

Facility Name & ID Number Avanti Wellness & Rehab

0045534 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	212	Skilled (SNF)	212	77,592	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	212	TOTALS	212	77,592	7

B. Census-For the entire report period.

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

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.74%

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

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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 12/01/2001

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

YES Date 12/01/2001 NO

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

YES NO If YES, enter number of beds certified 212 and days of care provided 6,832

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

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

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

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

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

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

Facility Name & ID Number

Avanti Wellness & Rehab

#0045534

Report Period Beginning:

01/01/16

Ending:

12/31/16

V. COST CENTER EXPENSES (continued)

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

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

Facility Name & ID Number Avanti Wellness & Rehab

0045534

Report Period Beginning:

01/01/16

Ending:

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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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(34)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,753	30		9
10	Interest and Other Investment Income	(365)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(848)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(9,885)	21		18
19	Entertainment	(3,498)	21		19
20	Contributions	(4,600)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,000)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,003,253)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,078,730)		\$	30

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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	183,064		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 183,064		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (895,666)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

Avanti Wellness & Rehab

ID# 0045534

Report Period Beginning: 01/01/16

Ending: 12/31/16

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

Avanti Wellness & Rehab

ID# 0045534

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	Total		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Avanti Wellness & Rehab# 0045534

Report Period Beginning:

01/01/16

Ending:

12/31/16**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

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

STATE OF ILLINOIS

Summary B

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

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,753	524,421										528,174	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(58,865)	687,505										628,640	32
33	Real Estate Taxes		567,369										567,369	33
34	Rent-Facility & Grounds		(1,771,671)										(1,771,671)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(3,578)	95,226										91,648	36
37	TOTAL Ownership	(58,690)	102,850										44,160	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(789,178)											(789,178)	43
44	TOTAL Special Cost Centers	(789,178)											(789,178)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,078,730)	184,454	(1,390)									(895,666)	45

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	14 Ambulance	\$ 10,539	Lifeline Ambulance	100.00%	\$ 9,149	\$ (1,390)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 10,539			\$ 9,149	\$ * (1,390)

* 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number

Avanti Wellness & Rehab

0045534

Report Period Beginning:

01/01/16

Ending:

12/31/16

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Avanti Wellness & Rehab

0045534

Report Period Beginning:

01/01/16

Ending:

12/31/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$	1	
2										2	
3										3	
4										4	
5										5	
6										6	
7										7	
8										8	
9										9	
10										10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$	13	

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

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

Facility Name & ID Number Avanti Wellness & Rehab

0045534

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Avanti Wellness & Rehab

0045534

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Lifeline Ambulance
 Street Address 2424 S. Wabash Ave
 City / State / Zip Code Chicago, IL 60616
 Phone Number (312) 949-9595
 Fax Number (312) 949-9262

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	14	Ambulance	Direct Allocation		\$	\$		\$ 9,149	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				\$	\$		\$ 9,149	25

Facility Name & ID Number Avanti Wellness & Rehab

0045534

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Avanti Wellness & Rehab

0045534

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Avanti Wellness & Rehab

0045534

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Avanti Wellness & Rehab

0045534

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Avanti Wellness & Rehab

0045534

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Avanti Wellness & Rehab

0045534

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Avanti Wellness & Rehab

0045534

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Avanti Wellness & Rehab

0045534

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Avanti Wellness & Rehab

0045534

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense
		YES	NO				Original	Balance			
A. Directly Facility Related											
Long-Term											
1	HUD		X	Mortgage			\$	\$ 16,573,152			\$ 687,702
2											
3											
4											
5					-						
Working Capital											
6	Bank of America		X	Line of Credit				2,326,106			100,538
7	Private Bank		X	Loan Payable				550,000			
8	See Supplemental Schedule				-			812,804			
9	TOTAL Facility Related						\$	\$ 20,262,062			\$ 788,240
B. Non-Facility Related*											
10	Interest Income		X								(365)
11	Judy Harris Trust	X									58,500
12	Non Allowable Interest										(58,500)
13	Interest Income - Bldg Co.		X		-						(197)
14	TOTAL Non-Facility Related						\$	\$			\$ (562)
15	TOTALS (line 9+line14)						\$	\$ 20,262,062			\$ 787,678

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

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

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

Facility Name & ID Number

Avanti Wellness & Rehab

0045534

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		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							\$	\$				\$						
2																		
3																		
4																		
5																		
6																		
7	TOTAL Long-Term																	
	Working Capital																	
8	Lincoln		X	Auto Loan			\$	\$ 12,804				\$						
9	Loan Advance		X	Loan Advance				800,000										
10																		
11																		
12																		
13																		
14	TOTAL Working Capital							812,804										
	B. Non-Facility Related*																	
15							\$	\$				\$						
16																		
17																		
18																		
19																		
20	TOTAL Non-Facility Related																	

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

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

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Avanti Wellness & Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0045534

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

Facility Name & ID Number Avanti Wellness & Rehab

0045534

Report Period Beginning:

01/01/16

Ending:

12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and an unlabeled column. Row 1: Facility, 2009, \$2,330,768, 1. Row 2: 2, 2. Row 3: TOTALS, \$2,330,768, 3.

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	212	2009	1964	\$ 9,756,249	\$ 524,421	35	\$ 325,994	\$ (198,427)	\$ 2,369,373	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		2002	258,372		20	10,879	10,879	210,435	9
10	Various		2003	125,406		20	2,489	2,489	110,408	10
11	Various		2004	63,667		20	2,166	2,166	48,664	11
12	Various		2005	70,739		20	1,888	1,888	54,844	12
13	Various		2006	32,275		20	1,253	1,253	25,009	13
14	Various		2007	33,549		20	2,359	2,359	26,014	14
15	Various		2008	34,393		20	2,336	2,336	20,483	15
16	Various		2009	95,565		20	8,102	8,102	63,448	16
17	Various		2010	36,676		20	2,572	2,572	16,599	17
18	Various		2011	48,999		20	4,562	4,562	25,023	18
19	Various		2012	60,727		20	3,600	3,600	16,702	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		3,019,339			152,578	152,578	773,391	67
68								68
69			101,050			(101,050)		69
70		\$ 13,635,956	\$ 625,471		\$ 520,778	\$ (104,693)	\$ 3,760,392	70

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

XI. OWNERSHIP COSTS (continued)

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

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

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

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

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

Facility Name & ID Number Avanti Wellness & Rehab

0045534

Report Period Beginning:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$ 13,665,444	\$ 625,471		\$ 522,508	\$ (102,964)	\$ 3,764,674
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
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23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34		\$ 13,665,444	\$ 625,471		\$ 522,508	\$ (102,964)	\$ 3,764,674

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

Facility Name & ID Number Avanti Wellness & Rehab

0045534

Report Period Beginning:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

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		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34		\$	\$		\$	\$	\$

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

Facility Name & ID Number Avanti Wellness & Rehab

0045534

Report Period Beginning:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 873,860	\$	\$ 96,670	\$ 96,670	10	\$ 752,839	71
72	Current Year Purchases	18,092		1,809	1,809	10	1,809	72
73	Fully Depreciated Assets	794,720				10	794,720	73
74								74
75	TOTALS	\$ 1,686,671	\$	\$ 98,479	\$ 98,479		\$ 1,549,368	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Conversion Van	2007	\$ 7,200	\$	\$	\$	5	\$ 7,200	76
77		Used 2013 Lincoln Auto SD/MKT	2015	32,304		8,238	8,238	5	13,083	77
78										78
79										79
80	TOTALS			\$ 39,504	\$	\$ 8,238	\$ 8,238		\$ 20,283	80

E. Summary of Care-Related Assets

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

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. _____ /2017 \$ _____

13. _____ /2018 \$ _____

14. _____ /2019 \$ _____

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: \$ 25,859 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Ford F-150	\$ 548	\$ 4,382	17
18					18
19					19
20					20
21	TOTAL		\$ 548	\$ 4,382	21

* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost			Units	Cost								
1	Licensed Occupational Therapist	39 - 01	hrs	\$ 533,325											\$ 533,325	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	174,537				17,212							191,749	2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39 - 01	hrs	670,569											670,569	4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39 - 02	# of prescrpts							559,245					559,245	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify): <u>See Supplemental</u>							167,454		160,647					328,101	13
14	TOTAL			\$ 1,378,431				\$ 184,666		\$ 719,892				\$	2,282,989	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Avanti Wellness & Rehab

0045534

Report Period Beginning: 01/01/16

Ending:

12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/16

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 10,381	\$ 24,217	1
2	Cash-Patient Deposits	26,414	26,414	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,260,859	5,260,859	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		55,848	6
7	Other Prepaid Expenses	78,298	2,015	7
8	Accounts Receivable (owners or related parties)	1,549,807	2,894,482	8
9	Other(specify): <u>See Attached Schedule</u>	11,493	386,991	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,937,252	\$ 8,650,826	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		2,330,768	13
14	Buildings, at Historical Cost		9,709,136	14
15	Leasehold Improvements, at Historical Cost	917,139	3,873,051	15
16	Equipment, at Historical Cost	1,226,524	2,774,586	16
17	Accumulated Depreciation (book methods)	(1,857,758)	(7,441,004)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):		(720,985)	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 285,905	\$ 10,525,552	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,223,157	\$ 19,176,378	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,987,100	\$ 2,046,516	26
27	Officer's Accounts Payable	1,312,804	1,312,804	27
28	Accounts Payable-Patient Deposits	29,711	29,711	28
29	Short-Term Notes Payable	2,626,106	2,878,279	29
30	Accrued Salaries Payable	622,235	622,235	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		577,095	32
33	Accrued Interest Payable		59,111	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	2,027,942	2,052,942	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 8,605,898	\$ 9,578,693	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		16,320,979	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 16,320,979	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,605,898	\$ 25,899,672	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,382,741)	\$ (6,723,294)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,223,157	\$ 19,176,378	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (790,986)	1
2	Restatements (describe):		2
3	Depreciation	4,796	3
4	Bad Debts	(125,873)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (912,063)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(470,678)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (470,678)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,382,741)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Avanti Wellness & Rehab

0045534

Report Period Beginning: 01/01/16

Ending: 12/31/16

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

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

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 13,690,438	1
2	Discounts and Allowances for all Levels	(2,610,387)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,080,051	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,203,226	6
7	Oxygen	3,840	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,207,066	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	34	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	435,313	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	60,626	19
20	Radiology and X-Ray		20
21	Other Medical Services	98,274	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 594,247	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	365	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 365	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,829	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,829	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,883,558	30

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

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

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

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

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

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

Facility Name & ID Number **Avanti Wellness & Rehab**

0045534

Report Period Beginning:

01/01/16

Ending:

12/31/16

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,984	2,080	\$ 100,509	\$ 48.32	1
2	Assistant Director of Nursing	1,304	1,648	77,868	47.25	2
3	Registered Nurses	31,572	34,593	1,079,463	31.20	3
4	Licensed Practical Nurses	32,187	35,665	930,376	26.09	4
5	CNAs & Orderlies	86,104	93,904	1,233,518	13.14	5
6	CNA Trainees					6
7	Licensed Therapist	30,631	33,661	1,378,431	40.95	7
8	Rehab/Therapy Aides	8,020	9,002	173,732	19.30	8
9	Activity Director	8,771	9,422	114,869	12.19	9
10	Activity Assistants	10,603	11,409	142,450	12.49	10
11	Social Service Workers	7,444	7,784	178,158	22.89	11
12	Dietician					12
13	Food Service Supervisor	1,832	2,080	59,912	28.80	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,450	24,913	277,107	11.12	15
16	Dishwashers					16
17	Maintenance Workers	2,098	2,526	38,520	15.25	17
18	Housekeepers	18,374	21,039	252,408	12.00	18
19	Laundry	7,081	7,710	73,727	9.56	19
20	Administrator	2,032	2,080	116,493	56.01	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,230	17,652	338,736	19.19	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,749	1,845	22,655	12.28	31
32	Other Health Care(specify)					32
33	Other(specify)	5,857	6,185	698,134	112.88	33
34	TOTAL (lines 1 - 33)	296,323	325,198	\$ 7,287,066 *	\$ 22.41	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	383	\$ 18,025	01-03	35
36	Medical Director	Monthly	24,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	81,212	10-03	38
39	Pharmacist Consultant	359	16,536	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,320	11-03	44
45	Social Service Consultant	29	1,811	12-03	45
46	Other(specify)				46
47	Geriatric Consulting	Monthly	50,040	10-03	47
48	Cardiologist	Visit	350	10-03	48
49	TOTAL (lines 35 - 48)	795	\$ 193,294		49

C. CONTRACT NURSES

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

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		
Amanda Andrews	Administrator	0	\$ 116,493	Workers' Compensation Insurance	\$ 123,713	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	82,652	Advertising: Employee Recruitment			
				FICA Taxes	353,548	Health Care Worker Background Check	16,038		
				Employee Health Insurance	243,686	(Indicate # of checks performed <u>1,604</u>)			
				Employee Meals	103,249	Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Licenses	2,537		
				Other Employee Benefits	63,302	Dues & Subscriptions	5,594		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 116,493						
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
Description			Amount		\$ 970,149	Less: Public Relations Expense	()		
LTC Consulting Services - Management Fees			\$ 176,400			Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 176,400	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	
Marcum	Accounting		\$ 25,970				Out-of-State Travel	\$	
Achieve Accreditation	Survey Consulting		9,778						
Documentation Solutions	HC Consulting		6,253						
Language Line	Interpretation Services		1,200				In-State Travel		
Marilyn Torres	Public Aid Consultant		300						
Metro Infectious Disease	Infectious Disease Consulting		20,000						
Terrill Consulting	MDS Consulting		28,797						
HDSI Health Systems	Payroll Processing		44,573				Seminar Expense	3,821	
Matrixcare	E.H.R		33,360						
eHeath Data Solutions	Risk Management Software		2,130						
Optima Healthcare Solutions	Point of Care		5,369						
See Supplemental Schedule			103,453				Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 281,182	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 3,821

* Attach copy of IMRF notifications

**See instructions.

