ownership Listing-1		
Avantara Libertyville							
ID#		0057851					
Report Period Beginning:		01/01/2025			Legacy Healthcare FS		
Ending:		12/31/2025			N/A		
-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)					Management		
-Owners of companies must be listed instead of company names.					Co./Home Office		
-Names of trust beneficiaries must be listed.					Ownership Percentage		
First Name	M.I.	Last Name	City	State	Ownership Percentage	Building Co. Ownership Percentage	Ownership Percentage
1	GPN Family Trust						1
2	Beneficiary						2
3	Rivka	Rajchenbach	Chicago	IL	14.87500		3
4	Bella	Rajchenbach	Chicago	IL	14.87500		4
5	Yitzchok	Rajchenbach	Chicago	IL	14.87500		5
6	Ziskind	Rajchenbach	Chicago	IL	14.87500		6
7							7
8	Oakway Operations LLC						8
9	Daniel	Garden	Chicago	IL	4.90000		9
10	Rebecca	Garden	Chicago	IL	2.60000		10
11	Mordechay	Ninio	Chicago	IL	4.90000		11
12	Sherie	Ninio	Chicago	IL	2.60000		12
13							13
14	Doros Generation Trust						14
15	Beneficiary						15
16	Ahuva	Shabat	Lincolnwood	IL	5.10000		16
17	Eliana	Shabat	Lincolnwood	IL	5.10000		17
18	Ayalet	Shabat	Lincolnwood	IL	5.10000		18
19	Ashira	Shabat	Lincolnwood	IL	5.10000		19
20	Leora	Shabat	Lincolnwood	IL	5.10000		20
21							21
22	Legacy Healthcare Financial Service						22
23	Chaim	Rajchenbach	Chicago	IL			50.00000
24	Menachem	Shabat	Lincolnwood	IL			50.00000
25							25
26							26
27	Note: Building Owner is Not Related Party in 2025						27
28							28
29							29
30							30
31							31
32							32
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74							74
75							75

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: 2/31/2025

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

Ending: 2/31/2025

(847) 683-2900

	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	Dietary	Census Days / Direct Allocation		121	\$ 17,417	\$ 188,860	38,033	\$ 188	1
2	3	Housekeeping	Census Days / Direct Allocation		121	39,313		38,033	425	2
3	5	Heat and other Utilities	Census Days / Direct Allocation		121	40,732		38,033	440	3
4	6	Maintenece	Census Days / Direct Allocation		121	1,086,339		38,033	8,072	4
5	7	Other (specify):*Employee Benefit	Census Days / Direct Allocation		121	115,823		38,033	684	5
6	9	Medical Director	Census Days / Direct Allocation		121	389,400	1,007,031	38,033	4,210	6
7	10	Nursing and Medical Records	Census Days / Direct Allocation		121	7,945,861	12,523,114	38,033	72,731	7
8	10A	Therapy	Census Days / Direct Allocation		121	176,684	152,483	38,033	1,910	8
9	11	Activities	Census Days / Direct Allocation		121	7,371		38,033	80	9
10	12	Social Services	Census Days / Direct Allocation		121	144,309	144,309	38,033	1,560	10
11	15	Other (specify):*Employee Benefit	Census Days / Direct Allocation		121	1,241,625		38,033	11,946	11
12	17	Administrative	Census Days / Direct Allocation		121	5,453,317		38,033	35,695	12
13	19	Professional Services	Census Days / Direct Allocation		121	4,691,102	5,453,317	38,033	50,718	13
14	20	Dues, Fees, Subscriptions & Prom	Census Days / Direct Allocation		121	116,052		38,033	1,255	14
15	21	Clerical & General Office Expense	Census Days / Direct Allocation		121	20,639,396	19,821,678	38,033	190,752	15
16	24	Travel and Seminar	Census Days / Direct Allocation		121	58,495		38,033	632	16
17	25	Other Admin. Staff Transportatio	Census Days / Direct Allocation		121	221,955		38,033	2,400	17
18	26	Insurance-Prop.Liab.Malpractice	Census Days / Direct Allocation		121	489,395		38,033	5,291	18
19	27	Other (specify):* Employee Benefit	Census Days / Direct Allocation		121	2,646,369		38,033	21,891	19
20	32	Interest	Census Days / Direct Allocation		121	(175,042)		38,033	(1,892)	20
21	34	Rent-Facility & Grounds	Census Days / Direct Allocation		121	1,102,008		38,033	11,914	21
22	35	Equipment Rental	Census Days / Direct Allocation		121	12,712		38,033	137	22
23	35	Auto Rental	Census Days / Direct Allocation		121	90,802		38,033	982	23
24										24
25	TOTALS					\$ 46,551,435	\$ 39,290,792		\$ 422,021	25

Ending: 2/31/2025

(847) 683-2900

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	5	Utilities	Census Days	3,517,851	121	\$ 31,540	\$ 38,033	\$ 341	1
	2	6	Repairs and Maintenance	Census Days	3,517,851	121	39,680	38,033	429	2
	3	19	Real Estate Appraisal Fee	Census Days	3,517,851	121	3,155	38,033	34	3
	4	20	Professional Fees	Census Days	3,517,851	121		38,033		4
	5	21	Office Expense	Census Days	3,517,851	121	2,733	38,033	30	5
	6	26	Insurance	Census Days	3,517,851	121	9,443	38,033	102	6
	7	30	Depreciation	Census Days	3,517,851	121	138,584	38,033	1,498	7
	8	32	Interest Expense	Census Days	3,517,851	121	87,057	38,033	941	8
	9	33	Real Estate Taxes	Census Days	3,517,851	121	103,201	38,033	1,116	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				\$ 415,393	\$		\$ 4,491	25

Ending: 2/31/2025

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	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	6	Utilities	Direct			\$	\$		\$ 5,918	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					\$	\$		\$ 5,918	25

Ending: 2/31/2025

()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct			\$	\$		\$ 25,422	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					\$	\$		\$ 25,422	25

Ending: 2/31/2025

()

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	10	Medical Supplies	Direct		\$	\$		\$ 21,596	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				\$	\$		\$ 21,596	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							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Forbright		X	Line of Credit								76,138	6
7	IPFS Corporation		X	Prepaid Insurance - Interest Only								943	7
8													8
9	TOTAL Facility Related						\$				\$	77,081	9
	B. Non-Facility Related*												
10	Interest Income		X									(27,538)	10
11													11
12													12
13	Allocated from CF St. Louis	X										941	13
14	TOTAL Non-Facility Related						\$				\$	(26,597)	14
15	TOTALS (line 9+line14)						\$				\$	50,484	15

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

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

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

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 41,805B. General Construction Type: ExteriorMasonryFrameSteelNumber of Stories3

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. List the bed capacity for the building if it differs from the licensed total. N/A
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
I. Are you presently operating under a sublease agreement? No
J. 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

K. 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	Allocated from CF St. Louis LLC					\$956	1
2							2
3	TOTALS					\$956	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					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

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	
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									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$	\$		\$	\$	\$	70

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

Facility Name & ID Number Avantara Libertyville

0057851

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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		\$	\$		\$	\$	\$	1
2	Replace Damaged Fusible Links On Fire Smoke Dampers (\$4,340)	2023	4,199		20	210	210	630	2
3	Replace 3 Circuit Brakers On 1St Flr Main Electrical Panel,Repai	2023	2,467		20	123	123	370	3
4	New Condensor For 3Rd Floor Nusing Station A/C (\$5,000)	2023	4,837		20	242	242	726	4
5	Install 2 Ton Fan Coil For Elevator Rm & Outdoor 2 Ton Conden	2023	7,256		20	363	363	1,088	5
6	Installation Of 5 Ptac Heat Pumps (\$3,685)	2023	3,565		20	178	178	535	6
7	Installation Of Avantara Libertyville 60" X 117" Monument Sign	2023	10,376		20	519	519	1,556	7
8	Dialysis Den Drywall Install, Paint, Flooring (\$26,883)	2023	26,007		20	1,300	1,300	3,901	8
9	Add Light Fixtures To 1St,2Nd,3Rd Floor Hallways (\$4,255)	2023	4,116		20	206	206	617	9
10	Replace 3 Pole Fixtures, Retrofit 11 Pole Light Fixtures (\$6,725)	2023	6,506		20	325	325	976	10
11	New Motor & Blade For 3Rd Flr Ac Unit, Replace Belts On Exhau	2023	3,287		20	164	164	493	11
12	Ice machine maintenance, roof exhaust motor repair, install new c	2024	2,725		20	136	136	273	12
13	Rewire and rework door access, keypad installations	2024	11,067		20	553	553	1,107	13
14	Visual inspection, Testing and servicing all fire smoke dampers, re	2025	6,950		20	348	348	695	14
15	LCN 4314ME-SF 24V LH AL Door Closer	2025	3,021		20	151	151	151	15
16	Remove and replace 3 sensors, install kitchen faucet & cartridges	2025	3,106		20	155	155	155	16
17	Fix broken pipe in shower, install valves, arcylic panel, cover plate	2025	3,250		20	163	163	163	17
18	Cover kitchen, vacuum, removal of loose grout joins, mixing new c	2025	4,496		20	225	225	225	18
19	Checked light photocells, wallpacks, lights, timer feeding & suppli	2025	4,743		20	237	237	237	19
20	Several scope of work for Vestibule, Lobby (Lounge/Reception), P	2025	1,358,035		20	67,902	67,902	67,902	20
21	Replacement of Floor Drains in 3rd floor shower room	2025	4,314		20	216	216	216	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31	Current year depreciation			36,688			(36,688)		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,474,323	\$ 36,688		\$ 73,716	\$ 37,028	\$ 82,015	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 12B, Carried Forward		\$ 1,474,323	\$ 36,688		\$ 73,716	\$ 37,028	\$ 82,015	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)		\$ 1,474,323	\$ 36,688		\$ 73,716	\$ 37,028	\$ 82,015	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		\$ 1,474,323	\$ 36,688		\$ 73,716	\$ 37,028	\$ 82,015	1
2									2
3	Related Party								3
4	Buildings:								4
5	Allocated from CF St. Louis, LLC	2016	5,146	102	35	147	45	1,470	5
6									6
7	Leasehold Improvements:								7
8	Allocated from CF St. Louis, LLC	2016	71,331	491	20	3,567	3,076	35,666	8
9	Allocated from CF St. Louis, LLC	2017	1,656	43	20	83	40	745	9
10	Allocated from CF St. Louis, LLC	2019	15,006	385	20	750	365	5,252	10
11	Allocated from CF St. Louis, LLC	2020	789	20	20	39	19	237	11
12	Allocated from CF St. Louis, LLC	2021	2,802	72	20	140	68	701	12
13	Allocated from CF St. Louis, LLC	2022	4,632	119	20	232	113	926	13
14	Allocated from CF St. Louis, LLC	2023	646	17	20	32	15	97	14
15									15
16	Allocated from Legacy HC	2018	85		20	4	4	34	16
17	Allocated from Legacy HC	2020	64		20	3	3	19	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)		\$ 1,576,480	\$ 37,937		\$ 78,714	\$ 40,777	\$ 127,162	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	\$164,155	\$31,478	\$16,416	\$(15,062)	10	\$8,169	71
72	Current Year Purchases					10		72
73	Fully Depreciated Assets	2,865				10	2,865	73
74								74
75	TOTALS	\$167,020	\$31,478	\$16,416	\$(15,062)		\$11,034	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$1,744,456	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$69,415	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$95,130	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$25,715	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$138,196	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.

Avantara Libertyville
0057851
Moveable Equipment Schedule
01/01/2025
12/31/2025

Company Name	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Accumulated Straight Line Depreciation
Line 28: Prior Years					
Avantara Libertyville	159,443	31,238	15,944	(15,294)	5,326
Allocated from Legacy HC	36	-	4	4	11
Allocated from CF St. Louis, LLC	4,676	240	468	228	2,832
Total	164,155	31,478	16,416	(15,062)	8,169

Line 29: Current Year

Avantara Libertyville	-	-	-	-	-
Allocated from Legacy HC	-	-	-	-	-
Allocated from CF St. Louis, LLC	-	-	-	-	-
Total	-	-	-	-	-

Line 30: Fully Depreciated

Avantara Libertyville	-	-	-	-	-
Allocated from Legacy HC	2,865	-	-	-	2,865
Allocated from CF St. Louis, LLC	-	-	-	-	-
Total	2,865	-	-	-	2,865

Total (Should tie to page 13)

Harmony Palos	159,443	31,238	15,944	(15,294)	5,326
Allocated from Legacy HC	2,901	-	4	4	2,876
Allocated from CF St. Louis, LLC	4,676	240	468	228	2,832
Total	167,020	31,478	16,416	(15,062)	11,034

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____
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:				\$ 1,394,773			3
4	Additions							4
5								5
6	Allocated from Legacy HC				11,914			6
7	TOTAL				\$ 1,406,687			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: \$ 25,922 Description: See Supplemental Schedule 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	Allocated from Legacy HC		\$	982	17
18					18
19					19
20					20
21	TOTAL		\$	982	21

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

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

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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

Facility Name & ID Number		Avantara Libertyville	STATE OF ILLINOIS	Page 14 - SUPP	
			# 0057851	Report Period Beginning:	1/1/2025 Ending: 12/31/2025
Supplemental Schedule Of Equipment Rental			12/31/2025		
	Description		Amount		
16A	Copiers		25,785		
16B	Air Fresheners		-		
16C	Allocation from Legacy HC		137		
16D					
16E					
16F					
16G					
16H					
16I					
16J					
16k					
		Total	25,922		

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ 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
		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)	\$			

- (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.

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	

- (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	10A-1	hrs	\$ 272,948		\$	\$		\$ 272,948	1
2	Licensed Speech and Language Development Therapist	10A-1	hrs	72,455					72,455	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-1	hrs	434,939					434,939	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				569,877		569,877	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			0		204,116	116,415		320,531	13
14	TOTAL			\$ 780,342		\$ 204,116	\$ 686,292		\$ 1,670,750	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.

SPECIAL SERVICES - SUPPLEMENTAL SCHEDULE

Special Services - Supplies (Column 6 - Other)			Amount	Special Services - Salary (Column 3 - Staff)			Amount
13A	Supplies - Medical	39-2	101,596	13U	Therapy Manager - Regular	10A-1	-
13B	Supplies - G-Tube	39-2	4,928	13V			
13C	Oxygen	39-2	9,891	13W			
13D				13X			
13E				13Y			
13F				13Z			
13G							0
13 H							
13I							
13J							
			116,415				
Special Services - Outside (Column 5 - Other)							
13K	Durable Medical Equipment	39-3	38,208				
13L	Radiology	39-3	30,124				
13M	Laboratory	39-3	134,250				
13N	Oxygen Equipment Rental	39-3	1,534				
13O							
13P							
13Q							
13R							
13S							
13T			204,116				

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 14,113	\$	1
2	Cash-Patient Deposits	750		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,013,523		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,536		6
7	Other Prepaid Expenses	153,303		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	416,164		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,612,389	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,457,186		15
16	Equipment, at Historical Cost	159,443		16
17	Accumulated Depreciation (book methods)	(104,041)		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	12,416,042		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 13,928,630	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 16,541,019	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,408,898	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	377,601		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,447		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	412,886		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,211,832	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	13,300,159		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 13,300,159	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 15,511,991	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,029,028	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 16,541,019	\$	48

*(See instructions.)

Supplemental Schedule Of Other Assets And Liabilities

As of 12/31/2025

Other Current Assets		Amount	Amount	Other Current Liabilities		Amount	Amount
09A	Refund	(36,782)		36A	Prepaid - Legal Fees	235,000	
09B	Exchange	96,565		36B	Accrued Accounting Fees	8,458	
09C	Insurance Refund Exchange	9,393		36C	Accrued Monthly Assessment Fee	196,513	
09D	Accounts Receivable - Quality Incentive	(198,767)		36D	Due To/From Medicare	(68,511)	
09E	C.N.A. Tenure Program	548,164		36E	Due To Bcbs - Upp	7,859	
09F	Employee Loans	(2,409)		36F	Due to Related Party	33,567	
09G				36G			
09H				36H			
09I				36I			
09J				36J			
		416,164	-			412,886	-
Other Non-Current Assets:		Amount	Amount	Other Non-Current Liabilities		Amount	Amount
23A	Right Of Use Asset	9,998,920		43A	Due To/From - 10 Pack Forbright Interco	2,966,250	
23B	Finance Right Of Use Asset	89,832		43B	Due To/From Others	150,000	
23C	Right Of Use Asset Acc Amortization	(848,141)		43C	Right Of Use Lease Liability	10,144,123	
23D	Finance Right Of Use Asset Acc Amortization	(52,402)		43D	Finance Lease Liability	39,786	
23E	Security Deposit	7,205		43E			
23F	Option/Rent Deposit	667,375		43F			
23G	Due To/From - Avantara Libertyville & Management C	-		43G			
23H	Due To/From Prior Owner	347		43H			
23I	Note Payable - 10 Pack Forbright	2,524,276		43I			
23J	Accrued Management Fees Entities	28,630		43J			
		#####	-			13,300,159	-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 337,124	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 337,124	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	862,480	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	(170,576)	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)	\$ 691,904	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)	\$ 1,029,028	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Avantara Libertyville

0057851

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

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	\$ 20,855,309	1
2	Discounts and Allowances for all Levels	(8,844,862)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,010,447	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,711,155	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,711,155	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	479,057	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	111,292	19
20	Radiology and X-Ray	27,681	20
21	Other Medical Services	258,444	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 876,474	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,324	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,324	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplement Schedule	385,954	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 385,954	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,985,354	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,835,004	31
32	Health Care	7,107,033	32
33	General Administration	3,078,323	33
	B. Capital Expense		
34	Ownership	1,819,828	34
	C. Ancillary Expense		
35	Special Cost Centers	1,719,281	35
36	Provider Participation Fee	563,405	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,122,874	40
41	Income before Income Taxes (line 30 minus line 40)**	862,480	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 862,480	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 2,193,532.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	3,011,073.00	45
46	MMAI-Medicaid is the Primary Payer	1,210,557.00	46
47	MMAI-Medicare is the Primary Payer	312,667.00	47
48	Private Pay	881,641.00	48
49	Medicare Part A	3,212,307.00	49
50	Other-(specify) Insurance	1,188,670.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,010,447	56

SUPPLEMENTAL SCHEDULE OF REVENUE			
	Special Services - Supplies (Column 6 - Other)		Amount
28A	Covid 19 State Stimulus		-
28B	Discounts Earned	(adj on pg 5)	593
28C	Quality Incentive		118,432
28D	Rebates	(adj on pg 5)	4,721
28E			
28F			
28G			
28H			
28I			
28J			
			123,746

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	2,000	2,170	\$ 157,786	\$ 72.71	1
2	Assistant Director of Nursing	1,920	2,078	101,841	49.01	2
3	Registered Nurses	24,455	29,863	1,339,426	44.85	3
4	Licensed Practical Nurses	25,288	32,813	1,312,000	39.98	4
5	CNAs & Orderlies	69,700	87,643	2,210,113	25.22	5
6	CNA Trainees					6
7	Licensed Therapist	17,079	19,192	800,357	41.70	7
8	Rehab/Therapy Aides	8,094	9,941	294,019	29.58	8
9	Activity Director	1,800	1,919	44,845	23.37	9
10	Activity Assistants	3,000	3,468	62,768	18.10	10
11	Social Service Workers	3,729	3,947	103,510	26.22	11
12	Dietician	785	844	31,084	36.83	12
13	Food Service Supervisor	1,872	1,936	61,909	31.98	13
14	Head Cook	5,731	6,814	149,620	21.96	14
15	Cook Helpers/Assistants	14,386	16,279	272,611	16.75	15
16	Dishwashers					16
17	Maintenance Workers	3,880	4,160	136,553	32.83	17
18	Housekeepers	11,219	12,436	214,180	17.22	18
19	Laundry	3,178	3,787	64,174	16.95	19
20	Administrator	1,976	2,080	179,646	86.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,928	2,080	63,821	30.68	23
24	Clerical	12,305	13,590	394,972	29.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,981	2,120	57,821	27.27	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	216,306	259,160	\$ 8,053,056 *	\$ 31.07	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	\$ 42,577	01-03	35
36	Medical Director	Monthly	36,300	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	8,516	10-03	38
39	Pharmacist Consultant	Monthly	21,045	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,441	11-03	44
45	Social Service Consultant	Monthly	7,582	12-03	45
46	Other(specify)				46
47	Rehabilitation	Monthly	48,000	10a-03	47
48	Dialysis	Monthly	92,844	10-03	48
49	TOTAL (lines 35 - 48)		\$ 259,305		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	5,275	\$ 280,278	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides		0	10-03	52
53	TOTAL (lines 50 - 52)	5,275	\$ 280,278		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Gomboc, Victoria	Administrator	0	\$ 179,646	Workers' Compensation Insurance	\$	68,801	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance		88,802	Advertising: Employee Recruitment		
				FICA Taxes		583,469	Health Care Worker Background Check		
				Employee Health Insurance		277,357	(Indicate # of checks performed 68)	682	
				Employee Meals			Patient Background Checks 727	7,273	
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)	26,100	
				401K Expense		43,370	Other Dues & Subscriptions	7,061	
				Union Pension			Licenses & Permits	3,979	
				Other Employee Benefits		34,854	Allocation from Legacy Healthcare Financial	1,255	
				Voluntary Benefit Contribution		45,197			
				Employee Physical Exams		10,003			
							Less: Public Relations Expense	()	
							PAC and Lobbying payments	(13,050)	
							All non-allowable advertising	()	

*** Attach copy of IMRF notifications**

****See instructions.**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

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

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Huron Consulting Group, LLC	Strategy Consultant	\$ 504
Optum	Claims Management	517
IIT/Sourcetek	Hospitality Solutions	600
Language Line Services Inc	Translation Services	4,192
Sogolytics, LLC	Data Analytics	670
Collaborative Healthcare Urgency G	Restoration Services	314
Aida Healthcare	Placement	496
TAP Innovations, LLC	Data Analytics	66
Personnel Planners	Unemployment Consultant	1,350
Compliant	Compliance	2,655
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 11,363

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	

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	\$
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed)	
Less: Public Relations Expense	()
PAC and Lobbying payments	()
All non-allowable advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

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

* Attach copy of IMRF notifications

**See instructions.

AVANTARA LIBERTYVILLE
0057851
Legal Schedule
01/01/2025 - 12/31/2025

Date	G/L Account No.	Payee/Vendor	Type of Service Provided	Amount	Adjustment	Adjusted Amount
2/8/2020	580063	Corporation Service Company	Statutory Representation	104	-	104
1/31/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianships	1,079	1,079	-
2/28/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianships	855	855	-
3/31/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianships	1,630	1,630	-
4/9/2025	580063	Meyer Magence	General Counsel	88	-	88
4/30/2025	580063	Forbright	RLOC retainage	50	50	-
4/30/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianships	1,731	1,731	-
5/31/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianships	1,123	1,123	-
6/30/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianships	3,032	3,032	-
7/31/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianships	866	866	-
8/10/2025	580063	Ciesla Beeler	Collections and Guardianships	1,735	1,735	-
8/25/2025	580063	Law Hesselbaum	General Counsel	85	-	85
8/31/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianships	2,184	2,184	-
9/30/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianships	906	906	-
10/1/2025	580063	Corporation Service Company	Statutory Representation	198	-	198
10/31/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianships	1,609	1,609	-
11/21/2025	580063	Neal, Gerber, & Eisenberg LLP	Matter Management	38	-	38
11/24/2025	580063	Meyer Magence	General Counsel	88	-	88
11/30/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianships	1,816	1,816	-
12/10/2025	580063	Law Hesselbaum	General Counsel	10,900	-	10,900
12/17/2025	580063	Neal, Gerber, & Eisenberg LLP	Matter Management	90	-	90
12/31/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianships	2,299	2,299	-
Total				32,504	20,915	11,589

XX. GENERAL INFORMATION:

- (1)

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

No
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
HEALTH CARE COUNCIL OF IL (HCCI)	13,050
	13,050 Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

HEALTH CARE COUNCIL OF IL (HCCI)	13,050
	13,050 Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

HEALTH CARE COUNCIL OF IL (HCCI)	26,100
	26,100 Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$	61,680	Line	10
----	--------	------	----
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$	563,405
----	---------

This amount is to be recorded on line 42 of Schedule V.
- (8)

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.

- (9)

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
- (10)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$	None	Has any meal income been offset against related costs?	N/A	Indicate the amount.	\$	
----	------	--	-----	----------------------	----	--
- (12)

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?

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% LN1

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

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
- (13)

Has an audit been performed by an independent certified public accounting firm?

Firm Name:

N/A

No
- (14)

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

Yes
- (15)

Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

Yes

Attach invoices and a summary of services for all architect and appraisal fees.