FOR BHF USE

LL1

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

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0054403

Facility Name: Clark Manor

Address: 7433 North Clark St (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 01/01/20 to 12/31/20 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 # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	97,722	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	97,722	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	19,358	57	3,251	22,666	8
9	SNF/PED					9
10	ICF	61,126	2,185	2,467	65,778	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	80,484	2,242	5,718	88,444	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.51%

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 3,171

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: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number Clark Manor # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		4,679	1,412,902	1,417,581		1,417,581	5,040	1,422,621			1
2	Food Purchase		952		952		952	9,588	10,540			2
3	Housekeeping	4,104	7,361	523,274	534,739		534,739	3,268	538,007			3
4	Laundry	161,714	32,922		194,636		194,636	222	194,858			4
5	Heat and Other Utilities			347,635	347,635		347,635	(5,723)	341,912			5
6	Maintenance	317,912	30,253	159,977	508,142		508,142	18,034	526,176			6
7	Other (specify):*											7
8	TOTAL General Services	483,730	76,167	2,443,788	3,003,685		3,003,685	30,430	3,034,115			8
	B. Health Care and Programs											
9	Medical Director			37,000	37,000		37,000		37,000			9
10	Nursing and Medical Records	5,665,585	285,467	63,270	6,014,322		6,014,322	154,670	6,168,992			10
10a	Therapy	138,914			138,914		138,914		138,914			10a
11	Activities	361,868	4,116	1,829	367,813		367,813	13	367,826			11
12	Social Services	429,382		7,534	436,916		436,916	8,754	445,670			12
13	CNA Training											13
14	Program Transportation			8,267	8,267		8,267		8,267			14
15	Other (specify):*							9,080	9,080			15
16	TOTAL Health Care and Programs	6,595,749	289,583	117,900	7,003,232		7,003,232	172,517	7,175,749			16
	C. General Administration											
17	Administrative	209,736			209,736		209,736	97,451	307,187			17
18	Directors Fees											18
19	Professional Services			230,230	230,230	(984)	229,246	3,012	232,257			19
20	Dues, Fees, Subscriptions & Promotions			101,288	101,288		101,288	(58,084)	43,204			20
21	Clerical & General Office Expenses	157,606	2,546	494,834	654,986		654,986	123,444	778,430			21
22	Employee Benefits & Payroll Taxes			1,119,691	1,119,691		1,119,691		1,119,691			22
23	Inservice Training & Education											23
24	Travel and Seminar			438	438		438	218	656			24
25	Other Admin. Staff Transportation			424	424		424	7,285	7,709			25
26	Insurance-Prop.Liab.Malpractice			410,007	410,007		410,007	620	410,627			26
27	Other (specify):*							39,059	39,059			27
28	TOTAL General Administration	367,342	2,546	2,356,912	2,726,800	(984)	2,725,816	213,003	2,938,819			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,446,821	368,296	4,918,600	12,733,717	(984)	12,732,733	415,950	13,148,683			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 #0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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							624,045	624,045			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,902	10,902		10,902	1,090,176	1,101,078			32
33	Real Estate Taxes			7,692	7,692	984	8,676	388,135	396,811			33
34	Rent-Facility & Grounds			2,738,004	2,738,004		2,738,004	(2,737,852)	152			34
35	Rent-Equipment & Vehicles			9,026	9,026		9,026	7,077	16,103			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,765,624	2,765,624	984	2,766,608	(628,420)	2,138,188			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		270,991	545,531	816,522		816,522	(11,866)	804,656			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			677,337	677,337		677,337		677,337			42
43	Other (specify):*			846,678	846,678		846,678	(846,678)	0			43
44	**TOTAL Special Cost Centers**		270,991	2,069,546	2,340,537		2,340,537	(858,544)	1,481,993			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,446,821	639,287	9,753,770	17,839,878		17,839,878	(1,071,014)	16,768,864			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 # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	(7,427)	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	613,532	30		9
10	Interest and Other Investment Income	(27,184)	32		10
11	Discounts, Allowances, Rebates & Refunds	(3,722)	10		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		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	(8,996)	21		18
19	Entertainment	(1,362)	21		19
20	Contributions	(34,403)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(260,484)	21		24
25	Fund Raising, Advertising and Promotional	(4,808)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(15,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,912,489)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,662,343)		$	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)	591,330		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 591,330		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,071,013)		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

ID# 0054403

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable Expense	$ (844,522)	43	1
2	Patient Personal Items	(6,479)	10	2
3	Sequestration Expense	(12,785)	21	3
4	Miscellaneous Income	(76)	21	4
5	Excise Tax	(115)	21	5
6	PAC Dues	(23,763)	20	6
7	Non-Allowable Expense	(2,156)	43	7
8	Non-Allowable Legal	(21,629)	19	8
9	Out of Period Dues	(573)	20	9
10	Bldg Co. - Permits & Licenses	(816)	20	10
11	Bldg Co. - Tax Tracking Fee	(316)	21	11
12	Bldg Co. - Title Fees	(25,567)	20	12
13	Building Co. - Accounting	(21,112)	19	13
14	Building - Legal	(44,909)	19	14
15	Building Co - Professional Fees - Loan	(183,638)	19	15
16	Building Co. - Asset Management Fees	(720,000)	06	16
17	Building Co. - Closing Costs	(4,033)	21	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**	(1,912,489)		49

Detail lines 29 and 35 of Page 5 starting in C12. DO NOT DRAG AND DROP CELLS.

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 5B**

Clark Manor

ID# 0054483
Report Period Beginning: 01/01/20
Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		b		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

Reference 1 Reference 2 Reference 3 Reference 4 Reference 5 Reference 6 Reference 7 Reference 9 Reference 10 Reference 10a Reference 11 Reference 12 Reference 13 Reference 14 Reference 15 Reference 17 Reference 18 Reference 19 Reference 20 Reference 21 Reference 22 Reference 23 Reference 24 Reference 25 Reference 26 Reference 27 Reference 30 Reference 31 Reference 32 Reference 33 Reference 34 Reference 35 Reference 36 Reference 38 Reference 39 Reference 40 Reference 41 Reference 42 Reference 43

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Clark Manor # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			5,040									5,040	1
2	Food Purchase			9,588									9,588	2
3	Housekeeping			3,268									3,268	3
4	Laundry			222									222	4
5	Heat and Other Utilities	(7,427)				1,704							(5,723)	5
6	Maintenance	(720,000)	720,000	16,383		1,652							18,034	6
7	Other (specify):*													7
8	**TOTAL General Services**	(727,427)	720,000	34,501		3,356							30,430	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(10,201)		167,584			(2,713)						154,670	10
10a	Therapy													10a
11	Activities			13									13	11
12	Social Services			8,754									8,754	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				9,080								9,080	15
16	**TOTAL Health Care and Programs**	(10,201)		176,351	9,080		(2,713)						172,517	16
	C. General Administration													
17	Administrative			97,451									97,451	17
18	Directors Fees													18
19	Professional Services	(271,288)	249,659	31,992		717		(8,069)					3,012	19
20	Fees, Subscriptions & Promotions	(89,930)	26,383	5,462		1							(58,084)	20
21	Clerical & General Office Expenses	(303,167)	4,349	421,866		396							123,444	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			218									218	24
25	Other Admin. Staff Transportation			7,285									7,285	25
26	Insurance-Prop.Liab.Malpractice			192		428							620	26
27	Other (specify):*			39,059									39,059	27
28	**TOTAL General Administration**	(664,385)	280,391	603,524		1,542		(8,069)					213,003	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,402,013)	1,000,391	814,376	9,080	4,898	(2,713)	(8,069)					415,950	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Clark Manor # 0054403 **Report Period Beginning:** 01/01/20 **Ending:** 12/31/20

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	613,532				10,513							624,045	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(27,184)	1,111,452			5,908							1,090,176	32
33	Real Estate Taxes		382,768			5,368							388,135	33
34	Rent-Facility & Grounds		(2,738,004)	49,470		(49,318)							(2,737,852)	34
35	Rent-Equipment & Vehicles				7,077								7,077	35
36	Other (specify):*													36
37	TOTAL Ownership	586,348	(1,243,784)	49,470	7,077	(27,530)							(628,420)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(11,866)				(11,866)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(846,678)											(846,678)	43
44	TOTAL Special Cost Centers	(846,678)							(11,866)				(858,544)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,662,343)	(243,393)	863,846	16,157	(22,632)	(2,713)	(8,069)	(11,866)				(1,071,014)	45

Facility Name & ID Number Clark Manor # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	Rent	$ 2,738,004	Rogers Property Holdings, LLC		$	$ (2,738,004)	1
2	V	32	Interest	1,118	Rogers Property Holdings, LLC		1,112,570	1,111,452	2
3	V	33	Real Estate Taxes		Rogers Property Holdings, LLC		382,768	382,768	3
4	V	21	Closing Costs		Rogers Property Holdings, LLC		4,033	4,033	4
5	V	20	Permits & Licenses		Rogers Property Holdings, LLC		816	816	5
6	V	21	Tax Tracking Fee		Rogers Property Holdings, LLC		316	316	6
7	V	20	Title Fees		Rogers Property Holdings, LLC		25,567	25,567	7
8	V	19	Professional Fees - Accounting		Rogers Property Holdings, LLC		21,112	21,112	8
9	V	19	Professional Fees - Legal		Rogers Property Holdings, LLC		44,909	44,909	9
10	V	19	Professional Fees - Loan		Rogers Property Holdings, LLC		183,638	183,638	10
11	V	06	Asset Management Fees		Rogers Property Holdings, LLC		720,000	720,000	11
12	V								12
13	V								13
14	Total			$ 2,739,122			$ 2,495,729	$ * (243,393)	14

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

Facility Name & ID Number Clark Manor # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

Facility Name & ID Number Clark Manor # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

Facility Name & ID Number Clark Manor # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 5,013	$ 5,013	15
16	V	01	Dietary Supplies		Legacy Healthcare Financial Services		27	27	16
17	V	02	Food		Legacy Healthcare Financial Services		9,588	9,588	17
18	V	03	Housekeeping		Legacy Healthcare Financial Services		3,268	3,268	18
19	V	04	Linen Replacement		Legacy Healthcare Financial Services		222	222	19
20	V	06	Maintenance Salary		Legacy Healthcare Financial Services		15,465	15,465	20
21	V	06	Repairs & Maintenance		Legacy Healthcare Financial Services		918	918	21
22	V	10	Nursing Salary		Legacy Healthcare Financial Services		128,002	128,002	22
23	V	10	Nurse/Medical Director Consultant		Legacy Healthcare Financial Services		12,081	12,081	23
24	V	10	Medical Supplies		Legacy Healthcare Financial Services		27,500	27,500	24
25	V	12	Social Service Salary		Legacy Healthcare Financial Services		8,720	8,720	25
26	V	11	Activities Program		Legacy Healthcare Financial Services		13	13	26
27	V	12	Social Service Consultant		Legacy Healthcare Financial Services		34	34	27
28	V	17	COO / Administrative Salary		Legacy Healthcare Financial Services		97,451	97,451	28
29	V	19	Professional Fees		Legacy Healthcare Financial Services		31,992	31,992	29
30	V	20	Dues / Licenses / Permits		Legacy Healthcare Financial Services		5,462	5,462	30
31	V	21	Clerical & General Wages		Legacy Healthcare Financial Services		393,193	393,193	31
32	V	21	Clerical & Office Expense		Legacy Healthcare Financial Services		28,672	28,672	32
33	V	24	Education & Seminars		Legacy Healthcare Financial Services		218	218	33
34	V	25	Travel		Legacy Healthcare Financial Services		7,285	7,285	34
35	V	26	Insurance - General		Legacy Healthcare Financial Services		192	192	35
36	V	27	Non-Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		39,059	39,059	36
37	V	34	Rent		Legacy Healthcare Financial Services		49,318	49,318	37
38	V	34	Offsite Storage / Parking		Legacy Healthcare Financial Services		152	152	38
39	Total			$			$ 863,846	$ * 863,846	39

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

Facility Name & ID Number Clark Manor # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		658	$ 658	15
16	V	35	Auto Rental		Legacy Healthcare Financial Services		6,419	6,419	16
17	V	15	Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		9,080	9,080	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			$			$ 16,157	$ * 16,157	39

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

Facility Name & ID Number Clark Manor # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 1,704	$ 1,704	15
16	V	6	Repairs & Maintenance		CF St. Louis LLC		1,652	1,652	16
17	V	19	Property Valuation Fee		CF St. Louis LLC		584	584	17
18	V	19	Accounting Fees		CF St. Louis LLC		133	133	18
19	V	20	Dues & Subscriptions		CF St. Louis LLC		1	1	19
20	V	21	Office Expense		CF St. Louis LLC		396	396	20
21	V	26	Insurance		CF St. Louis LLC		428	428	21
22	V	30	Depreciation		CF St. Louis LLC		10,513	10,513	22
23	V	32	Interest Expense		CF St. Louis LLC		5,908	5,908	23
24	V	33	Real Estate Taxes		CF St. Louis LLC		5,368	5,368	24
25	V								25
26	V	34	Rent	49,318	CF St. Louis LLC			(49,318)	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			$ 49,318			$ 26,686	$ * (22,632)	39

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

Facility Name & ID Number Clark Manor # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 6,287	$ (2,713)	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			$ 6,287	$ * (2,713)	39

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

Facility Name & ID Number Clark Manor # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	$ 35,220	ProPay HR		$ 27,151	$ (8,069)	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			$ 35,220			$ 27,151	$ * (8,069)	39

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

Facility Name & ID Number Clark Manor # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	39	Laboratory	$ 29,155	Lifescan Labs of Illinois		$ 17,289	$ (11,866)	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			$ 29,155			$ 17,289	$ * (11,866)	39

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

Facility Name & ID Number Clark Manor # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietician Salary	Available Bed Days	2,540,133	53	$ 130,303	$ 130,303	97,722	$ 5,013	1
2	01	Dietary Supplies	Available Bed Days	2,540,133	53	697		97,722	27	2
3	02	Food	Available Bed Days	2,540,133	53	249,220		97,722	9,588	3
4	03	Housekeeping	Available Bed Days	2,540,133	53	84,952		97,722	3,268	4
5	04	Linen Replacement	Available Bed Days	2,540,133	53	5,771		97,722	222	5
6	06	Maintenance Salary	Available Bed Days	2,540,133	53	401,986	401,986	97,722	15,465	6
7	06	Repairs & Maintenance	Available Bed Days	2,540,133	53	23,857		97,722	918	7
8	10	Nursing Salary	Available Bed Days	2,540,133	53	3,327,223	3,327,223	97,722	128,002	8
9	10	Nurse/Medical Director Consultan	Available Bed Days	2,540,133	53	314,035		97,722	12,081	9
10	10	Medical Supplies	Available Bed Days	2,540,133	53	714,824		97,722	27,500	10
11	12	Social Service Salary	Available Bed Days	2,540,133	53	226,662	226,662	97,722	8,720	11
12	11	Activities Program	Available Bed Days	2,540,133	53	335		97,722	13	12
13	12	Social Service Consultant	Available Bed Days	2,540,133	53	893		97,722	34	13
14	17	COO / Administrative Salary	Available Bed Days	2,540,133	53	2,533,078	2,533,078	97,722	97,451	14
15	19	Professional Fees	Available Bed Days	2,540,133	53	831,592		97,722	31,992	15
16	20	Dues / Licenses / Permits	Available Bed Days	2,540,133	53	141,983		97,722	5,462	16
17	21	Clerical & General Wages	Available Bed Days	2,540,133	53	10,220,453	10,220,453	97,722	393,193	17
18	21	Clerical & Office Expense	Available Bed Days	2,540,133	53	745,293		97,722	28,672	18
19	24	Education & Seminars	Available Bed Days	2,540,133	53	5,655		97,722	218	19
20	25	Travel	Available Bed Days	2,540,133	53	189,364		97,722	7,285	20
21	26	Insurance - General	Available Bed Days	2,540,133	53	4,997		97,722	192	21
22	27	Non-Nursing Payroll Taxes / Bene	Available Bed Days	2,540,133	53	1,015,274		97,722	39,059	22
23	34	Rent	Available Bed Days	2,540,133	53	1,281,940		97,722	49,318	23
24	34	Offsite Storage / Parking	Available Bed Days	2,540,133	53	3,949		97,722	152	24
25	TOTALS					$ 22,454,338	$ 16,839,706		$ 863,846	25

Facility Name & ID Number Clark Manor # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	35	Equipment Rental	Available Bed Days	2,540,133	53	17,109		97,722	658	1
2	35	Auto Rental	Available Bed Days	2,540,133	53	166,843		97,722	6,419	2
3	15	Nursing Payroll Taxes / Benefits	Available Bed Days	2,540,133	53	236,021		97,722	9,080	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					$ 419,973	$		$ 16,157	25

Facility Name & ID Number Clark Manor # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Available Bed Days	2,540,133	53	$ 44,301	$	97,722	$ 1,704	1
2	6	Repairs & Maintenance	Available Bed Days	2,540,133	53	42,932		97,722	1,652	2
3	19	Property Valuation Fee	Available Bed Days	2,540,133	53	15,181		97,722	584	3
4	19	Accounting Fees	Available Bed Days	2,540,133	53	3,453		97,722	133	4
5	20	Dues & Subscriptions	Available Bed Days	2,540,133	53	23		97,722	1	5
6	21	Office Expense	Available Bed Days	2,540,133	53	10,298		97,722	396	6
7	26	Insurance	Available Bed Days	2,540,133	53	11,124		97,722	428	7
8	30	Depreciation	Available Bed Days	2,540,133	53	273,261		97,722	10,513	8
9	32	Interest Expense	Available Bed Days	2,540,133	53	153,558		97,722	5,908	9
10	33	Real Estate Taxes	Available Bed Days	2,540,133	53	139,524		97,722	5,368	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					$ 693,655	$		$ 26,686	25

Facility Name & ID Number Clark Manor # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			$	$		$ 6,287	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					$	$		$ 6,287	25

Facility Name & ID Number Clark Manor # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			$	$		$ 27,151	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					$	$		$ 27,151	25

Facility Name & ID Number Clark Manor # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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: LIFESCAN LABS OF ILLINOIS, LLC
Street Address: 5255 GOLF RD
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: ((847) 663 - 8300
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	39	Laboratory	Direct			$	$		$ 17,289	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					$	$		$ 17,289	25

Facility Name & ID Number Clark Manor # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	CIBC Bank		X	Mortgage			$	$ 27,756,351			$ 1,100,793	1
2	CIBC Bank		X	Note Payable				1,250,450			11,777	2
3												3
4												4
5												5
	Working Capital											
6	CIBC Bank		X	Line of Credit				647,654			10,902	6
7	Allocated from CF St. Louis										5,908	7
8												8
9	TOTAL Facility Related						$	$ 29,654,455			$ 1,129,380	9
	B. Non-Facility Related*											
10	Interest Income		X								(27,184)	10
11	Interest Income - Bldg Co.		X								(1,118)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (28,302)	14
15	TOTALS (line 9+line14)						$	$ 29,654,455			$ 1,101,078	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 # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	404,285	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.)	$	396,987	2
3. Under or (over) accrual (line 2 minus line 1).	$	(7,298)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	403,125	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.)**	$	984	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.	$	396,811	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	295,285	8
	2016	322,748	9
	2017	346,889	10
	2018	385,033	11
	2019	391,619	12

2020 Accrual = $391,619 x 1.03 = $403,125 (rounded)

Allocated from CF St. Louis LLC: $5,368

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Clark Manor COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054403

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(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	$ 135,615.46	$ 135,615.46
2.	11-30-411-006-0000	Long Term Care Property	$ 135,615.66	$ 135,615.66
3.	11-30-411-007-0000	Long Term Care Property	$ 117,083.08	$ 117,083.08
4.	11-30-411-020-0000	Long Term Care Property	$ 3,305.00	$ 3,305.00
5.	10-23-406-034-0000	Home Office Allocation	$ 459,532.44	$ 5,367.85
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 851,151.64	$ 396,987.05

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 2019 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 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Clark Manor COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054403

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

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

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

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Clark Manor # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 1,700,000	1
2	Allocated from CF St. Louis, LLC			7,592	2
3	TOTALS			$ 1,707,592	3

Facility Name & ID Number Clark Manor # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	267		2017	1977	$ 16,072,397	$	35	$ 459,211	$ 459,211	$ 1,836,844	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2016	96,628		20	4,831	4,831	33,117	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 # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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)		357,334	9,692		16,991	7,299	76,011	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 16,526,359	$ 9,692		$ 481,033	$ 471,342	$ 1,945,972	70

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

Facility Name & ID Number Clark Manor # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 16,526,359	$ 9,692		$ 481,033	$ 471,342	$ 1,945,972	1
2	Paint, Drywall Repairs & Wallpaper Insallation In Hallways, Fror	2017	60,391		20	3,020	3,020	3,797	2
3	Repair Leaking Riser	2017	5,172		20	259	259	756	3
4	Flooring/Tiling/Vinyl Base - Floors 1-5 Hallway/Lobby	2017	72,745		20	3,637	3,637	4,437	4
5	Installation Of Door Operator-South Ambulance Entrance	2017	3,637		20	182	182	501	5
6	Kitchen Cooler/Freezer Shelving And Repairs	2017	4,700		20	235	235	605	6
7	Ambulance Entry Door Repairs	2017	4,008		20	200	200	515	7
8	Drywall Repairs, Pipe Foam Insulation	2017	3,750		20	188	188	416	8
9	Duct Work For Dryers	2017	5,868		20	293	293	602	9
10	Installed New Piping And Fittings To Replace The Leaking Water	2017	8,975		20	449	449	999	10
11	Installed Insulation For Copper Lines	2017	2,815		20	141	141	313	11
12	Installation Of 4 New Magnetic Locks On The 4Th Floor	2017	10,359		20	518	518	881	12
13	Installed Two New Grease Interceptors	2017	3,845		20	192	192	360	13
14	Rusted And Leaking Pipes Replacement	2017	5,415		20	271	271	554	14
15	Roofing Work	2017	7,250		20	363	363	871	15
16	Replace Pump Seals & Cupler On Hw Circulating Pump	2017	5,383		20	269	269	2,342	16
17	Boiler #2 Repairs - Ignition Module, Flow Switch, Ignition Cables	2017	5,849		20	292	292	2,749	17
18	Installation Of Gates With Springs	2017	5,750		20	288	288	1,697	18
19	Roof And Wall Retuckpointed	2017	17,500		20	875	875	2,713	19
20	2" Toilet Pipe	2017	2,822		20	141	141	437	20
21	30 Amp Double Pole Outlets	2017	4,900		20	245	245	760	21
22	Roof Repair On Lower Roof Area	2017	9,800		20	490	490	1,519	22
23	Hot Water Mixing Valve	2017	2,700		20	135	135	419	23
24	Repair Water Seepage From Columns/Scaffolding	2017	4,250		20	213	213	850	24
25	Replace Water Pump	2017	3,427		20	171	171	685	25
26	Phone System Installation And Programming ($7,495)	2018	6,937		20	347	347	1,443	26
27	Flrs 3,4,5-Conduit,Wiring,Outlets,Fabricated Frames-Drywall ($4	2018	3,934		20	197	197	818	27
28	Installation Of Aluminum Door ($11,900)	2018	11,015		20	551	551	2,093	28
29	Demo/Installation-2Nd Bathroom,Doors,Paint,Plumbing,Lights ($	2018	32,859		20	1,643	1,643	4,929	29
30	Curtains ($2,763)	2018	2,558		20	128	128	384	30
31	Install High Panels On Top Of Over Railings With Gate ($5,678)	2018	5,256		20	263	263	788	31
32	Fire System Installation-Maglock,Keypad,Siren For Outside Gate	2018	3,373		20	169	169	506	32
33	Plumbing Work - Install Rpz Valves ($16,045)	2018	14,851		20	743	743	2,228	33
34	TOTAL (lines 1 thru 33)		$ 16,868,451	$ 9,692		$ 498,138	$ 488,446	$ 1,988,939	34

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

Facility Name & ID Number Clark Manor # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 16,868,451	$ 9,692		$ 498,138	$ 488,446	$ 1,988,939	1
2	Install Ceiling Heater/Replace Motor Starter Switch ($2,850)	2018	2,638		20	132	132	396	2
3	Water Cooled Chiller - Replace Step Controller ($6,758)	2018	6,255		20	313	313	938	3
4	Elevator Pump Motor Repair ($5,143)	2018	4,760		20	238	238	714	4
5	Installation Of 3 Ton 120,000 Btu Roof Top Unit ($7,239)	2018	6,700		20	335	335	1,005	5
6	Furnish And Install New Exhaust Fan ($2,688)	2018	2,488		20	124	124	373	6
7	Room Signage ($14368.75)	2019	13,925		20	696	696	1,654	7
8	Installand Replaced Pipes/Pumps/Air Handler ($2650)	2019	2,568		20	128	128	349	8
9	Repaired Fire Alarm ($3539.24)	2019	3,430		20	171	171	496	9
10	Seal Coating And Restriping/Mill And Pave ($13680)	2019	13,257		20	663	663	1,461	10
11	Repaired A/C Compressor ($17648.82)	2019	17,103		20	855	855	1,885	11
12	Install New Pumping Unit For Elevator ($14450)	2019	14,003		20	700	700	1,061	12
13	Repaired Cooling Coil On Air Conditioners ($4284.56)	2019	4,152		20	208	208	350	13
14	Replacement Of Annunciator ($5,285)	2020	5,156		20	258	258	258	14
15	Replace Mag Lock On Se Exit Door - 3Rd Floor ($3,050)	2020	2,975		20	149	149	149	15
16	Install New 4 Ton Rooftop Unit ($8,544)	2020	8,334		20	417	417	417	16
17	Hvac Installation ($13,645)	2020	13,311		20	666	666	666	17
18	Exhaust Fan # 10 Replacement ($2,675)	2020	2,609		20	130	130	130	18
19	Pt Rm Ceiling Leak Repair, Repair 2 Rooftop Exhuast Fans ($3,14	2020	3,068		20	153	153	153	19
20	Caulking Around Windows ($21,000)	2020	20,486		20	1,024	1,024	1,024	20
21	Installation Of Indoor Water Heating Boiler ($38,497)	2020	37,554		20	1,878	1,878	1,878	21
22	Curtains ($3,702)	2020	3,611		20	181	181	185	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 17,056,835	$ 9,692		$ 507,557	$ 497,865	$ 2,004,482	34

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

Facility Name & ID Number Clark Manor # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 17,056,835	$ 9,692		$ 507,557	$ 497,865	$ 2,004,482	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 17,056,835	$ 9,692		$ 507,557	$ 497,865	$ 2,004,482	34

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

Facility Name & ID Number Clark Manor # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 17,056,835	$ 9,692		$ 507,557	$ 497,865	$ 2,004,482	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 17,056,835	$ 9,692		$ 507,557	$ 497,865	$ 2,004,482	34

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

Facility Name & ID Number Clark Manor # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
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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)		$	$		$	$	$	34

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

Facility Name & ID Number Clark Manor # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	40,882	1,898	35	1,168	(730)	5,840	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	253,822	6,262	20	12,691	6,429	63,456	9
10	Allocated from CF St. Louis, LLC	2017	5,891	145	20	295	149	1,178	10
11	Allocated from CF St. Louis, LLC	2019	53,397	1,317	20	2,670	1,353	5,340	11
12	Allocated from CF St. Louis, LLC	2019	2,808	69	20	140	71	140	12
13									13
14	Allocated from Legacy HC	2018	303		20	15	15	45	14
15	Allocated from Legacy HC	2020	229		20	11	11	11	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)		$ 357,334	$ 9,692		$ 16,991	$ 7,299	$ 76,011	34

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

Facility Name & ID Number Clark Manor # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 357,334	$ 9,692		$ 16,991	$ 7,299	$ 76,011	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 357,334	$ 9,692		$ 16,991	$ 7,299	$ 76,011	34

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

Facility Name & ID Number Clark Manor # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,104,568	$ 818	$ 110,457	$ 109,639	10	$ 463,020	71
72	Current Year Purchases	60,311	3	6,031	6,028	10	6,132	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,164,879	$ 821	$ 116,488	$ 115,667		$ 469,152	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)	$ 19,929,306	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 10,513	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 624,045	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 613,532	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,473,634	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 # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Financial				152			5
6								6
7	TOTAL				$ 152 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 9,684 Description: See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Legacy Financial		$	$ 6,419	17
18					18
19					19
20					20
21	TOTAL		$	$ 6,419	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 # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$		$ 162,038	$		$ 162,038	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			122,686			122,686	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			198,133			198,133	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				154,069		154,069	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					62,674	116,922		179,596	13
14	TOTAL			$		$ 545,531	$ 270,991		$ 816,522	14

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

Facility Name & ID Number Clark Manor # 0054403 Report Period Beginning: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,558,366	$ 2,679,114	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	622,016	622,016	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,657	9,657	6
7	Other Prepaid Expenses	761,432	931,027	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	155,814	155,814	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,107,285	$ 4,397,628	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	530,850	530,850	15
16	Equipment, at Historical Cost	498,083	1,298,083	16
17	Accumulated Depreciation (book methods)	(283,666)	(2,221,214)	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	1,954,274	8,749,908	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,699,541	$ 26,130,024	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,806,826	$ 30,527,652	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 677,688	$ 677,688	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	299,739	299,739	30
31	Accrued Taxes Payable (excluding real estate taxes)	343,715	343,715	31
32	Accrued Real Estate Taxes(Sch.IX-B)		403,125	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	2,046,192	2,299,086	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,367,334	$ 4,061,353	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	647,654	1,898,104	39
40	Mortgage Payable		27,756,351	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	6,100	5,593,188	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 653,754	$ 35,247,643	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,021,088	$ 39,308,996	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,785,738	$ (8,781,344)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,806,826	$ 30,527,652	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,303,097	1
2	Restatements (describe):		2
3	Real Estate Expense	(247,272)	3
4	Depreciation	(112,660)	4
5	Bad Debts/Sequestration	(103,289)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 839,876	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	945,862	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)**	$ 945,862	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,785,738	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	$ 28,021,025	1
2	Discounts and Allowances for all Levels	(12,417,097)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 15,603,928	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,094,965	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,094,965	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	150,527	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	42,554	19
20	Radiology and X-Ray	55	20
21	Other Medical Services	3,669	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 196,805	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	27,184	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 27,184	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	1,862,858	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,862,858	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 18,785,740	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,003,685	31
32	Health Care	7,003,232	32
33	General Administration	2,726,800	33
	B. Capital Expense		
34	Ownership	2,765,624	34
	C. Ancillary Expense		
35	Special Cost Centers	1,663,200	35
36	Provider Participation Fee	677,337	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,839,878	40
41	**Income before Income Taxes (line 30 minus line 40)****	945,862	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 945,862	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 13,625,415	44
45	Private Pay - Net Inpatient Revenue	298,071	45
46	Medicare - Net Inpatient Revenue	1,143,412	46
47	Other-(specify) Insurance	157,285	47
48	Other-(specify) Veterans	379,745	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 15,603,928	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	2,053	2,217	$ 129,686	$ 58.50	1
2	Assistant Director of Nursing	2,192	2,298	103,125	44.88	2
3	Registered Nurses	38,327	43,918	1,668,626	37.99	3
4	Licensed Practical Nurses	48,019	55,547	1,710,042	30.79	4
5	CNAs & Orderlies	106,094	128,700	1,996,770	15.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,320	9,164	138,914	15.16	8
9	Activity Director	1,792	2,078	38,760	18.65	9
10	Activity Assistants	21,999	24,381	323,108	13.25	10
11	Social Service Workers	14,200	15,145	325,214	21.47	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	15,865	17,162	317,912	18.52	17
18	Housekeepers	232	240	4,104	17.12	18
19	Laundry	10,420	11,791	161,714	13.71	19
20	Administrator	2,048	2,225	116,349	52.29	20
21	Assistant Administrator	2,048	2,160	93,387	43.23	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,608	7,129	157,606	22.11	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	2,000	2,146	42,073	19.61	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	7,834	8,484	119,433	14.08	33
34	TOTAL (lines 1 - 33)	290,051	334,785	$ 7,446,823 *	$ 22.24	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 1,412,902	01-03	35
36	Medical Director	Monthly	37,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	55,485	10-03	38
39	Pharmacist Consultant	Monthly	7,785	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,829	11-03	44
45	Social Service Consultant	Monthly	7,534	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 1,522,535		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
Robert Freitag	Administrator	0	$ 116,349
Lily Osei	Assistant Admin	0	93,387
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 209,736

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	$ 24,000
ProPay HR	Payroll Processing	35,220
Onyx Procurement Solutions	Procurement Services	19,170
MTS Consulting	Tax Consultant	1,901
Achieve Accreditation LLC	Accreditation Services	8,469
Compliagent	Compliance Services	3,761
Cortex Health Inc	Data Processing	8,743
Elaton Energy Services	Energy Mngmt Consulting	500
Personnel Planners	Unemployment Consulting	1,860
Telemedicine	Risk Prevention Software	7,408
See Attached	Legal	118,413
See Supplemental Schedule		784
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 230,230

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 144,697
Unemployment Compensation Insurance	37,736
FICA Taxes	569,682
Employee Health Insurance	284,437
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	20,072
401K Expense	35,632
Voluntary Benefit Contributions	16,995
Employee Physical Exams	10,440
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,119,691

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	$ 995
Advertising: Employee Recruitment	468
Health Care Worker Background Check	720
(Indicate # of checks performed 72)	
Patient Background Checks 233	2,325
Dues & Subscriptions	32,599
Licenses & Fees	633
See Supplemental Schedule	5,463
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 43,203

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	438
See Supplemental Schedule	218
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 656

* Attach copy of IMRF notifications

**See instructions.

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 - $47,526**

(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. $ **34,011** 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. $ **677,337**
This amount is to be recorded on line 42 of Schedule V.

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

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $

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

(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