FOR BHF USE

LL1

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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0054403

Facility Name: Clark Skilled Nursing Facility

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
			"Sub-S" Corp.		
		X	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 01/01/17 to 12/31/17 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 Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	17,961	29	4,903	22,893	8
9	SNF/PED					9
10	ICF	56,716	1,123	2,433	60,272	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	74,677	1,152	7,336	83,165	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.34%

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 4,825

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Clark Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	505,447	42,567	35,179	583,193		583,193		583,193			1
2	Food Purchase		506,926		506,926		506,926	(7,946)	498,980			2
3	Housekeeping	285,973	53,662	52,955	392,590		392,590	355	392,945			3
4	Laundry	168,431	17,027		185,458		185,458	9	185,467			4
5	Heat and Other Utilities			280,081	280,081		280,081	737	280,818			5
6	Maintenance	122,517	43,929	149,812	316,258		316,258	97,397	413,655			6
7	Other (specify):*											7
8	TOTAL General Services	1,082,368	664,111	518,027	2,264,506		2,264,506	90,552	2,355,058			8
	B. Health Care and Programs											
9	Medical Director			69,717	69,717		69,717	1,089	70,806			9
10	Nursing and Medical Records	4,611,740	62,750	205,235	4,879,725		4,879,725	152,993	5,032,718			10
10a	Therapy	213,175			213,175		213,175		213,175			10a
11	Activities	328,282	8,907	4,372	341,561		341,561	8,278	349,839			11
12	Social Services	310,280		11,105	321,385		321,385	2,973	324,358			12
13	CNA Training											13
14	Program Transportation			8,274	8,274		8,274		8,274			14
15	Other (specify):*							28,409	28,409			15
16	TOTAL Health Care and Programs	5,463,477	71,657	298,703	5,833,837		5,833,837	193,742	6,027,579			16
	C. General Administration											
17	Administrative	225,538			225,538		225,538	284,653	510,191			17
18	Directors Fees											18
19	Professional Services			175,262	175,262	(381)	174,881	(35,148)	139,733			19
20	Dues, Fees, Subscriptions & Promotions			89,206	89,206		89,206	(46,260)	42,946			20
21	Clerical & General Office Expenses	306,212	8,998	611,350	926,560		926,560	(103,568)	822,992			21
22	Employee Benefits & Payroll Taxes			1,213,749	1,213,749		1,213,749	(9,975)	1,203,774			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,523	3,523		3,523	3,283	6,806			24
25	Other Admin. Staff Transportation			1,068	1,068		1,068		1,068			25
26	Insurance-Prop.Liab.Malpractice			424,663	424,663		424,663	6,053	430,716			26
27	Other (specify):*							119,140	119,140			27
28	TOTAL General Administration	531,750	8,998	2,518,821	3,059,569	(381)	3,059,188	218,178	3,277,367			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,077,595	744,766	3,335,551	11,157,912	(381)	11,157,531	502,473	11,660,005			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 Skilled Nursing Facility #0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			66,727	66,727		66,727	552,950	619,677			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			137,189	137,189		137,189	932,587	1,069,776			32
33	Real Estate Taxes			312,000	312,000	381	312,381	7,664	320,045			33
34	Rent-Facility & Grounds			2,260,975	2,260,975		2,260,975	(2,259,735)	1,240			34
35	Rent-Equipment & Vehicles			8,199	8,199		8,199	7,538	15,737			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,785,090	2,785,090	381	2,785,471	(758,997)	2,026,474			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		379,028	643,671	1,022,699		1,022,699		1,022,699			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			598,360	598,360		598,360		598,360			42
43	Other (specify):*			801,022	801,022		801,022	(801,022)	(0)			43
44	**TOTAL Special Cost Centers**		379,028	2,043,053	2,422,081		2,422,081	(801,022)	1,621,059			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,077,595	1,123,794	8,163,694	16,365,083		16,365,083	(1,057,546)	15,307,537			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 Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,333)	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	551,576	30		9
10	Interest and Other Investment Income	(17,767)	32		10
11	Discounts, Allowances, Rebates & Refunds	(7,987)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(70)	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	(4,742)	21		18
19	Entertainment	(1,984)	21		19
20	Contributions	(15,475)	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	(346,879)	21		24
25	Fund Raising, Advertising and Promotional	(12,783)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,900,382)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,757,826)		$	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)	700,281		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 700,281		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,057,545)		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 Skilled Nursing Facility

ID# 0054403

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Personal Items	$ (7,544)	10	1
2	Bank Charges	(5,427)	21	2
3	Sequestration Expense	(47,950)	21	3
4	Pharmacy Discount	(6,087)	10	4
5	Non Allowable Expense	(801,022)	43	5
6	Additional R&M	23,035	06	6
7	Capitalized R&M	(7,677)	06	7
8	Bldg Co - Filing Fees	(282)	21	8
9	Bldg Co - Accounting	(918)	19	9
10	Bldg Co - Asset Management Fees	(969,996)	06	10
11	Miscellaneous Income	(3,011)	21	11
12	PAC Dues	(19,758)	20	12
13	Non Allowable Legal	(53,745)	19	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,900,382)		49

Clark Skilled Nursing Facility

ID# 0054403

Report Period Beginning: 01/01/17

Ending: 12/31/17

	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 Skilled Nursing Facility **#** 0054403 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(8,057)		80	31								(7,946)	2
3	Housekeeping			355									355	3
4	Laundry			9									9	4
5	Heat and Other Utilities	(1,333)				2,070							737	5
6	Maintenance	(954,638)	969,996	4,791	74,631	2,617							97,397	6
7	Other (specify):*													7
8	**TOTAL General Services**	(964,028)	969,996	5,236	74,662	4,686							90,552	8
	B. Health Care and Programs													
9	Medical Director			1,089									1,089	9
10	Nursing and Medical Records	(13,631)		67	167,077		(520)						152,993	10
10a	Therapy													10a
11	Activities			8,247	31								8,278	11
12	Social Services			130	2,843								2,973	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				28,409								28,409	15
16	**TOTAL Health Care and Programs**	(13,631)		9,534	198,359		(520)						193,742	16
	C. General Administration													
17	Administrative			37,487	247,166								284,653	17
18	Directors Fees													18
19	Professional Services	(54,663)	918	25,468	624	520		(8,015)					(35,148)	19
20	Fees, Subscriptions & Promotions	(48,016)		1,448	304	4							(46,260)	20
21	Clerical & General Office Expenses	(410,275)	282	297,402	9,021	2							(103,568)	21
22	Employee Benefits & Payroll Taxes				(9,975)								(9,975)	22
23	Inservice Training & Education													23
24	Travel and Seminar			1,914	1,369								3,283	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			1,605	3,911	536							6,053	26
27	Other (specify):*			61,025	58,115								119,140	27
28	**TOTAL General Administration**	(512,954)	1,200	426,350	310,536	1,062		(8,015)					218,178	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,490,613)	971,196	441,120	583,557	5,748	(520)	(8,015)					502,473	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Clark Skilled Nursing Facility **#** 0054403 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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	551,576			1,374								552,950	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(17,767)	940,972	31		9,351							932,587	32
33	Real Estate Taxes					7,664							7,664	33
34	Rent-Facility & Grounds		(2,259,996)	74,207	106	(74,053)							(2,259,735)	34
35	Rent-Equipment & Vehicles			5,434	2,104								7,538	35
36	Other (specify):*													36
37	**TOTAL Ownership**	533,809	(1,319,024)	79,672	3,584	(57,038)							(758,997)	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):*	(801,022)											(801,022)	43
44	**TOTAL Special Cost Centers**	(801,022)											(801,022)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,757,826)	(347,828)	520,792	587,141	(51,289)	(520)	(8,015)					(1,057,546)	45

Facility Name & ID Number Clark Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 2,259,996	Rogers Property Holdings, LLC	100.00%	$	$ (2,259,996)	1
2	V	21	Filing Fees		Rogers Property Holdings, LLC	100.00%	282	282	2
3	V	19	Accounting		Rogers Property Holdings, LLC	100.00%	918	918	3
4	V	06	Asset Management Fees		Rogers Property Holdings, LLC	100.00%	969,996	969,996	4
5	V	32	Interest - Mortgage		Rogers Property Holdings, LLC	100.00%	924,597	924,597	5
6	V	32	Interest - CapEx		Rogers Property Holdings, LLC	100.00%	16,375	16,375	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,259,996			$ 1,912,168	$ * (347,828)	14

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

Facility Name & ID Number Clark Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	2	FOOD	$	Legacy Healthcare Financial Services	100.00%	$ 80	$ 80	15
16	V	3	HOUSEKEEPING SUPPLIES		Legacy Healthcare Financial Services	100.00%	355	355	16
17	V	4	LINEN REPLACEMENT		Legacy Healthcare Financial Services	100.00%	9	9	17
18	V	6	UTILITIES		Legacy Healthcare Financial Services	100.00%	20	20	18
19	V	6	GROUNDS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	4,771	4,771	19
20	V	9	MEDICAL DIRECTOR CONSULTANT		Legacy Healthcare Financial Services	100.00%	1,089	1,089	20
21	V	10	MEDICAL SUPPLIES		Legacy Healthcare Financial Services	100.00%	67	67	21
22	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services	100.00%	8,247	8,247	22
23	V	12	SOCIAL SERVICE CONSULTANT		Legacy Healthcare Financial Services	100.00%	130	130	23
24	V	17	ADMINISTRATIVE SALARY		Legacy Healthcare Financial Services	100.00%	37,487	37,487	24
25	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	25,468	25,468	25
26	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	1,448	1,448	26
27	V	21	CLERICAL & GENERAL WAGES		Legacy Healthcare Financial Services	100.00%	289,405	289,405	27
28	V	21	CLERICAL & GENERAL OTHER COSTS		Legacy Healthcare Financial Services	100.00%	7,998	7,998	28
29	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	1,914	1,914	29
30	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	1,605	1,605	30
31	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	61,025	61,025	31
32	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	31	31	32
33	V	34	RENT		Legacy Healthcare Financial Services	100.00%	74,053	74,053	33
34	V	34	STORAGE		Legacy Healthcare Financial Services	100.00%	155	155	34
35	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services	100.00%	38	38	35
36	V	35	AUTO RENTAL		Legacy Healthcare Financial Services	100.00%	5,396	5,396	36
37	V								37
38	V								38
39	Total			$			$ 520,792	$ * 520,792	39

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

Facility Name & ID Number Clark Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	2	FOOD	$	Progressive Healthcare Consulting	100.00%	$ 31	$ 31	15
16	V	6	MAINTENANCE SALARY		Progressive Healthcare Consulting	100.00%	74,409	74,409	16
17	V	6	BUILDING MAINTENANCE AND R&M		Progressive Healthcare Consulting	100.00%	222	222	17
18	V	10	NURSING SALARIES		Progressive Healthcare Consulting	100.00%	182,807	182,807	18
19	V	11	ACTIVITIES PROGRAM		Progressive Healthcare Consulting	100.00%	31	31	19
20	V	12	CLERGY CONSULTANT		Progressive Healthcare Consulting	100.00%	2,836	2,836	20
21	V	12	SOCIAL SERVICE		Progressive Healthcare Consulting	100.00%	7	7	21
22	V	15	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	28,409	28,409	22
23	V	17	ADMIN SALARY- NON OWNER		Progressive Healthcare Consulting	100.00%	247,166	247,166	23
24	V	19	PROFESSIONAL FEES		Progressive Healthcare Consulting	100.00%	624	624	24
25	V	20	DUES, SUBSCRIPTIONS, LICENSES		Progressive Healthcare Consulting	100.00%	304	304	25
26	V	21	CLERICAL WAGES		Progressive Healthcare Consulting	100.00%	52,386	52,386	26
27	V	21	CLERICAL & GENERAL - OTHER		Progressive Healthcare Consulting	100.00%	559	559	27
28	V	24	SEMINARS		Progressive Healthcare Consulting	100.00%	1,369	1,369	28
29	V	27	EMP. BEN.-NON-NURSING		Progressive Healthcare Consulting	100.00%	58,115	58,115	29
30	V	26	INSURANCE		Progressive Healthcare Consulting	100.00%	3,911	3,911	30
31	V	30	DEPRECIATION		Progressive Healthcare Consulting	100.00%	1,374	1,374	31
32	V	34	STORAGE RENTAL		Progressive Healthcare Consulting	100.00%	106	106	32
33	V	35	AUTO RENTAL		Progressive Healthcare Consulting	100.00%	2,104	2,104	33
34	V								34
35	V	10	REIMB SALARIES - PROF CARE	15,730	Progressive Healthcare Consulting	100.00%		(15,730)	35
36	V	21	REIMB SALARIES - ADMINISTRATIVE	43,924	Progressive Healthcare Consulting	100.00%		(43,924)	36
37	V	22	REIMBURSED PAYROLL TAXES	9,975	Progressive Healthcare Consulting	100.00%		(9,975)	37
38	V								38
39	Total			$ 69,629			$ 656,770	$ * 587,141	39

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

Facility Name & ID Number Clark Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	100.00%	$ 2,070	$ 2,070	15
16	V	6	REPAIRS & MAINTENANCE		CF ST. LOUIS, LLC	100.00%	2,617	2,617	16
17	V	19	PROFESSIONAL FEES		CF ST. LOUIS, LLC	100.00%	520	520	17
18	V	20	DUES & SUBSCRIPTIONS		CF ST. LOUIS, LLC	100.00%	4	4	18
19	V	21	OFFICE EXPENSE		CF ST. LOUIS, LLC	100.00%	2	2	19
20	V	26	INSURANCE		CF ST. LOUIS, LLC	100.00%	536	536	20
21	V	32	INTEREST EXPENSE		CF ST. LOUIS, LLC	100.00%	9,351	9,351	21
22	V	33	REAL ESTATE TAXES		CF ST. LOUIS, LLC	100.00%	7,664	7,664	22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	74,053	CF ST. LOUIS, LLC	100.00%		(74,053)	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			$ 74,053			$ 22,764	$ * (51,289)	39

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

Facility Name & ID Number Clark Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 12,778	ReMED Services		$ 12,258	$ (520)	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			$ 12,778			$ 12,258	$ * (520)	39

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

Facility Name & ID Number Clark Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Services	$ 33,395	ProPay HR, LLC	24.00%	$ 25,380	$ (8,015)	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			$ 33,395			$ 25,380	$ * (8,015)	39

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

Facility Name & ID Number Clark Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	AURORA SUPPORTIVE LIVING	AURORA	SUPPORTIVE LIVING	1
2	DOROS GENERATION TRUST	50.00%	AVANTARA LONG GROVE	LONG GROVE	TERRACE GARDENS	MORTON GROVE	ASSISTED LIVING	2
3			AVANTARA PARK RIDGE	PARK RIDGE	LINCOLNSHIRE ASSISTED LIVI	LINCOLNSHIRE	ASSISTED LIVING	3
4			AZRIA MIDTOWN	OMAHA, NE	LEGACY HC & FINANCIAL SER	LINCOLNWOOD	HOME OFFICE/BKPG	4
5			AZRIA MONTCLAIR	OMAHA, NE	PROGRESSIVE HC	LINCOLNWOOD	NURSE CONSULTANT	5
6			AZRIA OLATHE	OLATHE, KS	ML GROUP DESIGN & DEV	SKOKIE	ASSET MANAGEMENT	6
7			BETHANY TERRACE	MORTON GROVE	REMED SERVICES LLC	LINCOLNWOOD	NURSING EQUIPMENT	7
8			CARLTON SKILLED NURSING FACILITY LLC	CHICAGO	PROPAY HR LLC	EVANSTON	PAYROLL PROCESSING	8
9			CEDAR SKILLED NURSING FACILITY	CEDAR CITY, UT	CF ST. LOUIS LLC	SKOKIE	BUILDING CO	9
10			CHALET SKILLED NURSING FACILITY LLC	CHICAGO	ROGERS PROPERTY HOLDINGS, LLC		BUILDING CO	10
11			ELMBROOK SKILLED NURSING FACILITY LLC	ELMHURST				11
12			EVANSTON SKILLED NURSING FACILITY LLC	EVANSTON				12
13			GROVE AT THE LAKE SKILLED NURSING FACILITY LLC	ZION				13
14			GROVE OF FOX VALLEY	AURORA				14
15			LAGRANGE SKILLED NURSING FACILITY LLC	LAGRANGE PARK				15
16			LAKEFRONT SKILLED NURSING FACILITY LLC	CHICAGO				16
17			LINCOLN PARK SKILLED NURSING FACILITY LLC	CHICAGO				17
18			LINCOLNSHIRE LIVING & REHAB CENTER LLC	LINCOLNSHIRE				18
19			NORTHBROOK SKILLED NURSING FACILITY LLC	NORTHBROOK				19
20			PARKER SKILLED NURSING FACILITY LLC	PARKER, CO				20
21			PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO				21
22			SKOKIE SKILLED NURSING FACILITY LLC	SKOKIE				22
23			ST. GEORGE SKILLED NURSING FACILITY	ST. GEORGE, UT				23
24			WARREN BARR LIVING AND REHAB	CHICAGO				24
25			WARREN BARR NORTH SHORE	HIGHLAND PARK				25
26			WARREN BARR SOUTH LOOP	CHICAGO				26
27								27
28								28
29								29
30								30

Facility Name & ID Number Clark Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

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

Facility Name & ID Number Clark Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	2	FOOD	AVAIL. BED DAYS	1,789,215	30	$ 1,460	$	97,455	$ 80	1
2	3	HOUSEKEEPING SUPPLIES	AVAIL. BED DAYS	1,789,215	30	6,519		97,455	355	2
3	4	LINEN REPLACEMENT	AVAIL. BED DAYS	1,789,215	30	171		97,455	9	3
4	6	UTILITIES	AVAIL. BED DAYS	1,789,215	30	372		97,455	20	4
5	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	1,789,215	30	87,596		97,455	4,771	5
6	9	MEDICAL DIRECTOR CONSU	AVAIL. BED DAYS	1,789,215	30	20,000		97,455	1,089	6
7	10	MEDICAL SUPPLIES	AVAIL. BED DAYS	1,789,215	30	1,237		97,455	67	7
8	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,789,215	30	151,405		97,455	8,247	8
9	12	SOCIAL SERVICE CONSULTA	AVAIL. BED DAYS	1,789,215	30	2,392		97,455	130	9
10	17	ADMINISTRATIVE SALARY	AVAIL. BED DAYS	1,789,215	30	688,242	688,242	97,455	37,487	10
11	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,789,215	30	467,580		97,455	25,468	11
12	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,789,215	30	26,590		97,455	1,448	12
13	21	CLERICAL & GENERAL WAG	AVAIL. BED DAYS	1,789,215	30	5,313,296	5,313,296	97,455	289,405	13
14	21	CLERICAL & GENERAL OTH	AVAIL. BED DAYS	1,789,215	30	146,833		97,455	7,998	14
15	24	SEMINARS	AVAIL. BED DAYS	1,789,215	30	35,138		97,455	1,914	15
16	26	INSURANCE	AVAIL. BED DAYS	1,789,215	30	29,475		97,455	1,605	16
17	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	1,789,215	30	1,120,380		97,455	61,025	17
18	32	INTEREST	AVAIL. BED DAYS	1,789,215	30	561		97,455	31	18
19	34	RENT	AVAIL. BED DAYS	1,789,215	30	1,359,562		97,455	74,053	19
20	34	STORAGE	AVAIL. BED DAYS	1,789,215	30	2,842		97,455	155	20
21	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,789,215	30	694		97,455	38	21
22	35	AUTO RENTAL	AVAIL. BED DAYS	1,789,215	30	99,069		97,455	5,396	22
23										23
24										24
25	TOTALS					$ 9,561,416	$ 6,001,539		$ 520,792	25

Facility Name & ID Number Clark Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: Progressive Healthcare Consulting
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	2	FOOD	AVAIL. BED DAYS	1,374,590	21	$ 432	$	97,455	$ 31	1
2	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,374,590	21	1,049,531	1,049,531	97,455	74,409	2
3	6	BUILDING MAINTENANCE AI	AVAIL. BED DAYS	1,374,590	21	3,133		97,455	222	3
4	10	NURSING SALARIES	AVAIL. BED DAYS	1,374,590	21	2,578,462	2,578,462	97,455	182,807	4
5	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,374,590	21	443		97,455	31	5
6	12	CLERGY CONSULTANT	AVAIL. BED DAYS	1,374,590	21	39,998		97,455	2,836	6
7	12	SOCIAL SERVICE	AVAIL. BED DAYS	1,374,590	21	95		97,455	7	7
8	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,374,590	21	400,703		97,455	28,409	8
9	17	ADMIN SALARY- NON OWNE	AVAIL. BED DAYS	1,374,590	21	3,486,246	3,486,246	97,455	247,166	9
10	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,374,590	21	8,800		97,455	624	10
11	20	DUES, SUBSCRIPTIONS, LICE	AVAIL. BED DAYS	1,374,590	21	4,293		97,455	304	11
12	21	CLERICAL WAGES	AVAIL. BED DAYS	1,374,590	21	738,904	738,904	97,455	52,386	12
13	21	CLERICAL & GENERAL - OTI	AVAIL. BED DAYS	1,374,590	21	7,880		97,455	559	13
14	24	SEMINARS	AVAIL. BED DAYS	1,374,590	21	19,314		97,455	1,369	14
15	27	EMP. BEN.-NON-NURSING	AVAIL. BED DAYS	1,374,590	21	819,705		97,455	58,115	15
16	26	INSURANCE	AVAIL. BED DAYS	1,374,590	21	55,168		97,455	3,911	16
17	30	DEPRECIATION	AVAIL. BED DAYS	1,374,590	21	19,384		97,455	1,374	17
18	34	STORAGE RENTAL	AVAIL. BED DAYS	1,374,590	21	1,500		97,455	106	18
19	35	AUTO RENTAL	AVAIL. BED DAYS	1,374,590	21	29,674		97,455	2,104	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 9,263,664	$ 7,853,142		$ 656,770	25

Facility Name & ID Number Clark Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	AVAIL. BED DAYS	1,789,215	30	$ 37,998	$	97,455	$ 2,070	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,789,215	30	48,042		97,455	2,617	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,789,215	30	9,551		97,455	520	3
4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,789,215	30	76		97,455	4	4
5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,789,215	30	32		97,455	2	5
6	26	INSURANCE	AVAIL. BED DAYS	1,789,215	30	9,839		97,455	536	6
7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,789,215	30	171,679		97,455	9,351	7
8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,789,215	30	140,710		97,455	7,664	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					$ 417,927	$		$ 22,764	25

Facility Name & ID Number Clark Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			$	$		$ 12,258	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					$	$		$ 12,258	25

Facility Name & ID Number Clark Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Services	Direct			$	$		$ 25,380	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					$	$		$ 25,380	25

Facility Name & ID Number Clark Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Private Bank		X	Mortgage			$	$ 16,293,333			$ 924,597	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Private Bank		X	Line of Credit							137,189	6
7	CapEx		X	Line of Credit				320,565			16,375	7
8												8
9	TOTAL Facility Related						$	$ 16,613,898			$ 1,078,161	9
	B. Non-Facility Related*											
10	Interest Income		X								(17,767)	10
11	Allocated from Legacy Healthca	X									31	11
12	Allocated from CF St. Louis	X									9,351	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (8,385)	14
15	TOTALS (line 9+line14)						$	$ 16,613,898			$ 1,069,776	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 Skilled Nursing Facility **#** 0054403 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 279,678	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.)		$ 330,412	2
3. Under or (over) accrual (line 2 minus line 1).		$ 50,734	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 268,930	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.)**		$ 381	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.		$ 320,045	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	334,059	8
	2013	310,228	9
	2014	289,149	10
	2015	295,285	11
	2016	322,748	12

2017 Accrual = $322,748 x .83 = $268,930

Allocated from CF St. Louis $7,664

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Clark Skilled Nursing Facility COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054403

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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 2016 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 2016.

	(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	$ 111,644.70	$ 111,644.70
2.	11-30-411-006-0000	Long Term Care Property	$ 111,644.91	$ 111,644.91
3.	11-30-411-007-0000	Long Term Care Property	$ 96,458.79	$ 96,458.79
4.	11-30-411-020-0000	Long Term Care Property	$ 2,999.76	$ 2,999.76
5.			$	$
6.	10-23-406-034-0000	Allocated from Home Office	$ 463,439.48	$ 7,664.20
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 786,187.64	$ 330,412.36

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 2016 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 2016 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2016.

Please complete the Real Estate Tax Statement below and include it in the 2017 cost report along with a copy of your 2016 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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Clark Skilled Nursing Facility COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054403

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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 2016 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 2016.

	(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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			35,404	2
3	TOTALS			$ 1,735,404	3

Facility Name & ID Number Clark Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 459,211	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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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 Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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
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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)		425,588			20,039	20,039	39,661	68
69	Financial Statement Depreciation			66,727			(66,727)		69
70	TOTAL (lines 4 thru 69)		$ 16,497,985	$ 66,727		$ 479,250	$ 412,523	$ 498,872	70

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

Facility Name & ID Number Clark Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 16,497,985	$ 66,727		$ 479,250	$ 412,523	$ 498,872	1
2	Locks, Keypads, And Power Supply	2016	11,168		20	1,489	1,489	1,489	2
3	Access Panels And Vinyl Baseboard	2016	18,750		20	2,344	2,344	2,344	3
4	Locks, Keypads, And Power Supply	2016	11,168		20	1,489	1,489	1,489	4
5	Water Box And Assembly Valve	2016	6,303		20	735	735	735	5
6	Wall Patch - 1St Floor Kitchen	2016	5,000		20	583	583	583	6
7	Carpet - Hallway & Main Lobby	2016	33,019		20	4,402	4,402	4,402	7
8	Carpet - Hallway & Main Lobby	2016	11,220		20	1,496	1,496	1,496	8
9	Paint, Drywall Repairs & Wallpaper Insallation In Hallways, Fron	2017	60,391		20	370	370	370	9
10	Repair Leaking Riser	2017	5,172		20	237	237	237	10
11	Flooring/Tiling/Vinyl Base - Floors 1-5 Hallway/Lobby	2017	72,745		20	381	381	381	11
12	Installation Of Door Operator-South Ambulance Entrance	2017	3,637		20	152	152	152	12
13	Kitchen Cooler/Freezer Shelving And Repairs	2017	4,700		20	176	176	176	13
14	Ambulance Entry Door Repairs	2017	4,008		20	150	150	150	14
15	Drywall Repairs, Pipe Foam Insulation	2017	3,750		20	109	109	109	15
16	Duct Work For Dryers	2017	5,868		20	147	147	147	16
17	Installed New Piping And Fittings To Replace The Leaking Water	2017	8,975		20	262	262	262	17
18	Installed Insulation For Copper Lines	2017	2,815		20	82	82	82	18
19	Installation Of 4 New Magnetic Locks On The 4Th Floor	2017	10,359		20	173	173	173	19
20	Installed Two New Grease Interceptors	2017	3,845		20	80	80	80	20
21	Rusted And Leaking Pipes Replacement	2017	5,415		20	135	135	135	21
22	Roofing Work	2017	7,250		20	242	242	242	22
23	Replace Pump Seals & Cupler On Hw Circulating Pump	2017	5,383		20	987	987	987	23
24	Boiler #2 Repairs - Ignition Module, Flow Switch, Ignition Cables	2017	5,849		20	1,170	1,170	1,170	24
25	Installation Of Gates With Springs	2017	5,750		20	671	671	671	25
26	Roof And Wall Retuckpointed	2017	17,500		20	875	875	875	26
27	2" Toilet Pipe	2017	2,822		20	141	141	141	27
28	30 Amp Double Pole Outlets	2017	4,900		20	245	245	245	28
29	Roof Repair On Lower Roof Area	2017	9,800		20	490	490	490	29
30	Hot Water Mixing Valve	2017	2,700		20	135	135	135	30
31	Repair Water Seepage From Columns/Scaffolding	2017	4,250		20	213	213	213	31
32	Replace Water Pump	2017	3,427		20	171	171	171	32
33									33
34	TOTAL (lines 1 thru 33)		$ 16,855,924	$ 66,727		$ 499,582	$ 432,855	$ 519,204	34

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

Facility Name & ID Number Clark Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 16,855,924	$ 66,727		$ 499,582	$ 432,855	$ 519,204	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 16,855,924	$ 66,727		$ 499,582	$ 432,855	$ 519,204	34

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

Facility Name & ID Number Clark Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 16,855,924	$ 66,727		$ 499,582	$ 432,855	$ 519,204	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		$ 16,855,924	$ 66,727		$ 499,582	$ 432,855	$ 519,204	34

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

Facility Name & ID Number Clark Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 16,855,924	$ 66,727		$ 499,582	$ 432,855	$ 519,204	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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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)		$ 16,855,924	$ 66,727		$ 499,582	$ 432,855	$ 519,204	34

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

Facility Name & ID Number Clark Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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
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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 Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	2016	57,882		35	1,654	1,654	3,308	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis	2016	359,365		20	17,968	17,968	35,936	9
10	Allocated from CF St. Louis	2017	8,341		20	417	417	417	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)		$ 425,588	$		$ 20,039	$ 20,039	$ 39,661	34

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

Facility Name & ID Number Clark Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 425,588	$		$ 20,039	$ 20,039	$ 39,661	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		$ 425,588	$		$ 20,039	$ 20,039	$ 39,661	34

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

Facility Name & ID Number Clark Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 147,272	$ 1,374	$ 31,015	$ 29,641	10	$ 36,203	71
72	Current Year Purchases	865,586		89,080	89,080	10	89,080	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,012,858	$ 1,374	$ 120,095	$ 118,721		$ 125,283	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)	$ 19,604,186	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 68,101	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 619,677	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 551,576	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 644,487	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 Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Storage				979			5
6	Allocated from Legacy Healthcare/Progressive				261			6
7	TOTAL				$ 1,240 **			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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 8,237 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Legacy Healthcare		$	$ 5,396	17
18	Allocated from Progressive HC			2,104	18
19					19
20					20
21	TOTAL		$	$ 7,500	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 Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Skilled Nursing Facility STATE OF ILLINOIS # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 177,309	$		$ 177,309	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			145,263			145,263	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			279,151			279,151	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				261,345		261,345	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					41,948	117,683		159,631	13
14	TOTAL			$		$ 643,671	$ 379,028		$ 1,022,699	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 Skilled Nursing Facility # 0054403 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(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	$ 1,000	$ 86,987	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,119,665	2,119,665	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	64,823	64,823	6
7	Other Prepaid Expenses	29,418	29,418	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	310,398	310,398	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,525,304	$ 2,611,291	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	336,690	336,690	15
16	Equipment, at Historical Cost	225,252	1,025,252	16
17	Accumulated Depreciation (book methods)	(78,873)	(300,082)	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	220,676	2,914,396	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 703,745	$ 21,748,653	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,229,049	$ 24,359,944	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 909,783	$ 909,783	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		320,565	29
30	Accrued Salaries Payable	470,899	470,899	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,763	20,763	31
32	Accrued Real Estate Taxes(Sch.IX-B)		268,930	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	224,054	224,054	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,625,499	$ 2,252,994	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		16,293,333	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	2,236,453	6,273,592	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,236,453	$ 22,566,925	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,861,952	$ 24,819,919	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (632,903)	$ (459,975)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,229,049	$ 24,359,944	48

***(See instructions.)**

Facility Name & ID Number Clark Skilled Nursing Facility **#** 0054403 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (324,515)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (324,515)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(308,388)	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)**	$ (308,388)	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)**	$ (632,903)	24 *

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

Facility Name & ID Number Clark Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 25,265,890	1
2	Discounts and Allowances for all Levels	(11,921,329)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,344,561	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,387,252	6
7	Oxygen	21	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,387,273	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	252,870	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,365	19
20	Radiology and X-Ray		20
21	Other Medical Services	12,774	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 290,009	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	17,767	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 17,767	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	17,085	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 17,085	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,056,695	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,264,506	31
32	Health Care	5,833,837	32
33	General Administration	3,059,569	33
	B. Capital Expense		
34	Ownership	2,785,090	34
	C. Ancillary Expense		
35	Special Cost Centers	1,823,721	35
36	Provider Participation Fee	598,360	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,365,083	40
41	**Income before Income Taxes (line 30 minus line 40)****	(308,388)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (308,388)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 11,827,343	44
45	Private Pay - Net Inpatient Revenue	121,644	45
46	Medicare - Net Inpatient Revenue	1,146,352	46
47	Other-(specify) Insurance	73,889	47
48	Other-(specify) Veterans	175,333	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 13,344,561	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	1,928	2,106	$ 103,501	$ 49.15	1
2	Assistant Director of Nursing	2,064	2,220	92,676	41.75	2
3	Registered Nurses	37,047	40,551	1,374,439	33.89	3
4	Licensed Practical Nurses	44,230	47,266	1,383,767	29.28	4
5	CNAs & Orderlies	123,150	134,765	1,626,414	12.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,590	12,702	213,175	16.78	8
9	Activity Director	1,936	2,226	53,234	23.91	9
10	Activity Assistants	23,132	25,225	275,048	10.90	10
11	Social Service Workers	16,297	17,334	310,280	17.90	11
12	Dietician	736	752	19,629	26.10	12
13	Food Service Supervisor	4,164	4,486	92,392	20.60	13
14	Head Cook	3,355	3,703	49,264	13.30	14
15	Cook Helpers/Assistants	26,379	28,988	344,162	11.87	15
16	Dishwashers					16
17	Maintenance Workers	5,520	6,220	122,517	19.70	17
18	Housekeepers	22,649	24,857	285,973	11.50	18
19	Laundry	13,976	15,179	168,431	11.10	19
20	Administrator	2,040	2,502	165,275	66.06	20
21	Assistant Administrator	1,920	2,533	60,263	23.79	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,624	16,705	306,212	18.33	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	2,052	30,943	15.08	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	359,601	392,372	$ 7,077,595 *	$ 18.04	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	$ 35,179	01-03	35
36	Medical Director	Monthly	69,717	09-03	36
37	Medical Records Consultant	Monthly	4,800	10-03	37
38	Nurse Consultant	Monthly	179,356	10-03	38
39	Pharmacist Consultant	Monthly	20,599	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	4,372	11-03	44
45	Social Service Consultant	Monthly	7,355	12-03	45
46	Other(specify) Clergy	Monthly	3,750	12-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 325,128		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	19	480	10-03	52
53	TOTAL (lines 50 - 52)	19	$ 480		53

Facility Name & ID Number Clark Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michael Kaplan	Administrator	0	$ 103,608
Aharon Adler	Administrator	0	24,681
David Meiselman	Administrator	0	36,986
Mandy Adams	Asst. Admin.	0	60,263
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 225,538

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	$ 21,608
ProPay HR	Payroll Processing	33,395
Achieve Accreditation	Accreditation	6,895
BlueOrange Compliance	Compliance	2,136
Deborah Cole	Estate Planning	1,000
IIT/Sourcetech	Data Processing	1,425
Jantzen Associates, Inc.	Financial Consultant	4,905
Lexisnexis Risk Solutions	Data Processing	80
McCabe Kirshner & Ballester	Insurance Solutions	1,460
MTS Consulting	Tax Consulting	150
Personnel Planners	Unemployment Consultant	1,604
See Supplemental Schedule		100,599
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 175,257

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 174,366
Unemployment Compensation Insurance	37,885
FICA Taxes	521,784
Employee Health Insurance	348,509
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	19,368
401K Expense	70,651
Voluntary Benefit Contributions	13,361
Employee Physical Exams	17,051
Employee Exam Fee	799
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,203,773

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 752)	7,525
Patient Background Checks 348	3,480
Dues & Subscriptions	22,493
Licenses & Permits	7,692
Allocated from Legacy Healthcare	1,448
Allocated from Progressive HC	304
See Supplemental Schedule	4
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 42,946

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,523
Allocated from Legacy Healthcare	1,914
Allocated from Progressive HC	1,369
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,806

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Clark Skilled Nursing Facility # 0054403 Report Period Beginning: 01/01/17 Ending: 12/31/17

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. **ICLTC $39,516**

(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. $ **19,990** 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. $ **598,360**
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? **No** Indicate the amount. $ **N/A**

(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? **Yes**
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? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted 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