FOR BHF USE

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0054403

Facility Name: Clark Manor Conv Center

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

County: Cook

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/18 to 12/31/18 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

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

Paid Preparer

(Signed) (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	19,957	34	3,522	23,513	8
9	SNF/PED					9
10	ICF	63,018	1,317	2,080	66,415	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	82,975	1,351	5,602	89,928	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.28%

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 3,455

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: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	544,592	41,365	5,266	591,223		591,223	1,792	593,015			1
2	Food Purchase		540,761		540,761		540,761	(15,892)	524,869			2
3	Housekeeping	308,109	67,544		375,653		375,653	2,819	378,472			3
4	Laundry	150,446	31,829		182,275		182,275	17	182,292			4
5	Heat and Other Utilities			316,370	316,370		316,370	(3,832)	312,538			5
6	Maintenance	150,075	35,488	150,007	335,570		335,570	17,468	353,038			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,153,222	716,987	471,643	2,341,852		2,341,852	2,372	2,344,224			8
	B. Health Care and Programs											
9	Medical Director			73,466	73,466		73,466		73,466			9
10	Nursing and Medical Records	4,790,473	69,612	178,106	5,038,191		5,038,191	69,764	5,107,955			10
10a	Therapy	224,517			224,517		224,517		224,517			10a
11	Activities	288,560	7,366	6,883	302,809		302,809	112	302,921			11
12	Social Services	328,685		8,639	337,324		337,324	6,979	344,303			12
13	CNA Training											13
14	Program Transportation			827	827		827		827			14
15	Other (specify):*							12,854	12,854			15
16	**TOTAL Health Care and Programs**	5,632,235	76,978	267,921	5,977,134		5,977,134	89,708	6,066,842			16
	C. General Administration											
17	Administrative	180,037			180,037		180,037	148,426	328,463			17
18	Directors Fees											18
19	Professional Services			166,603	166,603	(3,000)	163,603	(25,553)	138,050			19
20	Dues, Fees, Subscriptions & Promotions			94,385	94,385		94,385	(49,541)	44,844			20
21	Clerical & General Office Expenses	360,399	10,132	571,582	942,113		942,113	141,347	1,083,460			21
22	Employee Benefits & Payroll Taxes			1,137,894	1,137,894		1,137,894	(24,227)	1,113,667			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,615	7,615		7,615	4,264	11,879			24
25	Other Admin. Staff Transportation			769	769		769		769			25
26	Insurance-Prop.Liab.Malpractice			330,958	330,958		330,958	9,001	339,959			26
27	Other (specify):*							94,057	94,057			27
28	**TOTAL General Administration**	540,436	10,132	2,309,806	2,860,374	(3,000)	2,857,374	297,774	3,155,148			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	7,325,893	804,097	3,049,370	11,179,360	(3,000)	11,176,360	389,854	11,566,214			29

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

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

Facility Name & ID Number Clark Manor Conv Center #0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

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			92,133	92,133		92,133	536,762	628,895			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,301	32,301		32,301	1,120,426	1,152,727			32
33	Real Estate Taxes			312,000	312,000	3,000	315,000	7,602	322,602			33
34	Rent-Facility & Grounds			2,274,996	2,274,996		2,274,996	(2,274,738)	258			34
35	Rent-Equipment & Vehicles			9,138	9,138		9,138	6,710	15,848			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,720,568	2,720,568	3,000	2,723,568	(603,239)	2,120,329			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		262,737	712,439	975,176		975,176		975,176			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			632,034	632,034		632,034		632,034			42
43	Other (specify):*			845,078	845,078		845,078	(845,078)				43
44	**TOTAL Special Cost Centers**		262,737	2,189,551	2,452,288		2,452,288	(845,078)	1,607,210			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,325,893	1,066,834	7,959,489	16,352,216		16,352,216	(1,058,463)	15,293,753			45

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

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	(5,509)	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	(35,351)	30		9
10	Interest and Other Investment Income	(26,633)	32		10
11	Discounts, Allowances, Rebates & Refunds	(15,841)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(81)	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	(419)	21		18
19	Entertainment	(22,678)	21		19
20	Contributions	(10,250)	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	(287,276)	21		24
25	Fund Raising, Advertising and Promotional	(16,723)	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	(1,877,818)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,298,579)		$	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)	1,240,116		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,240,116		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,058,463)		37

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

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

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

Clark Manor Conv Center

ID# 0054403

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (150)	21	1
2	Patient Personal Items	(2,591)	10	2
3	Bank Charges	(8,349)	21	3
4	Sequestration Expense	(37,414)	21	4
5	Pharmacy Discount	(2,343)	10	5
6	Excise Tax	(148)	21	6
7	Non-Allowable Expense	(845,078)	43	7
8	Building Co - Filing Fees	(75)	21	8
9	Building Co - Accounting Fees	(5,456)	19	9
10	Building Co - Asset Management Fees	(720,000)	06	10
11	Additional R&M	1,135	06	11
12	PAC Dues	(23,096)	20	12
13	Non-Allowable Legal Fees	(33,100)	19	13
14	Donations	(500)	20	14
15	2017 Seminar Expense	(653)	24	15
16	Building Co - Amortization	(200,000)	36	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**	(1,877,818)		49

Clark Manor Conv Center

ID# 0054403

Report Period Beginning: 01/01/18

Ending: 12/31/18

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			1,792									1,792	1
2	Food Purchase	(15,922)		30									(15,892)	2
3	Housekeeping			2,819									2,819	3
4	Laundry			17									17	4
5	Heat and Other Utilities	(5,509)				1,677							(3,832)	5
6	Maintenance	(718,865)	720,000	14,076		2,257							17,468	6
7	Other (specify):*													7
8	**TOTAL General Services**	(740,296)	720,000	18,734		3,934							2,372	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(4,934)		115,500	(40,543)		(259)						69,764	10
10a	Therapy													10a
11	Activities			112									112	11
12	Social Services			6,979									6,979	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				12,854								12,854	15
16	**TOTAL Health Care and Programs**	(4,934)		122,591	(27,689)		(259)						89,708	16
	C. General Administration													
17	Administrative			148,426									148,426	17
18	Directors Fees													18
19	Professional Services	(38,556)	5,456	18,044		70		(10,567)					(25,553)	19
20	Fees, Subscriptions & Promotions	(50,569)		1,026		1							(49,541)	20
21	Clerical & General Office Expenses	(356,509)	75	620,970	(123,741)	552							141,347	21
22	Employee Benefits & Payroll Taxes				(24,227)								(24,227)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(653)		4,917									4,264	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			8,354		647							9,001	26
27	Other (specify):*			94,057									94,057	27
28	**TOTAL General Administration**	(446,287)	5,531	895,795	(147,968)	1,270		(10,567)					297,774	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,191,517)	725,531	1,037,119	(175,657)	5,204	(259)	(10,567)					389,854	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Clark Manor Conv Center # 0054403 **Report Period Beginning:** 01/01/18 **Ending:** 12/31/18

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	(35,351)	572,113										536,762	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(26,633)	1,139,017	55		7,987							1,120,426	32
33	Real Estate Taxes					7,602							7,602	33
34	Rent-Facility & Grounds		(2,274,996)	69,322		(69,064)							(2,274,738)	34
35	Rent-Equipment & Vehicles				6,710								6,710	35
36	Other (specify):*	(200,000)	200,000											36
37	**TOTAL Ownership**	(261,984)	(363,867)	69,377	6,710	(53,475)							(603,239)	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):*	(845,078)											(845,078)	43
44	**TOTAL Special Cost Centers**	(845,078)											(845,078)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(2,298,579)	361,664	1,106,496	(168,948)	(48,271)	(259)	(10,567)					(1,058,463)	45

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 2,274,996	Rogers Property Holdings, LLC		$	$ (2,274,996)	1
2	V	21	Filing Fees		Rogers Property Holdings, LLC		75	75	2
3	V	19	Accounting		Rogers Property Holdings, LLC		5,456	5,456	3
4	V	06	Asset Management Fees		Rogers Property Holdings, LLC		720,000	720,000	4
5	V	32	Interest - Mortgage		Rogers Property Holdings, LLC		1,059,194	1,059,194	5
6	V	32	Interest - CapEx		Rogers Property Holdings, LLC		20,840	20,840	6
7	V	32	Interest	46	Rogers Property Holdings, LLC		59,028	58,982	7
8	V	30	Depreciation		Rogers Property Holdings, LLC		572,113	572,113	8
9	V	36	Amoritization		Rogers Property Holdings, LLC		200,000	200,000	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,275,042			$ 2,636,706	$ * 361,664	14

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

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETICIAN SALARY	$	Legacy Healthcare Financial Services		$ 1,689	$ 1,689	15
16	V	01	DIETARY SUPPLIES		Legacy Healthcare Financial Services		103	103	16
17	V	02	FOOD		Legacy Healthcare Financial Services		30	30	17
18	V	03	HOUSEKEEPING		Legacy Healthcare Financial Services		2,819	2,819	18
19	V	04	LINEN REPLACEMENT		Legacy Healthcare Financial Services		17	17	19
20	V	06	MAINTENANCE SALARY		Legacy Healthcare Financial Services		11,986	11,986	20
21	V	06	REPAIRS AND MAINTENANCE		Legacy Healthcare Financial Services		2,090	2,090	21
22	V	10	NURSING SALARY		Legacy Healthcare Financial Services		110,833	110,833	22
23	V	10	NURSE CONSULTANT		Legacy Healthcare Financial Services		4,539	4,539	23
24	V	10	MEDICAL SUPPLIES		Legacy Healthcare Financial Services		127	127	24
25	V	12	SOCIAL SERVICE SALARY		Legacy Healthcare Financial Services		6,938	6,938	25
26	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services		112	112	26
27	V	12	SOCIAL SERVICE CONSULTANT		Legacy Healthcare Financial Services		41	41	27
28	V	17	CFO/ADMINISTRATIVE SALARY		Legacy Healthcare Financial Services		148,426	148,426	28
29	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services		18,044	18,044	29
30	V	20	DUES/LICENSE/PERMITS		Legacy Healthcare Financial Services		1,026	1,026	30
31	V	21	CLERICAL AND GENERAL WAGES		Legacy Healthcare Financial Services		603,514	603,514	31
32	V	21	CLERICAL AND OFFICE EXPENSE		Legacy Healthcare Financial Services		17,456	17,456	32
33	V	24	EDUCATION AND SEMINARS		Legacy Healthcare Financial Services		4,917	4,917	33
34	V	26	INSURANCE- GENERAL		Legacy Healthcare Financial Services		8,354	8,354	34
35	V	27	NON-NURSING PAYROLL TAXES/BENEFITS		Legacy Healthcare Financial Services		94,057	94,057	35
36	V	32	INTEREST		Legacy Healthcare Financial Services		55	55	36
37	V	34	RENT		Legacy Healthcare Financial Services		69,064	69,064	37
38	V	34	OFFSITE STORAGE/PARKING		Legacy Healthcare Financial Services		258	258	38
39	Total			$			$ 1,106,496	$ * 1,106,496	39

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

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services		360	$ 360	15
16	V	35	AUTO RENTAL		Legacy Healthcare Financial Services		6,350	6,350	16
17	V	15	NURSING PAYROLL TAXES/BENEFITS		Legacy Healthcare Financial Services		12,854	12,854	17
18	V								18
19	V	10	REIMB SALARIES - PROF CARE	40,543	Legacy Healthcare Financial Services			(40,543)	19
20	V	21	REIMB SALARIES - ADMINISTRATIVE	123,741	Legacy Healthcare Financial Services			(123,741)	20
21	V	22	REIMBURSED PAYROLL TAXES	24,227	Legacy Healthcare Financial Services			(24,227)	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			$ 188,511			$ 19,563	$ * (168,948)	39

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

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	CF St. Louis LLC		$ 1,677	$ 1,677	15
16	V	6	REPAIRS & MAINTENANCE		CF St. Louis LLC		2,257	2,257	16
17	V	19	PROFESSIONAL FEES		CF St. Louis LLC		70	70	17
18	V	20	DUES & SUBSCRIPTIONS		CF St. Louis LLC		1	1	18
19	V	21	OFFICE EXPENSE		CF St. Louis LLC		552	552	19
20	V	26	INSURANCE		CF St. Louis LLC		647	647	20
21	V	32	INTEREST EXPENSE		CF St. Louis LLC		7,987	7,987	21
22	V	33	REAL ESTATE TAXES		CF St. Louis LLC		7,602	7,602	22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	69,064	CF St. Louis LLC			(69,064)	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			$ 69,064			$ 20,793	$ * (48,271)	39

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

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Medical Supplies	$ 9,000	ReMED Services		$ 8,741	$ (259)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,000			$ 8,741	$ * (259)	39

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

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Processing	$ 40,361	ProPay HR LLC		$ 29,794	$ (10,567)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 40,361			$ 29,794	$ * (10,567)	39

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

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	GPN FAMILY TRUST	50.00%	ASTORIA PLACE SKILLED NURSING FACILITY LLC	CHICAGO	ROGERS PROPERTY HOLDINGS, LLC		BUILDING COMPANY	1
2	DOROS GENERATION TRUST	50.00%	AVANTARA BILLINGS	BILLINGS, MT	LEGACY HC & FINANCIAL SERV	LINCOLNWOOD	HOME OFFICE/BOOKKEEPI	2
3			AVANTARA ELGIN	ELGIN	ML GROUP DESIGN & DEV	SKOKIE	ASSET MANAGEMENT	3
4			AVANTARA LONG GROVE	LONG GROVE	REMED SERVICES LLC	LINCOLNWOOD	NURSING EQUIPMENT	4
5			AVANTARA PARK RIDGE	PARK RIDGE	AURORA SUPPORTIVE LIVING	AURORA	SUPPORTIVE LIVING	5
6			AZRIA MIDTOWN	OMAHA, NE	TERRACE GARDENS	MORTON GROVE	ASSISTED LIVING	6
7			AZRIA MONTCLAIR	OMAHA, NE	LINCOLNSHIRE ASSISTED LIVI	LINCOLNSHIRE	ASSISTED LIVING	7
8			AZRIA OLATHE	OLATHE, KS	CF ST. LOUIS LLC	SKOKIE	BUILDING COMPANY	8
9			BETHANY TERRACE	MORTON GROVE	PROPAY HR	EVANSTON	PAYROLL PROCESSING	9
10			CARLTON SKILLED NURSING FACILITY LLC	CHICAGO	ECOBRITE LINEN	SKOKIE	LAUNDRY SUPPLIES	10
11			CHALET SKILLED NURSING FACILITY LLC	CHICAGO				11
12			ELMBROOK SKILLED NURSING FACILITY LLC	ELMHURST				12
13			EVANSTON SKILLED NURSING FACILITY LLC	EVANSTON				13
14			GROVE AT THE LAKE SKILLED NURSING FACILITY LLC	ZION				14
15			GROVE OF FOX VALLEY	AURORA				15
16			GROVE OF ST. CHARLES	ST. CHARLES				16
17			LAGRANGE SKILLED NURSING FACILITY LLC	LAGRANGE PARK				17
18			LAKEFRONT SKILLED NURSING FACILITY LLC	CHICAGO				18
19			LINCOLN PARK SKILLED NURSING FACILITY LLC	CHICAGO				19
20			LINCOLNSHIRE LIVING & REHAB CENTER LLC	LINCOLNSHIRE				20
21			NORTHBROOK SKILLED NURSING FACILITY LLC	NORTHBROOK				21
22			PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO				22
23			SKOKIE SKILLED NURSING FACILITY LLC	SKOKIE				23
24			ST. GEORGE SKILLED NURSING FACILITY	ST. GEORGE, UT				24
25			VALLEY SKILLED NURSING FACILITY	BILLINGS, MT				25
26			WARREN BARR LIVING AND REHAB	CHICAGO				26
27			WARREN BARR NORTH SHORE	HIGHLAND PARK				27
28			WARREN BARR SOUTH LOOP	CHICAGO				28
29								29
30								30

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETICIAN SALARY	AVAIL. BED DAYS	1,918,919	34	$ 33,257	$ 33,257	97,455	$ 1,689	1
2	01	DIETARY SUPPLIES	AVAIL. BED DAYS	1,918,919	34	2,031		97,455	103	2
3	02	FOOD	AVAIL. BED DAYS	1,918,919	34	595		97,455	30	3
4	03	HOUSEKEEPING	AVAIL. BED DAYS	1,918,919	34	55,512		97,455	2,819	4
5	04	LINEN REPLACEMENT	AVAIL. BED DAYS	1,918,919	34	343		97,455	17	5
6	06	MAINTENANCE SALARY	AVAIL. BED DAYS	1,918,919	34	235,999	235,999	97,455	11,986	6
7	06	REPAIRS AND MAINTENANCE	AVAIL. BED DAYS	1,918,919	34	41,154		97,455	2,090	7
8	10	NURSING SALARY	AVAIL. BED DAYS	1,918,919	34	2,182,345	2,182,345	97,455	110,833	8
9	10	NURSE CONSULTANT	AVAIL. BED DAYS	1,918,919	34	89,384		97,455	4,539	9
10	10	MEDICAL SUPPLIES	AVAIL. BED DAYS	1,918,919	34	2,503		97,455	127	10
11	12	SOCIAL SERVICE SALARY	AVAIL. BED DAYS	1,918,919	34	136,611	136,611	97,455	6,938	11
12	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,918,919	34	2,204		97,455	112	12
13	12	SOCIAL SERVICE CONSULTAN	AVAIL. BED DAYS	1,918,919	34	800		97,455	41	13
14	17	CFO/ADMINISTRATIVE SALAR	AVAIL. BED DAYS	1,918,919	34	2,922,553	2,922,553	97,455	148,426	14
15	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,918,919	34	355,302		97,455	18,044	15
16	20	DUES/LICENSE/PERMITS	AVAIL. BED DAYS	1,918,919	34	20,207		97,455	1,026	16
17	21	CLERICAL AND GENERAL WA	AVAIL. BED DAYS	1,918,919	34	11,883,371	11,883,371	97,455	603,514	17
18	21	CLERICAL AND OFFICE EXPE	AVAIL. BED DAYS	1,918,919	34	343,715		97,455	17,456	18
19	24	EDUCATION AND SEMINARS	AVAIL. BED DAYS	1,918,919	34	96,819		97,455	4,917	19
20	26	INSURANCE- GENERAL	AVAIL. BED DAYS	1,918,919	34	164,496		97,455	8,354	20
21	27	NON-NURSING PAYROLL TAX	AVAIL. BED DAYS	1,918,919	34	1,852,008		97,455	94,057	21
22	32	INTEREST	AVAIL. BED DAYS	1,918,919	34	1,074		97,455	55	22
23	34	RENT	AVAIL. BED DAYS	1,918,919	34	1,359,900		97,455	69,064	23
24	34	OFFSITE STORAGE/PARKING	AVAIL. BED DAYS	1,918,919	34	5,072		97,455	258	24
25	TOTALS					$ 21,787,253	$ 17,394,136		$ 1,106,496	25

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,918,919	34	7,088		97,455	360	1
2	35	AUTO RENTAL	AVAIL. BED DAYS	1,918,919	34	125,028		97,455	6,350	2
3	15	NURSING PAYROLL TAXES/BE	AVAIL. BED DAYS	1,918,919	34	253,092		97,455	12,854	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					$ 385,208	$		$ 19,563	25

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	1,916,917	34	$ 32,982	$	97,455	$ 1,677	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,916,917	34	44,396		97,455	2,257	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,916,917	34	1,378		97,455	70	3
4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,916,917	34	23		97,455	1	4
5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,916,917	34	10,860		97,455	552	5
6	26	INSURANCE	AVAIL. BED DAYS	1,916,917	34	12,721		97,455	647	6
7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,916,917	34	157,106		97,455	7,987	7
8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,916,917	34	149,528		97,455	7,602	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					$ 408,994	$		$ 20,793	25

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: ReMED Services LLC
Street Address: 3424 Oakton Street, Suite 102
City / State / Zip Code: Skokie, IL
Phone Number: (847) 440-2600
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Medical Supplies	Direct			$	$		$ 8,741	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 8,741	25

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

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			$	$		$ 29,794	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					$	$		$ 29,794	25

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

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
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

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
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Private Bank		X	Mortgage			$	$ 15,973,333			$ 1,059,194	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Private Bank		X	Line of Credit				90,000			32,301	6
7	CapEx		X	Line of Credit				313,708			20,840	7
8	Loan Fees Interest										59,028	8
9	TOTAL Facility Related						$	$ 16,377,041			$ 1,171,364	9
	B. Non-Facility Related*											
10	Interest Income		X								(26,633)	10
11	Interest Income - Building Co.		X								(46)	11
12	Allocated from Legacy Healthcare		X								55	12
13	Allocated from CF St. Louis		X								7,987	13
14	TOTAL Non-Facility Related						$	$			$ (18,637)	14
15	TOTALS (line 9+line14)						$	$ 16,377,041			$ 1,152,727	15

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

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

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

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 264,935	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.)		$ 354,491	2
3. Under or (over) accrual (line 2 minus line 1).		$ 89,556	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 230,046	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.)**		$ 3,000	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.		$ 322,602	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	310,228	8
	2014	289,149	9
	2015	295,285	10
	2016	322,748	11
	2017	346,889	12

2018 Accrual = $346,889 x .66 = $230,046 (Rounded)

***Beginning Accrual Adjusted**

Allocated from CF St. Louis $7,602

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Clark Manor Conv Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054403

CONTACT PERSON REGARDING THIS REPORT

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

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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	$ 119,995.45	$ 119,995.45
2.	11-30-411-006-0000	Long Term Care Property	$ 119,995.66	$ 119,995.66
3.	11-30-411-007-0000	Long Term Care Property	$ 103,673.69	$ 103,673.69
4.	11-30-411-020-0000	Long Term Care Property	$ 3,224.07	$ 3,224.07
5.	10-23-406-034-0000	Allocated from Home Office	$ 492,481.94	$ 7,601.92
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 839,370.81	$ 354,490.79

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 2017 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 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Clark Manor Conv Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054403

CONTACT PERSON REGARDING THIS REPORT

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

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

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			10,033	2
3	TOTALS			$ 1,710,033	3

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 572,113	35	$ 459,211	$ (112,902)	$ 918,422	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		397,636			18,724	18,724	55,743	68
69	Financial Statement Depreciation			92,133			(92,133)		69
70	TOTAL (lines 4 thru 69)		$ 16,470,033	$ 664,246		$ 477,935	$ (186,311)	$ 974,165	70

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

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 16,470,033	$ 664,246		$ 477,935	$ (186,311)	$ 974,165	1
2	Locks, Keypads, And Power Supply	2016	11,168		20	1,489	1,489	2,978	2
3	Access Panels And Vinyl Baseboard	2016	18,750		20	2,344	2,344	4,688	3
4	Locks, Keypads, And Power Supply	2016	11,168		20	1,489	1,489	2,978	4
5	Water Box And Assembly Valve	2016	6,303		20	735	735	1,470	5
6	Wall Patch - 1St Floor Kitchen	2016	5,000		20	583	583	1,166	6
7	Carpet - Hallway & Main Lobby	2016	33,019		20	4,402	4,402	8,804	7
8	Carpet - Hallway & Main Lobby	2016	11,220		20	1,496	1,496	2,992	8
9	Paint, Drywall Repairs & Wallpaper Insallation In Hallways, Front	2017	60,391		20	370	370	740	9
10	Repair Leaking Riser	2017	5,172		20	237	237	474	10
11	Flooring/Tiling/Vinyl Base - Floors 1-5 Hallway/Lobby	2017	72,745		20	381	381	762	11
12	Installation Of Door Operator-South Ambulance Entrance	2017	3,637		20	152	152	304	12
13	Kitchen Cooler/Freezer Shelving And Repairs	2017	4,700		20	176	176	352	13
14	Ambulance Entry Door Repairs	2017	4,008		20	150	150	300	14
15	Drywall Repairs, Pipe Foam Insulation	2017	3,750		20	109	109	218	15
16	Duct Work For Dryers	2017	5,868		20	147	147	294	16
17	Installed New Piping And Fittings To Replace The Leaking Water I	2017	8,975		20	262	262	524	17
18	Installed Insulation For Copper Lines	2017	2,815		20	82	82	164	18
19	Installation Of 4 New Magnetic Locks On The 4Th Floor	2017	10,359		20	173	173	346	19
20	Installed Two New Grease Interceptors	2017	3,845		20	80	80	160	20
21	Rusted And Leaking Pipes Replacement	2017	5,415		20	135	135	270	21
22	Roofing Work	2017	7,250		20	242	242	484	22
23	Replace Pump Seals & Cupler On Hw Circulating Pump	2017	5,383		20	987	987	1,974	23
24	Boiler #2 Repairs - Ignition Module, Flow Switch, Ignition Cables	2017	5,849		20	1,170	1,170	2,340	24
25	Installation Of Gates With Springs	2017	5,750		20	671	671	1,342	25
26	Roof And Wall Retuckpointed	2017	17,500		20	875	875	1,750	26
27	2" Toilet Pipe	2017	2,822		20	141	141	282	27
28	30 Amp Double Pole Outlets	2017	4,900		20	245	245	490	28
29	Roof Repair On Lower Roof Area	2017	9,800		20	490	490	980	29
30	Hot Water Mixing Valve	2017	2,700		20	135	135	270	30
31	Repair Water Seepage From Columns/Scaffolding	2017	4,250		20	213	213	425	31
32	Replace Water Pump	2017	3,427		20	171	171	343	32
33	Phone System Installation And Programming ($7,495)	2018	6,937		20	749	749	749	33
34	TOTAL (lines 1 thru 33)		$ 16,834,909	$ 664,246		$ 499,016	$ (165,230)	$ 1,015,578	34

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

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 16,834,909	$ 664,246		$ 499,016	$ (165,230)	$ 1,015,578	1
2	Flrs 3,4,5-Conduit,Wiring,Outlets,Fabricated Frames-Drywall ($4,2	2018	3,934		20	425	425	425	2
3	Installation Of Aluminum Door ($11,900)	2018	11,015		20	992	992	992	3
4	Demo/Installation-2Nd Bathroom,Doors,Paint,Plumbing,Lights ($3	2018	32,859		20	1,643	1,643	1,643	4
5	Curtains ($2,763)	2018	2,558		20	128	128	128	5
6	Install High Panels On Top Of Over Railings With Gate ($5,678)	2018	5,256		20	263	263	263	6
7	Fire System Installation-Maglock,Keypad,Siren For Outside Gate (	2018	3,373		20	169	169	169	7
8	Plumbing Work - Install Rpz Valves ($16,045)	2018	14,851		20	743	743	743	8
9	Install Ceiling Heater/Replace Motor Starter Switch ($2,850)	2018	2,638		20	132	132	132	9
10	Water Cooled Chiller - Replace Step Controller ($6,758)	2018	6,255		20	313	313	313	10
11	Elevator Pump Motor Repair ($5,143)	2018	4,760		20	238	238	238	11
12	Installation Of 3 Ton 120,000 Btu Roof Top Unit ($7,239)	2018	6,700		20	335	335	335	12
13	Furnish And Install New Exhaust Fan ($2,688)	2018	2,488		20	124	124	124	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)		$ 16,931,595	$ 664,246		$ 504,520	$ (159,726)	$ 1,021,082	34

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

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 16,931,595	$ 664,246		$ 504,520	$ (159,726)	$ 1,021,082	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
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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)		$ 16,931,595	$ 664,246		$ 504,520	$ (159,726)	$ 1,021,082	34

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

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 16,931,595	$ 664,246		$ 504,520	$ (159,726)	$ 1,021,082	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 16,931,595	$ 664,246		$ 504,520	$ (159,726)	$ 1,021,082	34

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

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from CF St. Louis, LLC	2016	54,026		35	1,544	1,544	4,631	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	335,424		20	16,771	16,771	50,314	9
10	Allocated from CF St. Louis, LLC	2017	7,785		20	389	389	779	10
11									11
12									12
13	Allocated from Legacy HC	2018	400		20	20	20	20	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)		$ 397,636	$		$ 18,724	$ 18,724	$ 55,743	34

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

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 397,636	$		$ 18,724	$ 18,724	$ 55,743	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 397,636	$		$ 18,724	$ 18,724	$ 55,743	34

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

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 992,125	$	$ 118,022	$ 118,022	10	$ 237,857	71
72	Current Year Purchases	56,709		6,353	6,353	10	6,353	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,048,834	$	$ 124,375	$ 124,375		$ 244,210	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)	$ 19,690,462	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 664,246	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 628,895	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (35,351)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,265,292	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Legacy Healthcare				258			5
6								6
7	TOTAL				$ 258 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 9,498 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		$	$ 6,350	17
18					18
19					19
20					20
21	TOTAL		$	$ 6,350	21

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

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

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

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.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 241,911	$		$ 241,911	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			187,400			187,400	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			237,040			237,040	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				132,664		132,664	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					46,088	130,073		176,161	13
14	TOTAL			$		$ 712,439	$ 262,737		$ 975,176	14

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

STATE OF ILLINOIS

Facility Name & ID Number Clark Manor Conv Center # 0054403 Report Period Beginning: 01/01/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 926	$ 65,893	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,309,638	1,309,638	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(132,353)	(132,353)	6
7	Other Prepaid Expenses	24,399	31,899	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	388,240	388,240	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,590,850	$ 1,663,317	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	431,340	431,340	15
16	Equipment, at Historical Cost	297,054	1,097,054	16
17	Accumulated Depreciation (book methods)	(171,006)	(1,536,441)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	643,662	2,249,681	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,201,050	$ 20,014,031	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,791,900	$ 21,677,348	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 620,302	$ 620,303	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	90,000	403,708	29
30	Accrued Salaries Payable	503,619	503,619	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,329	23,329	31
32	Accrued Real Estate Taxes(Sch.IX-B)		230,046	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	239,763	239,763	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,477,013	$ 2,058,768	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		15,973,333	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	1,353,087	4,703,324	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,353,087	$ 20,676,657	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,830,100	$ 22,735,425	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (38,200)	$ (1,058,077)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,791,900	$ 21,677,348	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (632,903)	1	
2	Restatements (describe):		2	
3	Rounding	11	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (632,892)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	594,692	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)**	$ 594,692	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)**	$ (38,200)	24	*

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

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 27,243,472	1
2	Discounts and Allowances for all Levels	(12,229,282)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 15,014,190	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,704,746	6
7	Oxygen	17	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,704,763	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	139,119	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	23,351	19
20	Radiology and X-Ray		20
21	Other Medical Services	19,843	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 182,313	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	26,633	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 26,633	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	19,009	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 19,009	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,946,908	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,341,852	31
32	Health Care	5,977,134	32
33	General Administration	2,860,374	33
	B. Capital Expense		
34	Ownership	2,720,568	34
	C. Ancillary Expense		
35	Special Cost Centers	1,820,254	35
36	Provider Participation Fee	632,034	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,352,216	40
41	**Income before Income Taxes (line 30 minus line 40)****	594,692	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 594,692	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 13,851,863	44
45	Private Pay - Net Inpatient Revenue	126,799	45
46	Medicare - Net Inpatient Revenue	640,820	46
47	Other-(specify) Insurance	41,751	47
48	Other-(specify) Veterans	352,957	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 15,014,190	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	105,554	2,080	$ 108,929	$ 52.37	1
2	Assistant Director of Nursing	1,928	2,088	88,394	42.33	2
3	Registered Nurses	39,400	42,747	1,505,572	35.22	3
4	Licensed Practical Nurses	43,921	47,441	1,354,308	28.55	4
5	CNAs & Orderlies	120,843	131,222	1,682,675	12.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,126	12,201	224,517	18.40	8
9	Activity Director	2,104	2,409	54,094	22.45	9
10	Activity Assistants	18,178	20,207	234,466	11.60	10
11	Social Service Workers	15,732	16,805	328,685	19.56	11
12	Dietician	1,936	2,080	54,577	26.24	12
13	Food Service Supervisor	4,064	4,360	99,018	22.71	13
14	Head Cook	4,274	4,592	62,485	13.61	14
15	Cook Helpers/Assistants	24,874	26,553	328,512	12.37	15
16	Dishwashers					16
17	Maintenance Workers	5,979	6,440	150,075	23.30	17
18	Housekeepers	22,782	25,268	308,109	12.19	18
19	Laundry	10,848	12,160	150,446	12.37	19
20	Administrator	2,016	2,080	156,808	75.39	20
21	Assistant Administrator	883	934	23,229	24.87	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,042	22,653	360,399	15.91	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	1,917	2,047	31,785	15.53	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	1,383	1,534	18,810	12.27	33
34	TOTAL (lines 1 - 33)	460,784	387,901	$ 7,325,893 *	$ 18.89	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	$ 5,266	01-03	35
36	Medical Director	Monthly	73,466	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	149,935	10-03	38
39	Pharmacist Consultant	Monthly	28,171	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	6,883	11-03	44
45	Social Service Consultant	Monthly	5,639	12-03	45
46	Other(specify) Clergy	Monthly	3,000	12-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 272,360		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michael Kaplan	Administrator	0	$ 156,808
Mandy S. Adams	Assistant Admin.	0	23,229
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 180,037

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting Fees	$ 28,428
Paycor	Payroll Processing	40,361
Compliance Resources Inc.	Compliance Audit	169
Achieve Accreditation	Accreditation Services	9,381
Integra Scripts, LLC	Pharmacy Mngmt Services	500
IIT/Sourcetech	Data Processing	1,790
MTS Consulting	Tax Consultant	2,590
First Real Estate Services	Real Estate Appraisal	2,750
Personnel Planners	Unemployment Consultant	2,219
Compliagent	Business Mngmt Consultant	7,198
Intacct Corporation	Data Processing	1,839
See Supplemental Schedule		69,379
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 166,602

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 159,042
Unemployment Compensation Insurance	44,383
FICA Taxes	534,132
Employee Health Insurance	282,527
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	21,843
401K Expense	28,178
Voluntary Benefit Contributions	23,378
Employee Physical Exams	20,184
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,113,667

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 89)	893
Patient Background Checks 148	1,480
Dues & Subscriptions	33,255
Licenses & Permits	6,199
Allocated from Legacy Healthcare	1,026
Allocated from CF St. Louis	1
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 44,844

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,962
Allocated from Legacy Healthcare	4,917
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,879

* Attach copy of IMRF notifications

**See instructions.

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI - $46,191**

(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. $ **31,594** 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. $ **632,034**
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