

		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: 0055046

Facility Name: Avantara of Elgin

Address: 1950 Larkin Avenue Elgin 60123
Number City Zip Code

County: Kane

Telephone Number: (847) 742-7070 Fax # (847) 742-7248

HFS ID Number:

Date of Initial License for Current Owners: 09/01/2018

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 of Elgin # 0055046 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>112</u>	Skilled (SNF)	<u>112</u>	<u>40,880</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>112</u>	TOTALS	<u>112</u>	<u>40,880</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				348		2,371	2,342	5,061	8
9	SNF/PED									9
10	ICF	7,716	12,069	6,325		4,856			30,966	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	7,716	12,069	6,325	348	4,856	2,371	2,342	36,027	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 88.13%

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 09/01/2018

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 09/01/2018 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 112

Medicare Intermediary National Government Services

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 of Elgin # 0055046 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		23,399	839,798	863,197		863,197	178	863,375			1
2	Food Purchase		2,516		2,516		2,516		2,516			2
3	Housekeeping		3,995	393,030	397,025		397,025	403	397,428			3
4	Laundry	79,272	16,158	122,167	217,597		217,597		217,597			4
5	Heat and Other Utilities			278,069	278,069		278,069	(22,947)	255,122			5
6	Maintenance	89,878	18,570	152,698	261,146		261,146	6,685	267,831			6
7	Other (specify):*							648	648			7
8	TOTAL General Services	169,150	64,638	1,785,762	2,019,550		2,019,550	(15,033)	2,004,517			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000	3,988	21,988			9
10	Nursing and Medical Records	3,642,436	138,371	982,401	4,763,208		4,763,208	67,004	4,830,212			10
10a	Therapy	199,421			199,421		199,421	1,809	201,230			10a
11	Activities	130,252	12,548	1,547	144,347		144,347	75	144,422			11
12	Social Services	116,666		4,318	120,984		120,984	1,478	122,462			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							11,316	11,316			15
16	TOTAL Health Care and Programs	4,088,775	150,919	1,006,266	5,245,960		5,245,960	85,670	5,331,630			16
	C. General Administration											
17	Administrative	152,640			152,640		152,640	33,812	186,452			17
18	Directors Fees											18
19	Professional Services			127,139	127,139		127,139	48,810	175,949			19
20	Dues, Fees, Subscriptions & Promotions			53,624	53,624		53,624	(29,561)	24,063			20
21	Clerical & General Office Expenses	429,588	2,211	486,612	918,411		918,411	(107,438)	810,973			21
22	Employee Benefits & Payroll Taxes			567,517	567,517		567,517		567,517			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,099	1,099		1,099	599	1,698			24
25	Other Admin. Staff Transportation							2,273	2,273			25
26	Insurance-Prop.Liab.Malpractice			514,262	514,262		514,262	5,109	519,371			26
27	Other (specify):*							20,736	20,736			27
28	TOTAL General Administration	582,228	2,211	1,750,253	2,334,692		2,334,692	(25,660)	2,309,032			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,840,153	217,768	4,542,281	9,600,202		9,600,202	44,977	9,645,179			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			265,378	265,378		265,378	(108,333)	157,045			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,726	22,726		22,726	409,005	431,731			32
33	Real Estate Taxes			150,829	150,829		150,829	(501)	150,328			33
34	Rent-Facility & Grounds			707,800	707,800		707,800	(696,514)	11,286			34
35	Rent-Equipment & Vehicles			15,429	15,429		15,429	1,060	16,489			35
36	Other (specify):*											36
37	TOTAL Ownership			1,162,162	1,162,162		1,162,162	(395,283)	766,879			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		484,946	819,559	1,304,505		1,304,505		1,304,505			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*			660,235	660,235		660,235	(660,235)				43
44	TOTAL Special Cost Centers		484,946	1,479,794	1,964,740		1,964,740	(660,235)	1,304,505			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,840,153	702,714	7,184,237	12,727,104		12,727,104	(1,010,541)	11,716,563			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	(23,687)	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	65,165	30		9
10	Interest and Other Investment Income	(1,449)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(10,506)	21		18
19	Entertainment	(5,644)	21		19
20	Contributions	(12,000)	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	(198,070)	21		24
25	Fund Raising, Advertising and Promotional	(9,006)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax		21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(842,300)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,037,497)		\$	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)	396,670		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 396,670		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (640,827)		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

Avantara of Elgin

ID# 0055046

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

NON-ALLOWABLE EXPENSES			Sch. V Line
	Amount	Reference	
1	Political Action Committee Payments	\$ (9,744)	20
2	Other Expenses Related to Lobbying Activities		
3	Non-Allowable Expense	(660,235)	43
4	Bank Charges	(12,868)	21
5	Patient Personal Items	(651)	10
6	Sequestration Expense	(61,069)	21
7	Non-Allowable Legal	5,473	19
8	Building Co. - Amortization	(32,321)	36
9	Building Co. - Asset Management Fees	(25,200)	06
10	Building Co. - Zoning and filing fees	(3,826)	19
11	Building Co. - Professional fees	(4,425)	19
12	Building Co. -Other	(37,434)	19
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49	Total	(842,300)	

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Avantara of Elgin # 0055046 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	178	0	0	0	0	0	0	0	0	178	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	403	0	0	0	0	0	0	0	0	403	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(23,687)	0	417	323	0	0	0	0	0	0	0	(22,947)	5
6	Maintenance	(25,200)	25,200	7,646	406	(1,367)	0	0	0	0	0	0	6,685	6
7	Other (specify):*	0	0	648	0	0	0	0	0	0	0	0	648	7
8	TOTAL General Services	(48,887)	25,200	9,292	729	(1,367)	0	0	0	0	0	0	(15,033)	8
	B. Health Care and Programs													
9	Medical Director	0	0	3,988	0	0	0	0	0	0	0	0	3,988	9
10	Nursing and Medical Records	(651)	0	68,895	0	0	(1,240)	0	0	0	0	0	67,004	10
10a	Therapy	0	0	1,809	0	0	0	0	0	0	0	0	1,809	10a
11	Activities	0	0	75	0	0	0	0	0	0	0	0	75	11
12	Social Services	0	0	1,478	0	0	0	0	0	0	0	0	1,478	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	11,316	0	0	0	0	0	0	0	0	11,316	15
16	TOTAL Health Care and Programs	(651)	0	87,561	0	0	(1,240)	0	0	0	0	0	85,670	16
	C. General Administration													
17	Administrative	0	0	33,812	0	0	0	0	0	0	0	0	33,812	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(40,212)	45,685	48,042	32	0	0	(4,737)	0	0	0	0	48,810	19
20	Fees, Subscriptions & Promotions	(30,750)	0	1,189	0	0	0	0	0	0	0	0	(29,561)	20
21	Clerical & General Office Expenses	(288,157)	0	180,691	28	0	0	0	0	0	0	0	(107,438)	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	599	0	0	0	0	0	0	0	0	599	24
25	Other Admin. Staff Transportation	0	0	2,273	0	0	0	0	0	0	0	0	2,273	25
26	Insurance-Prop.Liab.Malpractice	0	0	5,012	97	0	0	0	0	0	0	0	5,109	26
27	Other (specify):*	0	0	20,736	0	0	0	0	0	0	0	0	20,736	27
28	TOTAL General Administration	(359,119)	45,685	292,354	157	0	0	(4,737)	0	0	0	0	(25,660)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(408,657)	70,885	389,207	886	(1,367)	(1,240)	(4,737)	0	0	0	0	44,977	29

Summary B

12/31/2025

	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	65,165	(174,917)	0	1,419	0	0	0	0	0	0	0	(108,333)
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0
32	Interest	(1,449)	411,355	(1,793)	892	0	0	0	0	0	0	0	409,005
33	Real Estate Taxes	0	(1,558)	0	1,057	0	0	0	0	0	0	0	(501)
34	Rent-Facility & Grounds	0	(707,800)	11,286	0	0	0	0	0	0	0	0	(696,514)
35	Rent-Equipment & Vehicles	0	0	1,060	0	0	0	0	0	0	0	0	1,060
36	Other (specify):*	(32,321)	32,321	0	0	0	0	0	0	0	0	0	0
37	TOTAL Ownership	31,395	(440,599)	10,553	3,368	0	0	0	0	0	0	0	(395,283)
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0
43	Other (specify):*	(660,235)	0	0	0	0	0	0	0	0	0	0	(660,235)
44	TOTAL Special Cost Centers	(660,235)	0	0	0	0	0	0	0	0	0	0	(660,235)
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,037,497)	(369,714)	399,760	4,254	(1,367)	(1,240)	(4,737)	0	0	0	0	(1,010,541)

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	34	Rent	\$ 707,800	Larkin Ave Property Holdings LLC		\$	(707,800)	1
2	V	33	Real Estate Taxes	150,829	Larkin Ave Property Holdings LLC		149,271	(1,558)	2
3	V	06	Asset Management Fees		Larkin Ave Property Holdings LLC		25,200	25,200	3
4	V	32	Interest	22,726	Larkin Ave Property Holdings LLC		434,081	411,355	4
5	V	30	Depreciation	265,378	Larkin Ave Property Holdings LLC		90,461	(174,917)	5
6	V	36	Amortization		Larkin Ave Property Holdings LLC		32,321	32,321	6
7	V	19	Zoning and filing fees		Larkin Ave Property Holdings LLC		3,826	3,826	7
8	V	19	Professional fees - accounting		Larkin Ave Property Holdings LLC		4,425	4,425	8
9	V	19	Other costs		Larkin Ave Property Holdings LLC		37,434	37,434	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,146,733			\$ 777,019	\$ * (369,714)	14

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

Facility Name & ID Number

Avantara of Elgin

0055046

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	Larkin Ave Property Holdings LLC		Building Company	1
2	Avantara Arrowhead	Rapid City, SD	Bella Terra Wheeling	Wheeling, IL	Legacy HC & Financial	Lincolnwood	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 & Interiors	Skokie	Asset Management	4
5	Avantara Clark City	Clark, SD	Cardinal Grove Independent & Assisted Living	Garner, IA	ReMED Services LLC	Lincolnwood	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 of Elgin

0055046

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 Belmont	Belmont, 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		\$ 178	\$ 178	15
16	V	3	Housekeeping		Legacy Healthcare Financial Services		403	403	16
17	V	5	Heat and other Utilities		Legacy Healthcare Financial Services		417	417	17
18	V	6	Maintenece		Legacy Healthcare Financial Services		7,646	7,646	18
19	V	7	Other (specify):*Employee Benefits		Legacy Healthcare Financial Services		648	648	19
20	V	9	Medical Director		Legacy Healthcare Financial Services		3,988	3,988	20
21	V	10	Nursing and Medical Records		Legacy Healthcare Financial Services		68,895	68,895	21
22	V	10A	Therapy		Legacy Healthcare Financial Services		1,809	1,809	22
23	V	11	Activities		Legacy Healthcare Financial Services		75	75	23
24	V	12	Social Services		Legacy Healthcare Financial Services		1,478	1,478	24
25	V	15	Other (specify):*Employee Benefits		Legacy Healthcare Financial Services		11,316	11,316	25
26	V	17	Administrative		Legacy Healthcare Financial Services		33,812	33,812	26
27	V	19	Professional Services		Legacy Healthcare Financial Services		48,042	48,042	27
28	V	20	Dues, Fees, Subscriptions & Promotions		Legacy Healthcare Financial Services		1,189	1,189	28
29	V	21	Clerical & General Office Expenses		Legacy Healthcare Financial Services		180,691	180,691	29
30	V	24	Travel and Seminar		Legacy Healthcare Financial Services		599	599	30
31	V	25	Other Admin. Staff Transportation		Legacy Healthcare Financial Services		2,273	2,273	31
32	V	26	Insurance-Prop.Liab.Malpractice		Legacy Healthcare Financial Services		5,012	5,012	32
33	V	27	Other (specify):* Employee Benefits		Legacy Healthcare Financial Services		20,736	20,736	33
34	V	32	Interest		Legacy Healthcare Financial Services		(1,793)	(1,793)	34
35	V	34	Rent-Facility & Grounds		Legacy Healthcare Financial Services		11,286	11,286	35
36	V	35	Equipment Rental		Legacy Healthcare Financial Services		130	130	36
37	V	35	Auto Rental		Legacy Healthcare Financial Services		930	930	37
38	V								38
39	Total			\$			\$ 399,760	\$ * 399,760	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	5	Utilities	\$	CF St. Louis LLC		\$ 323	\$ 323	15
16	V	6	Repairs and Maintenance		CF St. Louis LLC		406	406	16
17	V	19	Real Estate Appraisal Fee		CF St. Louis LLC		32	32	17
18	V	20	Professional Fees		CF St. Louis LLC		0		18
19	V	21	Office Expense		CF St. Louis LLC		28	28	19
20	V	26	Insurance		CF St. Louis LLC		97	97	20
21	V	30	Depreciation		CF St. Louis LLC		1,419	1,419	21
22	V	32	Interest Expense		CF St. Louis LLC		892	892	22
23	V	33	Real Estate Taxes		CF St. Louis LLC		1,057	1,057	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			\$			\$ 4,254	\$ * 4,254	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	6	Maintenance	\$ 6,000	ML Group Design & Development		\$ 4,633	\$ (1,367)	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			\$ 4,633	\$ * (1,367)	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	\$ 18,315	ReMED Services		\$ 17,075	\$ (1,240)	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			\$ 18,315			\$ 17,075	\$ * (1,240)	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	\$ 20,796	ProPay HR LLC		\$ 16,059	\$ (4,737)	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			\$ 20,796			\$ 16,059	\$ * (4,737)	39

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

STATE OF ILLINOIS					Ownership Listing-1			
Avantara of Elgin								
ID#		0055046						
Report Period Beginning:		01/01/2025			Legacy Healthcare FS			
Ending:		12/31/2025			Larkin Ave Property Holdings LLC			
-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.								
First Name	M.I.	Last Name	City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Co./Home Office Ownership Percentage	
1		GPN Family Trust					1	
2		Rivka	Rajchenbach	Chicago	IL	10.62500	12.00000	2
3		Bella	Rajchenbach	Chicago	IL	10.62500	12.00000	3
4		Yitzchok	Rajchenbach	Chicago	IL	10.62500	12.00000	4
5		Ziskind	Rajchenbach	Chicago	IL	10.62500	12.00000	5
6							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		Ahuva	Shabat	Lincolnwood	IL	8.50000	2.40000	15
16		Eliana	Shabat	Lincolnwood	IL	8.50000	2.40000	16
17		Ayalet	Shabat	Lincolnwood	IL	8.50000	2.40000	17
18		Ashira	Shabat	Lincolnwood	IL	8.50000	2.40000	18
19		Leora	Shabat	Lincolnwood	IL	8.50000	2.40000	19
20							20	
21		Legacy Healthcare Financial Service					21	
22		Chaim	Rajchenbach	Chicago	IL	10.00000	50.00000	22
23		Menachem	Shabat	Lincolnwood	IL	10.00000	50.00000	23
24							24	
25		Larkin Ave Property Holdings LLC (PropCo)					25	
26		Chaim	Rajchenbach	Chicago	IL	3.40000		26
27		Yoseph	Rajchenbach	Chicago	IL	3.40000		27
28		Avrohom	Rajchenbach	Chicago	IL	3.40000		28
29		Moshe	Rajchenbach	Chicago	IL	3.40000		29
30							30	
31		Larkin Ave Investors II (6.40% Holder)					31	
32		Yitzhak	Rosenblum	Lincolnwood	IL	0.42700		32
33		Mordechay	Ninio	Chicago	IL	0.42700		33
34		Daniel	Garden	Chicago	IL	0.42700		34
35		Ben	Shibe	Chicago	IL	0.42700		35
36		Shai	Berdugo	Skokie	IL	0.42700		36
37		Chaim	Rajchenbach	Chicago	IL	1.70700		37
38		Menachem	Shabat	Lincolnwood	IL	1.70700		38
39		Mordechai	Kaplan	Chicago	IL	0.42700		39
40		Eli	Davis	Skokie	IL	0.42700		40
41							41	
42							42	
43							43	
44							44	
45							45	
46							46	
47							47	
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72							72	
73							73	
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		\$ 178	1
2	3	Housekeeping	Census Days / Direct Allocation		121	39,313			403	2
3	5	Heat and other Utilities	Census Days / Direct Allocation		121	40,732			417	3
4	6	Maintenece	Census Days / Direct Allocation		121	1,086,339			7,646	4
5	7	Other (specify):*Employee Benefi	Census Days / Direct Allocation		121	115,823			648	5
6	9	Medical Director	Census Days / Direct Allocation		121	389,400	1,007,031		3,988	6
7	10	Nursing and Medical Records	Census Days / Direct Allocation		121	7,945,861	12,523,114		68,895	7
8	10A	Therapy	Census Days / Direct Allocation		121	176,684	152,483		1,809	8
9	11	Activities	Census Days / Direct Allocation		121	7,371			75	9
10	12	Social Services	Census Days / Direct Allocation		121	144,309	144,309		1,478	10
11	15	Other (specify):*Employee Benefi	Census Days / Direct Allocation		121	1,241,625			11,316	11
12	17	Administrative	Census Days / Direct Allocation		121	5,453,317			33,812	12
13	19	Professional Services	Census Days / Direct Allocation		121	4,691,102	5,453,317		48,042	13
14	20	Dues, Fees, Subscriptions & Prom	Census Days / Direct Allocation		121	116,052			1,189	14
15	21	Clerical & General Office Expense	Census Days / Direct Allocation		121	20,639,396	19,821,678		180,691	15
16	24	Travel and Seminar	Census Days / Direct Allocation		121	58,495			599	16
17	25	Other Admin. Staff Transportatio	Census Days / Direct Allocation		121	221,955			2,273	17
18	26	Insurance-Prop.Liab.Malpractice	Census Days / Direct Allocation		121	489,395			5,012	18
19	27	Other (specify):* Employee Benefi	Census Days / Direct Allocation		121	2,646,369			20,736	19
20	32	Interest	Census Days / Direct Allocation		121	(175,042)			(1,793)	20
21	34	Rent-Facility & Grounds	Census Days / Direct Allocation		121	1,102,008			11,286	21
22	35	Equipment Rental	Census Days / Direct Allocation		121	12,712			130	22
23	35	Auto Rental	Census Days / Direct Allocation		121	90,802			930	23
24										24
25	TOTALS					\$ 46,551,435	\$ 39,290,792		\$ 399,760	25

Facility Name & ID Number Avantara of Elgin # 0055046 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

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 CF St. Louis LLC
Street Address 3450 Oakton Street
City / State / Zip Code Skokie, IL 60076
Phone Number (847) 676-5300
Fax Number (847) 676-5348

	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,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	Utilities	Census Days	3,517,851	121	\$ 31,540	\$	36,027	\$ 323	1
2	6	Repairs and Maintenance	Census Days	3,517,851	121	39,680		36,027	406	2
3	19	Real Estate Appraisal Fee	Census Days	3,517,851	121	3,155		36,027	32	3
4	20	Professional Fees	Census Days	3,517,851	121			36,027		4
5	21	Office Expense	Census Days	3,517,851	121	2,733		36,027	28	5
6	26	Insurance	Census Days	3,517,851	121	9,443		36,027	97	6
7	30	Depreciation	Census Days	3,517,851	121	138,584		36,027	1,419	7
8	32	Interest Expense	Census Days	3,517,851	121	87,057		36,027	892	8
9	33	Real Estate Taxes	Census Days	3,517,851	121	103,201		36,027	1,057	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	\$		\$ 4,254	25

Facility Name & ID Number Avantara of Elgin # 0055046 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

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 ML Group Design and Development
Street Address 3424 Oakton St.
City / State / Zip Code Skokie, IL 60076
Phone Number (847) 676-5300
Fax Number (

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Direct			\$	\$		(1,367)	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					\$	\$		(1,367)	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			\$	\$		\$ 16,059	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					\$	\$		\$ 16,059	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	CIBC Bank		X	Mortgage Payable		10/1/2018	\$ 9,120,000	\$ 5,870,771			\$ 434,081	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	CIBC Bank		X	Line of Credit							21,791	6	
7	IPFS Corporation		X	Prepaid Insurance - Interest Only							65	7	
8	Marsh & McLennan Agency		X	Prepaid Insurance - Interest Only							870	8	
9	TOTAL Facility Related						\$ 9,120,000	\$ 5,870,771			\$ 456,807	9	
	B. Non-Facility Related*												
10	Interest Income		X								(1,449)	10	
11	Interest Income - Bldg Co.		X									11	
12	Allocated from CF St. Louis	X									892	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (557)	14	
15	TOTALS (line 9+line14)						\$ 9,120,000	\$ 5,870,771			\$ 456,250	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.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2024 report.			\$	<u>140,811</u>	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.)			\$	<u>150,328</u>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	<u>9,517</u>	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<u>140,811</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.					
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<u>150,328</u>	7
Assessed Value from Real Estate Tax Bill:	2024	<u>1,634,619</u>	8		
Real Estate Tax Bill for Calendar Year:	2020	<u>124,728</u>	9		
	2021	<u>128,163</u>	10		
	2022	<u>133,233</u>	11		
	2023	<u>143,646</u>	12		
	2024	<u>149,271</u>	13		
<u>2025 Accrual = \$140,811 = Same as PY</u>					
<u>Allocated from CF St. Louis: \$1,057</u>					

		FOR BHF USE ONLY		
14	FROM R. E. TAX STATEMENT FOR 2024	\$		14
15	PLUS APPEAL COST FROM LINE 5	\$		15
16	LESS REFUND FROM LINE 6	\$		16
17	AMOUNT TO USE FOR RATE CALCULATION	\$		17

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 of Elgin	COUNTY	Kane
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CONTACT PERSON REGARDING THIS REPORT Steven N. Lavenda

A. Summary of Real Estate Tax Cost

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

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,260B. General Construction Type: Exterior BrickFrame Wood/MasonryNumber of Stories 1

C. Does the Operating Entity? (a) Own the Facility (X) (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (X) (a) Own the Equipment (X) (b) Rent equipment from a Related Organization. (X) (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

F. 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?
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 X NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	115,500	2018	\$ 392,000	1
2	Allocated from CF St. Louis LLC			905	2
3	TOTALS	115,500		\$ 392,905	3

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

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)		\$ 5,894,031	\$ 90,461		\$ 185,502	\$ 95,041	\$ 1,331,938	70

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

Facility Name & ID Number Avantara of Elgin

0055046

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	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		\$ 5,894,031	\$ 90,461		\$ 185,502	\$ 95,041	\$ 1,331,938	1
2	Current year depreciation			232,932			(232,932)		2
3	New Tile And Grout In Shower Room (\$3,650)	2022	3,551		20	178	178	710	3
4	3 Large Rtus-Replace Filters & Belts,Repair 2 Roof Top Exhaust I	2022	3,245		20	162	162	649	4
5	Patch Attic Leaks, Replace Air Compressor, New Low Air Switch	2022	6,588		20	329	329	1,318	5
6	Replace Air Compressor, Repair 14 Leaks In Attic (\$12,721)	2022	12,376		20	619	619	1,856	6
7	5 Shower Rms - New Tile,Wall Repairs (\$3,650)	2022	3,551		20	178	178	533	7
8	Installed New Kitchen Condensing Unit (\$22,500)	2022	21,890		20	1,095	1,095	3,284	8
9	Replace Broken 4" Cast Iron Drain Line In Kitchen Drain System	2022	7,054		20	353	353	1,058	9
10	Light Fixtures For Parking Lot, New Wall Lights By Reception (\$	2022	7,976		20	399	399	1,196	10
11	Installation Of New Fire Sprinkler Piping (\$4,645)	2022	4,519		20	226	226	678	11
12	Replacement Of Sprinkler System (\$13,840)	2022	13,465		20	673	673	2,020	12
13	Painting Of Therapy Room, Shower Room,East & West Side Corr	2023	9,481		20	474	474	1,422	13
14	Install New Maglock On Kitchen Exit Door (\$2,716)	2023	2,627		20	131	131	394	14
15	Install New Single Ptrap, Drain Pipe In Eyewash Station Of Janito	2023	4,353		20	218	218	653	15
16	Plug Potholes In Parking Lot (\$6,275)	2023	6,070		20	304	304	911	16
17	Repair Cracked Plumbing Vent Seams & Leaking Drain Line In B	2023	2,564		20	128	128	385	17
18	Install Cameras,Alarm System With Mag Locks On All Exit Doors	2023	12,093		20	605	605	1,814	18
19	Installation Of Booster Heater - 6 Gl 45Kw (\$5,089)	2023	4,923		20	246	246	738	19
20	Sprinkler System Replacement (%587,492)	2023	568,340		20	28,417	28,417	85,251	20
21	Replace fan blades and fan motors on Tru (\$3,120)	2023	3,018		20	151	151	453	21
22	Replace 32 outlets and install gang ring and cover plates	2024	5,132		20	257	257	513	22
23	Repair gutters, large roof exhaust fans and kitchen hood repair	2024	3,400		20	170	170	340	23
24	7 LED pole lights and mounts, and 2 horns and installation of 5	2024	5,652		20	283	283	565	24
25	Installation of repair of rear pair doors	2024	2,783		20	139	139	278	25
26	Social Room, MDS, Maintenance and Supervisor office floor repla	2024	6,577		20	329	329	658	26
27	Installation of new equipment New Norton Fire Closer Assy Room	2025	4,189		20	209	209	209	27
28	Replacement Of Sprinkler System and Vic Dry Flex heads	2025	3,194		20	160	160	160	28
29	Repair of Ice machine in nursing station & roof exhaust motor and	2025	2,900		20	145	145	145	29
30	Removal of clinical sinks	2025	3,080		20	154	154	154	30
31	Repair and Installation in the Gazebo	2025	7,950		20	398	398	398	31
32	Flooring and dish room cleaning labor	2025	4,496		20	225	225	225	32
33	Rooftop unit thermostat installation	2025	30,000		20	1,500	1,500	1,500	33
34	TOTAL (lines 1 thru 33)		\$ 6,671,068	\$ 323,393		\$ 224,353	\$ (99,040)	\$ 1,442,404	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		\$ 6,671,068	\$ 323,393		\$ 224,353	\$ (99,040)	\$ 1,442,404	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)		\$ 6,671,068	\$ 323,393		\$ 224,353	\$ (99,040)	\$ 1,442,404	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	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 12C, Carried Forward		\$ 6,671,068	\$ 323,393		\$ 224,353	\$ (99,040)	\$ 1,442,404	1
2									2
3	Buildings:								3
4	Allocated from CF St. Louis, LLC.	2016	4,875	96	35	139	43	1,393	4
5									5
6									6
7	Leasehold Improvements:								7
8	Allocated from CF St. Louis, LLC.	2016	67,569	465	20	3,378	2,913	33,784	8
9	Allocated from CF St. Louis, LLC.	2017	1,568	40	20	78	38	706	9
10	Allocated from CF St. Louis, LLC.	2019	14,215	365	20	711	346	4,975	10
11	Allocated from CF St. Louis, LLC.	2020	748	19	20	37	18	224	11
12	Allocated from CF St. Louis, LLC.	2021	2,654	68	20	133	65	664	12
13	Allocated from CF St. Louis, LLC.	2022	4,388	113	20	219	106	878	13
14	Allocated from CF St. Louis, LLC.	2023	612	16	20	31	15	92	14
15									15
16	Allocated from Legacy HC	2018	81		20	4	4	32	16
17	Allocated from Legacy HC	2020	61		20	3	3	18	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)		\$ 6,767,839	\$ 324,575		\$ 229,087	\$ (95,488)	\$ 1,485,170	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	\$ 1,899,082	\$ 30,833	\$ 189,908	\$ 159,075	10	\$ 1,120,637	71
72	Current Year Purchases	32,757	1,698	3,276	1,578	10	3,276	72
73	Fully Depreciated Assets	2,714				10	2,714	73
74								74
75	TOTALS	\$ 1,934,553	\$ 32,531	\$ 193,183	\$ 160,652		\$ 1,126,626	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,095,297	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 357,106	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 422,271	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 65,165	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,611,797	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 of Elgin
0055046
Moveable Equipment Schedule
01/01/2025
12/31/2025

Company Name	Cost	Current Book Depreciation	Straight Line Depreciation	Accumulate d Straight Line Adjustments Depreciation	
Line 28:					
Prior Years					
Avantara of Elgin	1,054,586	30,748	105,459	74,711	781,925
Larkin Ave Property Holdings LLC	840,000	-	84,000	84,000	336,000
Allocated from Legacy HC	34	-	3	3	10
Allocated from CF St. Louis, LLC	4,462	85	446	361	2,702
Total	1,899,082	30,833	189,908	159,075	1,120,637

Line 29:					
Current Year					
Avantara of Elgin	32,757	1,698	3,276	1,578	3,276
Larkin Ave Property Holdings LLC	-	-	-	-	-
Allocated from Legacy HC	-	-	-	-	-
Allocated from CF St. Louis, LLC	-	-	-	-	-
Total	32,757	1,698	3,276	1,578	3,276

Line 30:					
Fully Depreciated					
Avantara of Elgin	-	-	-	-	-
Larkin Ave Property Holdings LLC	-	-	-	-	-
Allocated from Legacy HC	2,714	-	-	-	2,714
Allocated from CF St. Louis, LLC	-	-	-	-	-
Total	2,714	-	-	-	2,714

Total (Should tie to page 13)					
Avantara of Elgin	1,087,343	32,446	108,734	76,288	785,200
Larkin Ave Property Holdings LLC	840,000	-	84,000	84,000	336,000
Allocated from Legacy HC	2,748	-	3	3	2,724
Allocated from CF St. Louis, LLC	4,462	85	446	361	2,702
Total	1,934,553	32,531	193,183	160,652	1,126,626

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	Offsite Storage				820			5
6	Allocated from Legacy HC				11,286			6
7	TOTAL				\$ 12,106			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: \$ 15,559 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		\$	\$ 930	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 930	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	\$

Supplemental Schedule of Equipment Rental

12/31/2025

	Description	Amount
16A	Copiers	9,969
16B	Air Fresheners	5,460
16C	Allocation from Legacy HC	130
16D		
16E		
16F		
16G		
16 H		
16I		
16J		
		15,559

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	39 - 03	hrs	\$		\$ 236,936	\$		\$ 236,936	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			142,046			142,046	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			256,958			256,958	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				339,324		339,324	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					183,619	145,622		329,241	13
14	TOTAL			\$		\$ 819,559	\$ 484,946		\$ 1,304,505	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	132,568	13U	
13B	Supplies - G-Tube	39-2	3,731	13V	
13C	Oxygen	39-2	9,323	13W	
13D	Supplies - Vent	39-2	-	13X	
13E				13Y	
13F				13Z	
13G					-
13 H					
13I					
13J					
			145,622		
Special Services - Outside (Column 5 - Other)					
13K	Durable Medical Equipment	39-3	101,060		
13L	Oxygen Equipment Rental	39-3	3,724		
13M	Radiology	39-3	20,957		
13N	Laboratory	39-3	38,412		
13O	Therapy Equiment Rental	39-3	19,466		
13P					
13Q					
13R					
13S					
13T			183,619		

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 95,283	\$ 161,324	1
2	Cash-Patient Deposits	300	300	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,602,862	1,602,862	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,868	12,868	6
7	Other Prepaid Expenses	3,537	3,537	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached</u>	162,744	137,307	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,877,594	\$ 1,918,198	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		392,000	13
14	Buildings, at Historical Cost		3,528,000	14
15	Leasehold Improvements, at Historical Cost	2,364,872	2,364,872	15
16	Equipment, at Historical Cost	274,133	1,954,133	16
17	Accumulated Depreciation (book methods)	(1,209,107)	(2,704,953)	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): <u>See Attached</u>	153,537	1,468,268	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,583,435	\$ 7,002,320	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,461,029	\$ 8,920,518	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,313,633	\$ 1,313,633	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,130	27,130	28
29	Short-Term Notes Payable	850,000	850,000	29
30	Accrued Salaries Payable	166,010	166,010	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,898	3,898	31
32	Accrued Real Estate Taxes(Sch.IX-B)		140,811	32
33	Accrued Interest Payable	439	30,476	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached</u>	47,928	52,128	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,409,038	\$ 2,584,086	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,870,771	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached</u>	2,380,746	2,380,746	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,380,746	\$ 8,251,517	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,789,784	\$ 10,835,603	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,328,755)	\$ (1,915,085)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,461,029	\$ 8,920,518	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	10,106.00	10,106.00	36A	Prepaid- Legal Fees	-	-
09B	Exchange	(12,043)	(12,043)	36B	Accrued Accounting Fees	15,907	15,907
09C	Insurance Refund Exchange	(4,812)	(4,812)	36C	Accrued Monthly Assessment Fee	32,461	32,461
09D	Accounts Receivable - Quality Incentive	(187,308)	(187,308)	36D	Union Dues Payable	-	-
09E	C.N.A. Tenure Program	356,801	356,801	36E	Due to/from Medicare	(13,984)	(13,984)
09F	Bad Debt Part A - MMAI	-	-	36F	Due to BCBS - UPP	13,544	13,544
09G	Deferred Rent Receivable		-	36G			-
09H	Accrued R/E Tax Reimb		(140,811)	36H			
09I				36I			
09J				36J			
		162,744	21,933			47,928	47,928
Other Non-Current Assets:		Amount	Amount	Other Non-Current Liabilities		Amount	Amount
23A	Right Of Use Asset	-	-	43A	Due To/From - Avantara Elgin & Management Company	(401,822)	(401,822)
23B	Due To/From - Grove Of St. Charles & Avantara Elgi	128,537	128,537	43B	Due To/From Propco	(1,545,534)	(1,545,534)
23C	Due to/From	25,000	(214,633)	43C	Due To/From Prior Owner	(38,202)	(38,202)
23D	Due to/from HPE		-	43D	Due To/From Members - Entities	(365,000)	(365,000)
23E	Due to/from St Charles Property Holdings		240,721	43E	Accrued Management Fees Entities	(10,188)	(10,188)
23F	Due to/from Cascade Capital Group LLC		(28,437)	43F	Right Of Use Lease Liability	-	-
23G	Due to/from OpCo		1,536,779	43G			
23H	Due to/from Operator		-	43H			
23I	Due to/from Title Company		-	43I			
23J	See next page		(194,699)	43J			
		153,537	1,468,268			(2,360,746)	(2,360,746)

Supplemental Schedule Of Other Assets And Liabilities			As of 12/31/2025				
<u>Other Current Assets</u>		<u>Amount</u>	<u>Amount</u>	<u>Other Current Liabilities</u>		<u>Amount</u>	<u>Amount</u>
09A				36A			
09B				36B			
09C				36C			
09D				36D			
09E				36E			
09F				36F			
09G				36G			
09H				36H			
09I				36I			
09J				36J			
		<u>-</u>	<u>-</u>			<u>-</u>	<u>-</u>
<u>Other Non-Current Assets:</u>		<u>Amount</u>	<u>Amount</u>	<u>Other Non-Current Liabilities</u>		<u>Amount</u>	<u>Amount</u>
23A	Good Faith Deposit		-	43A			
23B	Financing Fees		65,798	43B			
23C	A/A Financing Fee		(10,497)	43C			
23D	Due to Member - Menachem & Ahuva Shabat Descendant		(50,000)	43D			
23E	Due to Member - GPN Family Trust		(50,000)	43E			
23F	Accrued Distributions		(150,000)	43F			
23G				43G			
23H				43H			
23I				43I			
23J				43J			
		<u>-</u>	<u>(194,699)</u>			<u>-</u>	<u>-</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,410,020)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,410,020)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	226,444	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	(145,179)	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)	\$ 81,265	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)	\$ (1,328,755)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 15,513,136	1
2	Discounts and Allowances for all Levels	(5,263,597)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,249,539	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,508,484	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,508,484	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	318,896	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	81,235	19
20	Radiology and X-Ray	17,835	20
21	Other Medical Services	198,836	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 616,802	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,449	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,449	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Quality Incentive</u>	182,567	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 182,567	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,558,841	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,019,550	31
32	Health Care	5,245,960	32
33	General Administration	2,334,692	33
	B. Capital Expense		
34	Ownership	1,162,162	34
	C. Ancillary Expense		
35	Special Cost Centers	1,964,740	35
36	Provider Participation Fee	605,293	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,332,397	40
41	Income before Income Taxes (line 30 minus line 40)**	226,444	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 226,444	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 2,244,304.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	3,510,433.00	45
46	MMAI-Medicaid is the Primary Payer	1,839,713.00	46
47	MMAI-Medicare is the Primary Payer	74,171.00	47
48	Private Pay	1,169,363.00	48
49	Medicare Part A	505,341.00	49
50	Other-(specify) <u>Insurance</u>	906,214.00	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)	\$ 10,249,539	56

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,984	2,260	\$ 178,328	\$ 78.91	1
2	Assistant Director of Nursing	2,000	2,160	101,633	47.05	2
3	Registered Nurses	29,570	34,329	1,521,126	44.31	3
4	Licensed Practical Nurses	10,241	11,678	533,462	45.68	4
5	CNAs & Orderlies	47,635	56,022	1,307,887	23.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,909	6,589	199,421	30.27	8
9	Activity Director	1,992	2,160	63,786	29.53	9
10	Activity Assistants	3,675	3,930	66,466	16.91	10
11	Social Service Workers	3,968	4,328	116,666	26.96	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,569	2,776	89,878	32.38	17
18	Housekeepers					18
19	Laundry	4,044	4,484	79,272	17.68	19
20	Administrator	1,952	2,160	152,640	70.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,959	16,887	429,588	25.44	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	130,498	149,763	\$ 4,840,153 *	\$ 32.32	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	\$ 839,798	01-03	35
36	Medical Director	Monthly	59,700	10-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	7,813	10-03	38
39	Pharmacist Consultant	Monthly	17,654	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	1,547	11-03	44
45	Social Service Consultant	Monthly	4,318	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 930,830		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	9,769	\$ 534,794	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	16,159	377,254	10-03	52
53	TOTAL (lines 50 - 52)	25,928	\$ 912,048		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Avantara of Elgin

0055046

Report Period Beginning: 01/01/2025

Page 21

Ending: 12/31/2025

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership %

Amount

Jessica Avelino

\$ 152,640

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 152,640

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

See Attached

Legal

\$ 6,977

People Powered LLC

23,521

Legacy Healthcare Financial Services

22,919

Propay HR LLC

18,711

HCCI

15,957

Apploi Corp

10,378

Achieve Accreditation LLC

9,346

Onyx Procurement Solutions, LLC

6,400

Aida Healthcare

4,344

Compliagent

2,930

PR Paycor

2,084

See Supplemental Schedule

3,570

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 127,139

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 25,606

Unemployment Compensation Insurance

25,876

FICA Taxes

356,591

Employee Health Insurance

71,049

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

401K Expense

31,665

Voluntary Benefit Contribution

17,301

Employee Physical Exams

9,341

Other Employee Benefits

30,088

TOTAL (agree to Schedule V, line 22, col.8)

\$ 567,517

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

Description

Line #

Amount

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$ 1,990

Advertising: Employee Recruitment

Health Care Worker Background Check

(Indicate # of checks performed 10)

991

Patient Background Checks

280

280

2,802

Association Dues (total from pg 22, #4)

19,488

Other Dues & Subscriptions

5,120

Licenses & Permits

2,227

Allocation from Legacy Healthcare Financial

1,189

Less: Public Relations Expense

()

PAC and Lobbying payments

(9,744)

All non-allowable advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 24,063

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

1,099

Alloction from Legacy HC

599

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 1,698

* Attach copy of IMRF notifications

**See instructions.

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
			\$	Workers' Compensation Insurance		\$	IDPH License Fee	\$
				Unemployment Compensation Insurance			Advertising: Employee Recruitment	
				FICA Taxes			Health Care Worker Background Check	
				Employee Health Insurance			(Indicate # of checks performed)	
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*				
TOTAL (agree to Schedule V, line 17, col. 1)			\$					
(List each licensed administrator separately.)								
B. Administrative - Other								
Description			Amount				Less: Public Relations Expense	()
			\$				PAC and Lobbying payments	()
							All non-allowable advertising	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V,		\$	TOTAL (agree to Sch. V	\$
(Attach a copy of any management service agreement)				line 22, col.8)			line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Personnel Planners			\$ 1,200			\$	Out-of-State Travel	\$
Sogolytics, LLC			670					
Optum			517					
Huron Consulting Group, LLC			504				In-State Travel	
Medical Imaging Specialists Inc			400					
Language Line Services, Inc.			214					
TAP Innovations, LLC			66					
							Seminar Expense	
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V,	
(For legal fee disclosure, see page 39 of instructions)			\$ 3,570				line 24, col. 8)	\$

* Attach copy of IMRF notifications

**See instructions.

AVANTARA OF ELGIN
0055046
Legal Schedule
01/01/2025 - 12/31/2025

Date	G/L Account No.	Payee/Vendor	Type of Service Provided	Amount	Adjustment	Adjusted Amount
1/31/2025	580063	Stone Pogrund & Korey LLC	Collection and Guardianship	95	95	-
2/8/2025	580063	Corporation Service Company	Statutory Representation	104	-	104
2/28/2025	580063	Stone Pogrund & Korey LLC	Collection and Guardianship	55	55	-
3/31/2025	580063	Stone Pogrund & Korey LLC	Collection and Guardianship	303	303	-
4/30/2025	580063	Stone Pogrund & Korey LLC	Collection and Guardianship	105	105	-
5/31/2025	580063	Stone Pogrund & Korey LLC	Collection and Guardianship	50	50	-
6/9/2025	580063	Corporation Service Company	Matter Management	198	-	198
6/10/2025	580063	Meyer Magence	General Counsel	88	-	88
7/1/2025	580063	Meyer Magence	General Counsel	175	-	175
8/25/2025	580063	Law Hesselbaum	Regulatory Compliance	85	-	85
9/27/2024	580063	Neal, Gerber, & Eisenberg LLP	General Counsel	(122)	-	(122)
9/30/2025	580063	Stone Pogrund & Korey LLC	Collection and Guardianship	83	83	-
10/31/2025	580063	Stone Pogrund & Korey LLC	Collection and Guardianship	254	254	-
11/18/2025	580063	Meyer Magence	General Counsel	263	-	263
11/30/2025	580063	Stone Pogrund & Korey LLC	Collection and Guardianship	523	523	-
11/21/2025	580063	Neal, Gerber, & Eisenberg LLP	General Counsel	38	-	38
12/17/2025	580063	Neal, Gerber, & Eisenberg LLP	General Counsel	90	-	90
12/31/2025	580063	Stone Pogrund & Korey LLC	Collection and Guardianship	588	-	588
12/31/2025	580063	CIBC Bank	Retainage fee	1,500	1,500	-
12/31/2025	580063	CIBC Bank	Retainage fee	2,505	2,505	-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
Total				6,977	5,473	1,505

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)	9,744
	9,744 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)	9,744
	9,744 Total
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

HEALTH CARE COUNCIL OF IL (HCCI)	19,488
	19,488 Total
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$	72,215	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.

\$	605,293
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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.

\$		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?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

100% 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?

No

Firm Name:

N/A
- (14) Have all costs which do not relate to the provision of long term care been adjusted out 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.