		FOR BHF USE					

LL1

2019
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2019)

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: 0054403

Facility Name: Clark Manor Convalescent Center

Address: 7433 N Clark Street (Number) Chicago (City) 60626 (Zip Code)

County: Cook

Telephone Number: (773) 338-8778 **Fax #** (773) 764-7449

HFS ID Number:

Date of Initial License for Current Owners: 8/31/2016

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/19 to 12/31/19 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)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	267	Skilled (SNF)	267	97,455	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	267	TOTALS	267	97,455	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	20,690	56	2,338	23,084	8
9	SNF/PED					9
10	ICF	65,334	2,160	2,595	70,089	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	86,024	2,216	4,933	93,173	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.61%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/31/2016

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/31/2016 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 267 and days of care provided 2,254

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2019 Fiscal Year: 12/31/2019

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

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	137,296	11,515	1,046,776	1,195,587		1,195,587	3,942	1,199,529			1
2	Food Purchase		124,206		124,206		124,206	1,195	125,401			2
3	Housekeeping	75,079	22,403	386,950	484,432		484,432	3,006	487,438			3
4	Laundry	153,671	32,545		186,216		186,216		186,216			4
5	Heat and Other Utilities			361,513	361,513		361,513	(5,256)	356,257			5
6	Maintenance	178,941	29,965	157,290	366,196		366,196	22,990	389,186			6
7	Other (specify):*											7
8	TOTAL General Services	544,987	220,634	1,952,529	2,718,150		2,718,150	25,876	2,744,026			8
	B. Health Care and Programs											
9	Medical Director			64,420	64,420		64,420		64,420			9
10	Nursing and Medical Records	5,095,956	75,946	57,864	5,229,766		5,229,766	76,631	5,306,397			10
10a	Therapy	271,253			271,253		271,253		271,253			10a
11	Activities	338,746	7,662	6,111	352,519		352,519	46	352,565			11
12	Social Services	399,764		5,696	405,460		405,460	6,750	412,210			12
13	CNA Training											13
14	Program Transportation			6,047	6,047		6,047	97	6,144			14
15	Other (specify):* Alloc Related Co Benefits							19,640	19,640			15
16	TOTAL Health Care and Programs	6,105,719	83,608	140,138	6,329,465		6,329,465	103,165	6,432,630			16
	C. General Administration											
17	Administrative	167,666			167,666		167,666	138,700	306,366			17
18	Directors Fees											18
19	Professional Services			123,623	123,623	(45)	123,578	12,764	136,342			19
20	Dues, Fees, Subscriptions & Promotions			108,991	108,991		108,991	(61,631)	47,360			20
21	Clerical & General Office Expenses	476,088	4,039	506,851	986,978		986,978	60,357	1,047,335			21
22	Employee Benefits & Payroll Taxes			1,182,826	1,182,826		1,182,826	(39,009)	1,143,817			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,861	10,861		10,861	3,460	14,321			24
25	Other Admin. Staff Transportation			494	494		494	36,815	37,309			25
26	Insurance-Prop.Liab.Malpractice			266,585	266,585		266,585	24,094	290,679			26
27	Other (specify):*							108,289	108,289			27
28	TOTAL General Administration	643,754	4,039	2,200,231	2,848,024	(45)	2,847,979	283,840	3,131,819			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,294,460	308,281	4,292,898	11,895,639	(45)	11,895,594	412,881	12,308,475			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 Clark Manor Convalescent Center #0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							602,409	602,409			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,998	32,998		32,998	1,074,274	1,107,272			32
33	Real Estate Taxes			312,000	312,000	45	312,045	253,864	565,909			33
34	Rent-Facility & Grounds			2,280,000	2,280,000		2,280,000	(2,279,833)	167			34
35	Rent-Equipment & Vehicles			7,598	7,598		7,598	7,478	15,076			35
36	Other (specify):*			4,589	4,589		4,589	(4,589)				36
37	**TOTAL Ownership**			2,637,185	2,637,185	45	2,637,230	(346,397)	2,290,833			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		310,077	554,486	864,563		864,563		864,563			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			692,392	692,392		692,392		692,392			42
43	Other (specify):*			902,258	902,258		902,258	(902,258)				43
44	**TOTAL Special Cost Centers**		310,077	2,149,136	2,459,213		2,459,213	(902,258)	1,556,955			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,294,460	618,358	9,079,219	16,992,037		16,992,037	(835,774)	16,156,263			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 Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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 Reference	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	(6,971)	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	602,409	30		9
10	Interest and Other Investment Income	(9,510)	32		10
11	Discounts, Allowances, Rebates & Refunds	(3,679)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(30)	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	(10,515)	21		18
19	Entertainment	(5,390)	21		19
20	Contributions	(31,800)	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	(260,683)	21		24
25	Fund Raising, Advertising and Promotional	(11,416)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,841)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,757,680)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,497,106)		$	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)	661,332		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 661,332		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (835,774)		37

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

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

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

Clark Manor Convalescent Center

ID# 0054403

Report Period Beginning: 01/01/19

Ending: 12/31/19

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Personal Items	(3,020)	10	1
2	Bank Charges	(4,210)	21	2
3	Sequestration Expense	(26,545)	21	3
4	Theft & Damages Loss	(178)	21	4
5	Non-Allowable Expense	(902,258)	43	5
6	PAC Dues	(19,091)	20	6
7	Non-Allowable Legal Fees	(21,531)	19	7
8	Non-Allowable Entertainment	(904)	20	8
9	2020 Seminars	(918)	24	9
10	Building Co. - Transfer Tax - Closing Cost	(27,711)	21	10
11	Building Co. - Bank Fees	(10,000)	21	11
12	Building Co. - Filing Fees	(100)	21	12
13	Building Co. - Accounting	(5,345)	19	13
14	Building Co. - Legal Expense	(10,445)	19	14
15	Building Co. - Asset Management Fees	(720,000)	06	15
16	Non-Allowable Expense	(723)	21	16
17	Personal Property Tax	(4,589)	36	17
18	Non-Allowable Expense	(112)	21	18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,757,680)		49

Clark Manor Convalescent Center

ID# 0054403

Report Period Beginning: 01/01/19

Ending: 12/31/19

	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 Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			3,942									3,942	1
2	Food Purchase	(3,709)		4,904									1,195	2
3	Housekeeping			3,006									3,006	3
4	Laundry													4
5	Heat and Other Utilities	(6,971)				1,715							(5,256)	5
6	Maintenance	(720,000)	720,000	21,229		1,760							22,990	6
7	Other (specify):*													7
8	**TOTAL General Services**	(730,680)	720,000	33,081		3,475							25,876	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(3,020)		79,675			(24)						76,631	10
10a	Therapy													10a
11	Activities			46									46	11
12	Social Services			6,750									6,750	12
13	CNA Training													13
14	Program Transportation			97									97	14
15	Other (specify):*				19,640								19,640	15
16	**TOTAL Health Care and Programs**	(3,020)		86,569	19,640		(24)						103,165	16
	C. General Administration													
17	Administrative			138,700									138,700	17
18	Directors Fees													18
19	Professional Services	(37,322)	15,790	44,719		13		(10,437)					12,764	19
20	Fees, Subscriptions & Promotions	(63,211)		1,579		1							(61,631)	20
21	Clerical & General Office Expenses	(348,008)	37,811	370,284		270							60,357	21
22	Employee Benefits & Payroll Taxes				(39,009)								(39,009)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(918)		4,378									3,460	24
25	Other Admin. Staff Transportation			36,815									36,815	25
26	Insurance-Prop.Liab.Malpractice			23,589		505							24,094	26
27	Other (specify):*			108,289									108,289	27
28	**TOTAL General Administration**	(449,458)	53,601	728,354	(39,009)	790		(10,437)					283,840	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,183,158)	773,601	848,004	(19,369)	4,265	(24)	(10,437)					412,881	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 **Report Period Beginning:** 01/01/19 **Ending:** 12/31/19

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	602,409											602,409	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(9,510)	1,076,552			7,232							1,074,274	32
33	Real Estate Taxes		247,272			6,592							253,864	33
34	Rent-Facility & Grounds		(2,280,000)	61,799		(61,632)							(2,279,833)	34
35	Rent-Equipment & Vehicles				7,478								7,478	35
36	Other (specify):*	(4,589)											(4,589)	36
37	**TOTAL Ownership**	588,310	(956,176)	61,799	7,478	(47,809)							(346,397)	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):*	(902,258)											(902,258)	43
44	**TOTAL Special Cost Centers**	(902,258)											(902,258)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,497,106)	(182,575)	909,802	(11,891)	(43,544)	(24)	(10,437)					(835,774)	45

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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. [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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 2,280,000	Rogers Property Holdings, LLC		$	$ (2,280,000)	1
2	V	21	Filing Fees		Rogers Property Holdings, LLC		100	100	2
3	V	19	Accounting		Rogers Property Holdings, LLC		5,345	5,345	3
4	V	06	Asset Management Fees		Rogers Property Holdings, LLC		720,000	720,000	4
5	V	32	Interest - Mortgage		Rogers Property Holdings, LLC		1,056,093	1,056,093	5
6	V	32	Interest - CapEx		Rogers Property Holdings, LLC		20,732	20,732	6
7	V	32	Interest	273	Rogers Property Holdings, LLC			(273)	7
8	V	21	Transfer Tax - Closing Cost		Rogers Property Holdings, LLC		27,711	27,711	8
9	V	21	Bank Fees		Rogers Property Holdings, LLC		10,000	10,000	9
10	V	19	Legal		Rogers Property Holdings, LLC		10,445	10,445	10
11	V	33	Real Estate Tax Expense	312,000	Rogers Property Holdings, LLC		559,272	247,272	11
12	V								12
13	V								13
14	Total			$ 2,592,273			$ 2,409,698	$ * (182,575)	14

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

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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	GPN Family Trust	50.00%	Astoria Place Skilled Nursing Facility LLC	Chicago	Rogers Property Holdings LLC		Building COmpany	1
2	DOROS Generation Trust	50.00%	Avantara Arlington	Arlington, SD	Legacy HC & Financial Services	Lincolnwood	Home Office/Bookkeeping	2
3			Avantara Armour	Armour, SD	CF St. Louis LLC	Skokie	Building Company	3
4			Avantara Arrowhead	Rapid City, SD	ML Group Design & Development	Skokie	Asset Management	4
5			Avantara Billings	Billings, MT	ReMED Services LLC	Lincolnwood	Nursing Equipment	5
6			Avantara Clark	Clark, SD	Propay HR	Evanston	Payroll Processing	6
7			Avantara Elgin	Elgin	Ecobrite Linen	Skokie	Laundry Supplies	7
8			Avantara Evergreen Park	Evergreen Park	Aurora Supportive Living	Aurora	Supportive Living	8
9			Avantara Groton	Groton, SD	Terrace Gardens	Morton Grove	Assisted Living	9
10			Avantara Huron	Huron, SD	Lincolnshire Assisted Living Center	Lincolnshire	Assisted Living	10
11			Avantara Ipswich	Ipswich, SD	Wellshire Park Place	Milbank, SD	Assisted Living	11
12			Avantara Lake Norden	Lake Norden, SD	Wellshire Huron	Huron, SD	Assisted Living	12
13			Avantara Long Grove	Long Grove				13
14			Avantara Milbank	Milbank, SD				14
15			Avantara Mountainview	Rapid City, SD				15
16			Avantara North	Rapid City, SD				16
17			Avantara Norton	Sioux Falls, SD				17
18			Avantara Park Ridge	Park Ridge				18
19			Avantara Pierre	Pierre, SD				19
20			Avantara Redfield	Redfield, SD				20
21			Avantara Salem	Salem, SD				21
22			Avantara St. Cloud	Rapid City, SD				22
23			Avantara Watertown	Watertown, SD				23
24			Bella Terra Streamwood	Streamwood				24
25			Bella Terra Wheeling	Wheeling				25
26			Bethany Terrace	Morton Grove				26
27			Carlton Skilled Nursing Facility LLC	Chicago				27
28			Chalet Skilled Nursing Facility LLC	Chicago				28
29			Elmbrook Skilled Nursing Facility LLC	Elmhurst				29
30			Evanston Skilled Nursing Facility LLC	Evanston				30

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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			Grove at the Lake Skilled Nursing Facility LLC	Zion				1
2			Grove of Berwyn	Berwyn				2
3			Grove of Fox Valley	Aurora				3
4			Grove of St. Charles	St. Charles				4
5			Lagrange Skilled Nursing Facility LLC	Lagrange Park				5
6			Lakefront Skilled Nursing Facility LLC	Chicago				6
7			Lincoln Park Skilled Nursing Facility LLC	Chicago				7
8			Lincolnshire Living & Rehab Center LLC	Lincolnshire				8
9			Northbrook Skilled Nursing Facility LLC	Northbrook				9
10			Peterson Park Associates Limited Partnership	Chicago				10
11			Skokie Skilled Nursing Facility LLC	Skokie				11
12			St. George Skilled Nursing Facility	St. George, UT				12
13			Valley Skilled Nursing Facility	Billings, MT				13
14			Warren Barr Living And Rehab	Chicago				14
15			Warren Barr North Shore	Highland Park				15
16			Warren Barr South Loop	Chicago				16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietician Salary	$	Legacy Healthcare Financial Services		$ 3,768	$ 3,768	15
16	V	01	Dietary Supplies		Legacy Healthcare Financial Services		174	174	16
17	V	02	Food		Legacy Healthcare Financial Services		4,904	4,904	17
18	V	03	Housekeeping		Legacy Healthcare Financial Services		3,006	3,006	18
19	V	06	Maintenance Salary		Legacy Healthcare Financial Services		19,006	19,006	19
20	V	06	Repairs & Maintenance		Legacy Healthcare Financial Services		2,224	2,224	20
21	V	10	Nursing Salary	64,848	Legacy Healthcare Financial Services		138,380	73,532	21
22	V	10	Nurse/Medical Director Consultant		Legacy Healthcare Financial Services		6,065	6,065	22
23	V	10	Medical Supplies		Legacy Healthcare Financial Services		78	78	23
24	V	12	Social Service Salary		Legacy Healthcare Financial Services		6,372	6,372	24
25	V	11	Activities Program		Legacy Healthcare Financial Services		46	46	25
26	V	12	Social Service Consultant		Legacy Healthcare Financial Services		378	378	26
27	V	14	Patient Transportation		Legacy Healthcare Financial Services		97	97	27
28	V	17	COO / Administrative Salary		Legacy Healthcare Financial Services		138,700	138,700	28
29	V	19	Professional Fees		Legacy Healthcare Financial Services		44,719	44,719	29
30	V	20	Dues / Licenses / Permits		Legacy Healthcare Financial Services		1,579	1,579	30
31	V	21	Clerical & General Wages	203,042	Legacy Healthcare Financial Services		552,872	349,830	31
32	V	21	Clerical & Office Expense		Legacy Healthcare Financial Services		20,455	20,455	32
33	V	24	Education & Seminars		Legacy Healthcare Financial Services		4,378	4,378	33
34	V	25	Travel		Legacy Healthcare Financial Services		36,815	36,815	34
35	V	26	Insurance - General		Legacy Healthcare Financial Services		23,589	23,589	35
36	V	27	Non-Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		108,289	108,289	36
37	V	34	Rent		Legacy Healthcare Financial Services		61,632	61,632	37
38	V	34	Offsite Storage / Parking		Legacy Healthcare Financial Services		167	167	38
39	Total			$ 267,891			$ 1,177,693	$ * 909,802	39

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

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Equipment Rental		Legacy Healthcare Financial Services		86	$ 86	15
16	V	35	Auto Rental		Legacy Healthcare Financial Services		7,392	7,392	16
17	V	15	Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		19,640	19,640	17
18	V	22	Employee Benefits	39,009	Legacy Healthcare Financial Services			(39,009)	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			$ 39,009			$ 27,118	$ * (11,891)	39

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

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	CF St. Louis LLC		$ 1,715	$ 1,715	15
16	V	6	Repairs & Maintenance		CF St. Louis LLC		1,760	1,760	16
17	V	19	Professional Fees		CF St. Louis LLC		13	13	17
18	V	20	Dues & Subscriptions		CF St. Louis LLC		1	1	18
19	V	21	Office Expense		CF St. Louis LLC		270	270	19
20	V	26	Insurance		CF St. Louis LLC		505	505	20
21	V	32	Interest Expense		CF St. Louis LLC		7,232	7,232	21
22	V	33	Real Estate Taxes		CF St. Louis LLC		6,592	6,592	22
23	V								23
24	V								24
25	V	34	Rent	61,632	CF St. Louis LLC			(61,632)	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			$ 61,632			$ 18,088	$ * (43,544)	39

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

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Medical Supplies	$ 9,000	ReMED Services LLC		$ 8,976	$ (24)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,000			$ 8,976	$ * (24)	39

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

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Processing	$ 40,469	ProPay HR LLC		$ 30,032	$ (10,437)	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			$ 40,469			$ 30,032	$ * (10,437)	39

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

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.**

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.**

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.**

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.**

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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.

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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 [X]

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

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

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

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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 [X] NO [ ]

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

Name of Related Organization: Legacy Healthcare Financial Services
Street Address: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 679-9797
Fax Number: (847) 683-2900

	1 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	01	Dietician Salary	Available Bed Days	2,157,364	52	$ 83,412	$ 83,412	97,455	$ 3,768	1
2	01	Dietary Supplies	Available Bed Days	2,157,364	52	3,862		97,455	174	2
3	02	Food	Available Bed Days	2,157,364	52	108,556		97,455	4,904	3
4	03	Housekeeping	Available Bed Days	2,157,364	52	66,543		97,455	3,006	4
5	06	Maintenance Salary	Available Bed Days	2,157,364	52	420,731	420,731	97,455	19,006	5
6	06	Repairs & Maintenance	Available Bed Days	2,157,364	52	49,227		97,455	2,224	6
7	10	Nursing Salary	Available Bed Days	2,157,364	52	3,063,332	3,063,332	97,455	138,380	7
8	10	Nurse/Medical Director Consultan	Available Bed Days	2,157,364	52	134,265		97,455	6,065	8
9	10	Medical Supplies	Available Bed Days	2,157,364	52	1,732		97,455	78	9
10	12	Social Service Salary	Available Bed Days	2,157,364	52	141,061	141,061	97,455	6,372	10
11	11	Activities Program	Available Bed Days	2,157,364	52	1,020		97,455	46	11
12	12	Social Service Consultant	Available Bed Days	2,157,364	52	8,366		97,455	378	12
13	14	Patient Transportation	Available Bed Days	2,157,364	52	2,147		97,455	97	13
14	17	COO / Administrative Salary	Available Bed Days	2,157,364	52	3,070,400	3,070,400	97,455	138,700	14
15	19	Professional Fees	Available Bed Days	2,157,364	52	989,949		97,455	44,719	15
16	20	Dues / Licenses / Permits	Available Bed Days	2,157,364	52	34,952		97,455	1,579	16
17	21	Clerical & General Wages	Available Bed Days	2,157,364	52	12,238,949	12,238,949	97,455	552,872	17
18	21	Clerical & Office Expense	Available Bed Days	2,157,364	52	452,802		97,455	20,455	18
19	24	Education & Seminars	Available Bed Days	2,157,364	52	96,921		97,455	4,378	19
20	25	Travel	Available Bed Days	2,157,364	52	814,982		97,455	36,815	20
21	26	Insurance - General	Available Bed Days	2,157,364	52	522,189		97,455	23,589	21
22	27	Non-Nursing Payroll Taxes / Bene	Available Bed Days	2,157,364	52	2,397,200		97,455	108,289	22
23	34	Rent	Available Bed Days	2,157,364	52	1,364,347		97,455	61,632	23
24	34	Offsite Storage / Parking	Available Bed Days	2,157,364	52	3,689		97,455	167	24
25	TOTALS					$ 26,070,633	$ 19,017,885		$ 1,177,693	25

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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 [X] NO [ ]

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

Name of Related Organization: Legacy Healthcare Financial Services
Street Address: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 679-9797
Fax Number: (847) 683-2900

	1 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	35	Equipment Rental	Available Bed Days	2,157,364	52	1,905		97,455	86	1
2	35	Auto Rental	Available Bed Days	2,157,364	52	163,643		97,455	7,392	2
3	15	Nursing Payroll Taxes / Benefits	Available Bed Days	2,157,364	52	434,774		97,455	19,640	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					$ 600,322	$		$ 27,118	25

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Available Bed Days	2,157,364	52	$ 37,960	$	97,455	$ 1,715	1
2	6	Repairs & Maintenance	Available Bed Days	2,157,364	52	38,965		97,455	1,760	2
3	19	Professional Fees	Available Bed Days	2,157,364	52	281		97,455	13	3
4	20	Dues & Subscriptions	Available Bed Days	2,157,364	52	23		97,455	1	4
5	21	Office Expense	Available Bed Days	2,157,364	52	5,978		97,455	270	5
6	26	Insurance	Available Bed Days	2,157,364	52	11,190		97,455	505	6
7	32	Interest Expense	Available Bed Days	2,157,364	52	160,092		97,455	7,232	7
8	33	Real Estate Taxes	Available Bed Days	2,157,364	52	145,917		97,455	6,592	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					$ 400,406	$		$ 18,088	25

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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 [X] NO [ ]

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

Name of Related Organization: ReMED Services LLC
Street Address: 3424 Oakton Street, Suite 102
City / State / Zip Code: Skokie, IL
Phone Number: (847) 440-2600
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	10	Medical Supplies	Direct			$	$		$ 8,976	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					$	$		$ 8,976	25

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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 [X] NO [ ]

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

Name of Related Organization: ProPay HR LLC
Street Address: 2201 W. Main St.
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905 3268
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	19	Payroll Processing	Direct			$	$		$ 30,032	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					$	$		$ 30,032	25

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
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13										13
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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 Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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			$	$ 15,653,333			$ 1,056,093	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CIBC Bank		X	Line of Credit				490,000			32,998	6
7	CIBC Bank		X	Line of Credit				306,228			20,732	7
8	Allocated from CF St. Louis		X								7,232	8
9	TOTAL Facility Related						$	$ 16,449,562			$ 1,117,055	9
	B. Non-Facility Related*											
10	Interest Income		X								(9,510)	10
11	Interest Income - Building Co.		X								(273)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (9,783)	14
15	TOTALS (line 9+line14)						$	$ 16,449,562			$ 1,107,272	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.)

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2018 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 230,046	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.)		$ 391,625	2
3. Under or (over) accrual (line 2 minus line 1).		$ 161,579	3
4. Real Estate Tax accrual used for 2019 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 404,285	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.)		$ 45	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.		$ 565,909	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2014	289,149	8
	2015	295,285	9
	2016	322,748	10
	2017	346,889	11
	2018	385,033	12

2019 Accrual = $385,033 x 1.05 = $404,285

Allocated from CF St. Louis LLC: $6,592

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2018	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2018 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Clark Manor Convalescent Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054403

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2018 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 2018.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-30-411-005-0000	Long Term Care Property	$ 133,334.86	$ 133,334.86
2.	11-30-411-006-0000	Long Term Care Property	$ 133,335.06	$ 133,335.06
3.	11-30-411-007-0000	Long Term Care Property	$ 115,114.11	$ 115,114.11
4.	11-30-411-020-0000	Long Term Care Property	$ 3,249.41	$ 3,249.41
5.	10-23-406-034-0000	Home Office Allocation	$ 480,588.35	$ 6,591.52
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 865,621.79	$ 391,624.96

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? X 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 2018 tax bills which were listed in Section A to this statement. Be sure to use the 2018 tax bill which is normally paid during 2019.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2018 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 2018 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2018.

Please complete the Real Estate Tax Statement below and include it in the 2019 cost report along with a copy of your 2018 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.

2018 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Clark Manor Convalescent Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054403

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2018 tax bills which were listed in Section A to this statement. Be sure to use the 2018 tax bill which is normally paid during 2019.

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

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 49,255 B. General Construction Type: Exterior _____ Frame _____ Number of Stories 5

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. 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 1,700,000	1
2	Allocated from CF St. Louis, LLC			8,915	2
3	TOTALS			$ 1,708,915	3

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	267		2017	1977	$ 16,072,397	$	35	$ 459,211	$ 459,211	$ 1,377,633	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		416,017			19,772	19,772	69,302	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 16,488,414	$		$ 478,983	$ 478,983	$ 1,446,935	70

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

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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		$ 16,488,414	$		$ 478,983	$ 478,983	$ 1,446,935	1
2	Locks, Keypads, And Power Supply	2016	11,168		20	558	558	3,536	2
3	Access Panels And Vinyl Baseboard	2016	18,750		20	938	938	5,626	3
4	Locks, Keypads, And Power Supply	2016	11,168		20	558	558	3,536	4
5	Water Box And Assembly Valve	2016	6,303		20	315	315	1,785	5
6	Wall Patch - 1St Floor Kitchen	2016	5,000		20	250	250	1,416	6
7	Carpet - Hallway & Main Lobby	2016	33,019		20	440	440	9,244	7
8	Carpet - Hallway & Main Lobby	2016	11,220		20	150	150	3,142	8
9	Paint, Drywall Repairs & Wallpaper Insallation In Hallways, Fro	2017	60,391		20	37	37	777	9
10	Repair Leaking Riser	2017	5,172		20	24	24	498	10
11	Flooring/Tiling/Vinyl Base - Floors 1-5 Hallway/Lobby	2017	72,745		20	38	38	800	11
12	Installation Of Door Operator-South Ambulance Entrance	2017	3,637		20	15	15	319	12
13	Kitchen Cooler/Freezer Shelving And Repairs	2017	4,700		20	18	18	370	13
14	Ambulance Entry Door Repairs	2017	4,008		20	15	15	315	14
15	Drywall Repairs, Pipe Foam Insulation	2017	3,750		20	11	11	229	15
16	Duct Work For Dryers	2017	5,868		20	15	15	309	16
17	Installed New Piping And Fittings To Replace The Leaking Water	2017	8,975		20	26	26	550	17
18	Installed Insulation For Copper Lines	2017	2,815		20	8	8	172	18
19	Installation Of 4 New Magnetic Locks On The 4Th Floor	2017	10,359		20	17	17	363	19
20	Installed Two New Grease Interceptors	2017	3,845		20	8	8	168	20
21	Rusted And Leaking Pipes Replacement	2017	5,415		20	14	14	284	21
22	Roofing Work	2017	7,250		20	24	24	508	22
23	Replace Pump Seals & Cupler On Hw Circulating Pump	2017	5,383		20	99	99	2,073	23
24	Boiler #2 Repairs - Ignition Module, Flow Switch, Ignition Cables	2017	5,849		20	117	117	2,457	24
25	Installation Of Gates With Springs	2017	5,750		20	67	67	1,409	25
26	Roof And Wall Retuckpointed	2017	17,500		20	88	88	1,838	26
27	2" Toilet Pipe	2017	2,822		20	14	14	296	27
28	30 Amp Double Pole Outlets	2017	4,900		20	25	25	515	28
29	Roof Repair On Lower Roof Area	2017	9,800		20	49	49	1,029	29
30	Hot Water Mixing Valve	2017	2,700		20	14	14	284	30
31	Repair Water Seepage From Columns/Scaffolding	2017	4,250		20	213	213	638	31
32	Replace Water Pump	2017	3,427		20	171	171	514	32
33	Phone System Installation And Programming ($7,495)	2018	6,937		20	347	347	1,096	33
34	TOTAL (lines 1 thru 33)		$ 16,853,291	$		$ 483,664	$ 483,664	$ 1,493,029	34

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

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 16,853,291	$		$ 483,664	$ 483,664	$ 1,493,029	1
2	Flrs 3,4,5-Conduit,Wiring,Outlets,Fabricated Frames-Drywall ($4	2018	3,934		20	197	197	622	2
3	Installation Of Aluminum Door ($11,900)	2018	11,015		20	551	551	1,543	3
4	Demo/Installation-2Nd Bathroom,Doors,Paint,Plumbing,Lights ($	2018	32,859		20	1,643	1,643	3,286	4
5	Curtains ($2,763)	2018	2,558		20	128	128	256	5
6	Install High Panels On Top Of Over Railings With Gate ($5,678)	2018	5,256		20	263	263	526	6
7	Fire System Installation-Maglock,Keypad,Siren For Outside Gate	2018	3,373		20	169	169	337	7
8	Plumbing Work - Install Rpz Valves ($16,045)	2018	14,851		20	743	743	1,485	8
9	Install Ceiling Heater/Replace Motor Starter Switch ($2,850)	2018	2,638		20	132	132	264	9
10	Water Cooled Chiller - Replace Step Controller ($6,758)	2018	6,255		20	313	313	625	10
11	Elevator Pump Motor Repair ($5,143)	2018	4,760		20	238	238	476	11
12	Installation Of 3 Ton 120,000 Btu Roof Top Unit ($7,239)	2018	6,700		20	335	335	670	12
13	Furnish And Install New Exhaust Fan ($2,688)	2018	2,488		20	124	124	249	13
14	Room Signage ($14368.75)	2019	13,925		20	958	958	958	14
15	Installand Replaced Pipes/Pumps/Air Handler ($2650)	2019	2,568		20	221	221	221	15
16	Repaired Fire Alarm ($3539.24)	2019	3,430		20	324	324	324	16
17	Seal Coating And Restriping/Mill And Pave ($13680)	2019	13,257		20	798	798	798	17
18	Repaired A/C Compressor ($17648.82)	2019	17,103		20	1,030	1,030	1,030	18
19	Install New Pumping Unit For Elevator ($14450)	2019	14,003		20	361	361	361	19
20	Repaired Cooling Coil On Air Conditioners ($4284.56)	2019	4,152		20	143	143	143	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)		$ 17,018,416	$		$ 492,333	$ 492,333	$ 1,507,202	34

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

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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 12C, Carried Forward		$ 17,018,416	$		$ 492,333	$ 492,333	$ 1,507,202	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)		$ 17,018,416	$		$ 492,333	$ 492,333	$ 1,507,202	34

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

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 17,018,416	$		$ 492,333	$ 492,333	$ 1,507,202	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)		$ 17,018,416	$		$ 492,333	$ 492,333	$ 1,507,202	34

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

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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	Allocated from CF St. Louis, LLC	2016	48,004		35	1,372	1,372	5,486	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	298,040		20	14,902	14,902	59,608	9
10	Allocated from CF St. Louis, LLC	2017	6,918		20	346	346	1,038	10
11	Allocated from CF St. Louis, LLC	2019	62,699		20	3,135	3,135	3,135	11
12									12
13	Allocated from Legacy HC	2018	356		20	18	18	36	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)		$ 416,017	$		$ 19,772	$ 19,772	$ 69,302	34

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

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 416,017	$		$ 19,772	$ 19,772	$ 69,302	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		$ 416,017	$		$ 19,772	$ 19,772	$ 69,302	34

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

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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	$ 1,046,114	$	$ 104,485	$ 104,485	10	$ 348,005	71
72	Current Year Purchases	66,573		5,590	5,590	10	5,590	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,112,687	$	$ 110,075	$ 110,075		$ 353,595	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)	$ 19,840,018	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 602,409	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 602,409	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,860,798	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.

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Legacy Healthcare				167			5
6								6
7	TOTAL				$ 167 **			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: *

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.	/2020	$
13.	/2021	$
14.	/2022	$

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: $ 7,382 Description: See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility		$	$ 303	17
18	Allocated from Legacy Healthcare			7,392	18
19					19
20					20
21	TOTAL		$	$ 7,695	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.

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

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	$		$ 159,943	$		$ 159,943	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			141,486			141,486	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			206,487			206,487	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				184,881		184,881	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					46,570	125,196		171,766	13
14	TOTAL			$		$ 554,486	$ 310,077		$ 864,563	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.

STATE OF ILLINOIS

Facility Name & ID Number Clark Manor Convalescent Center # 0054403 Report Period Beginning: 01/01/19 Ending: 12/31/19

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/19 (last day of reporting year)

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	$ 926	$ 61,618	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,151,863	2,151,863	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(181,130)	(181,130)	6
7	Other Prepaid Expenses	81,920	236,515	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	102,594	378,092	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,156,173	$ 2,646,958	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,700,000	13
14	Buildings, at Historical Cost		16,072,397	14
15	Leasehold Improvements, at Historical Cost	489,826	489,826	15
16	Equipment, at Historical Cost	374,632	1,174,632	16
17	Accumulated Depreciation (book methods)	(171,006)	(1,536,441)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	1,059,709	2,865,728	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,753,161	$ 20,766,142	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,909,334	$ 23,413,100	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 628,499	$ 628,500	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	490,000	796,228	29
30	Accrued Salaries Payable	488,735	488,735	30
31	Accrued Taxes Payable (excluding real estate taxes)	24,598	24,598	31
32	Accrued Real Estate Taxes(Sch.IX-B)		404,285	32
33	Accrued Interest Payable		38,000	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	270,388	270,388	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,902,220	$ 2,650,734	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		15,653,333	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	704,017	4,643,239	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 704,017	$ 20,296,572	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,606,237	$ 22,947,306	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,303,097	$ 465,794	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,909,334	$ 23,413,100	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (38,200)	1
2	Restatements (describe):		2
3	Sequestration	(10,048)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (48,248)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,351,345	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)**	$ 1,351,345	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)**	$ 1,303,097	24 *

*** This must agree with page 17, line 47.**

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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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 30,285,459	1
2	Discounts and Allowances for all Levels	(13,461,886)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 16,823,573	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,285,290	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,285,290	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	194,133	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,989	19
20	Radiology and X-Ray		20
21	Other Medical Services	4,208	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 221,330	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,510	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,510	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	3,679	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,679	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 18,343,382	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,718,150	31
32	Health Care	6,329,465	32
33	General Administration	2,848,024	33
	B. Capital Expense		
34	Ownership	2,637,185	34
	C. Ancillary Expense		
35	Special Cost Centers	1,766,821	35
36	Provider Participation Fee	692,392	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,992,037	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,351,345	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,351,345	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 15,490,827	44
45	Private Pay - Net Inpatient Revenue	395,200	45
46	Medicare - Net Inpatient Revenue	467,810	46
47	Other-(specify) Insurance	11,783	47
48	Other-(specify) Veterans	457,953	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 16,823,573	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.**

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,952	2,220	$ 116,268	$ 52.37	1
2	Assistant Director of Nursing	2,032	2,120	91,383	43.11	2
3	Registered Nurses	37,652	43,529	1,561,706	35.88	3
4	Licensed Practical Nurses	41,544	48,806	1,463,262	29.98	4
5	CNAs & Orderlies	121,298	135,973	1,804,110	13.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,791	14,026	271,253	19.34	8
9	Activity Director	1,923	1,995	39,866	19.98	9
10	Activity Assistants	21,454	23,362	298,880	12.79	10
11	Social Service Workers	12,471	13,230	295,512	22.34	11
12	Dietician	455	479	12,737	26.59	12
13	Food Service Supervisor	924	951	21,972	23.10	13
14	Head Cook	723	851	12,442	14.62	14
15	Cook Helpers/Assistants	6,382	6,940	90,145	12.99	15
16	Dishwashers					16
17	Maintenance Workers	7,407	8,125	178,941	22.02	17
18	Housekeepers	5,800	6,879	75,079	10.91	18
19	Laundry	10,664	11,901	153,671	12.91	19
20	Administrator	2,048	2,160	137,006	63.43	20
21	Assistant Administrator	598	696	30,660	44.05	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	26,681	28,900	476,088	16.47	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	1,864	2,070	34,603	16.72	31
32	Other Health Care(specify)					32
33	Other(specify)	8,846	9,779	128,876	13.18	33
34	TOTAL (lines 1 - 33)	325,509	364,992	$ 7,294,460 *	$ 19.99	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 1,046,776	01-03	35
36	Medical Director	Monthly	64,420	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	55,782	10-03	38
39	Pharmacist Consultant	Monthly	2,082	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	6,111	11-03	44
45	Social Service Consultant	Monthly	4,946	12-03	45
46	Other(specify) Clergy	Monthly	750	12-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 1,180,867		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michael Kaplan	Administrator	0	$ 96,818
Robert Freitag	Administrator	0	40,188
Lily Osei	Assistant Admin.	0	30,660
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 167,666

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
Marcum LLP	Accounting Fees	$ 26,117
ProPay HR LLC	Payroll Processing	40,469
Telemedicine	Telecommunication Service	3,481
Achieve Accreditation	Accreditation Services	6,562
IIT/Sourcetech	Data Processing	300
MTS Consulting	Tax Consultant	5,537
Personnel Planners	Unemployment Consultant	1,635
Compliagent	Compliance	4,322
PSD Solutions	Cloud Computing	502
2401 Inc.	Architect Fees	2,600
Moshe Calamaro & Associates	Structural Engineers	3,038
See Supplemental Schedule		29,061
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 123,624

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 176,494
Unemployment Compensation Insurance	51,126
FICA Taxes	526,051
Employee Health Insurance	313,818
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	16,963
401K Expense	31,056
Voluntary Benefit Contributions	8,689
Employee Physical Exams	19,620
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,143,817

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	$ 2,080
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 204)	2,049
Patient Background Checks 625	6,247
Dues & Subscriptions	29,932
Licenses & Permits	5,472
Allocated from Legacy Healthcare	
Allocated from CF St. Louis	
See Supplemental Schedule	1,580
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 47,360

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	9,943
See Supplemental Schedule	4,378
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,321

* Attach copy of IMRF notifications

**See instructions.

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI - $38,181**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **36,412** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **692,392**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

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

(15) 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. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **N/A**

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.