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: 0055996

Facility Name: Skokie Meadows

Address: 4600 West Golf Road (Number) Skokie (City) 60076 (Zip Code)

County: Cook

Telephone Number: (847) 679-1157 **Fax #** (847) 679-0432

HFS ID Number:

Date of Initial License for Current Owners: 2/1/2020

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 02/01/20 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) 05/27/2021 (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title) Steven N. Lavenda, CPA — Partner
(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 Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	89	Intermediate (ICF)	89	29,815	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	89	TOTALS	89	29,815	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					8
9	SNF/PED					9
10	ICF	17,837	106	8,078	26,021	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,837	106	8,078	26,021	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.27%

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 2/1/2020

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/2020 NO [ ]

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

Medicare Intermediary N/A

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 Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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	176,042	15,976	4,606	196,624		196,624		196,624			1
2	Food Purchase		95,699		95,699		95,699	(4)	95,695			2
3	Housekeeping	197,910	13,713	1,000	212,623		212,623	945	213,568			3
4	Laundry		7,522	106	7,628		7,628		7,628			4
5	Heat and Other Utilities			42,749	42,749		42,749	552	43,301			5
6	Maintenance	37,688	8,415	65,046	111,149		111,149	30,263	141,412			6
7	Other (specify):*							1,571	1,571			7
8	**TOTAL General Services**	411,640	141,325	113,507	666,472		666,472	33,326	699,798			8
	B. Health Care and Programs											
9	Medical Director			32,980	32,980		32,980		32,980			9
10	Nursing and Medical Records	1,251,403	185,808	11,157	1,448,368		1,448,368	(61,604)	1,386,764			10
10a	Therapy											10a
11	Activities	55,996	15,989		71,985		71,985		71,985			11
12	Social Services	108,339		12,394	120,733		120,733		120,733			12
13	CNA Training											13
14	Program Transportation			647	647		647		647			14
15	Other (specify):*							13,224	13,224			15
16	**TOTAL Health Care and Programs**	1,415,738	201,797	57,178	1,674,713		1,674,713	(48,380)	1,626,333			16
	C. General Administration											
17	Administrative	114,727		170,795	285,522		285,522	(119,659)	165,863			17
18	Directors Fees											18
19	Professional Services			86,412	86,412	(16,957)	69,455	175	69,630			19
20	Dues, Fees, Subscriptions & Promotions			42,445	42,445		42,445	(14,815)	27,630			20
21	Clerical & General Office Expenses		537	70,122	70,659		70,659	46,322	116,981			21
22	Employee Benefits & Payroll Taxes			324,593	324,593		324,593		324,593			22
23	Inservice Training & Education											23
24	Travel and Seminar			886	886		886	28	914			24
25	Other Admin. Staff Transportation			4,234	4,234		4,234	1,690	5,924			25
26	Insurance-Prop.Liab.Malpractice			74,038	74,038		74,038	2,122	76,160			26
27	Other (specify):*							24,558	24,558			27
28	**TOTAL General Administration**	114,727	537	773,525	888,789	(16,957)	871,832	(59,578)	812,253			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,942,105	343,659	944,210	3,229,974	(16,957)	3,213,017	(74,633)	3,138,384			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 Skokie Meadows #0055996 Report Period Beginning: 02/01/20 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			5,913	5,913		5,913	178,617	184,530			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							103,750	103,750			32
33	Real Estate Taxes					16,957	16,957	183,612	200,569			33
34	Rent-Facility & Grounds			372,953	372,953		372,953	(363,507)	9,446			34
35	Rent-Equipment & Vehicles			2,148	2,148		2,148	9,712	11,860			35
36	Other (specify):*							27,238	27,238			36
37	**TOTAL Ownership**			381,014	381,014	16,957	397,971	139,421	537,392			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,377	8,151	9,528		9,528		9,528			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*	16,547		23,449	39,996		39,996	(39,996)	(0)			43
44	**TOTAL Special Cost Centers**	16,547	1,377	31,600	49,524		49,524	(39,996)	9,528			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,958,652	345,036	1,356,824	3,660,512		3,660,512	24,792	3,685,304			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 Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(230)	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	175,996	30		9
10	Interest and Other Investment Income	(327)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4)	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				18
19	Entertainment				19
20	Contributions	(6,000)	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	(43,162)	21		24
25	Fund Raising, Advertising and Promotional	(1,500)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(143,684)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (18,911)		$	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)	43,704		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 43,704		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 24,793		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

Skokie Meadows

ID# 0055996

Report Period Beginning: 02/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (1,496)	21	1
2	Laboratory Veterans	(35,823)	10	2
3	Pharmacy Veterans	(77,393)	10	3
4	Radiology Veterans	(1,060)	10	4
5	Patient Needs	(170)	10	5
6	Salaries - Marketing	(16,547)	43	6
7	Marketing Expense	(23,194)	43	7
8	Credit Card/Pymt Process Fees	(63)	21	8
9	Additional R&M	23,284	06	9
10	PAC Dues	(8,259)	20	10
11	Promotion Fees	(255)	43	11
12	Bldg Co - Bank Charges & Fees	(175)	21	12
13	Bldg Co - Legal & Professional Services	(2,533)	19	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(143,684)		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**

Skokie Meadows

IDH 0055996
Report Period Beginning: 02/01/20
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 Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(4)											(4)	2
3	Housekeeping			945									945	3
4	Laundry													4
5	Heat and Other Utilities	(230)		782									552	5
6	Maintenance	23,284		6,847	131								30,263	6
7	Other (specify):*			1,571									1,571	7
8	**TOTAL General Services**	23,050		10,145	131								33,326	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(114,446)		52,842									(61,604)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			13,224									13,224	15
16	**TOTAL Health Care and Programs**	(114,446)		66,066									(48,380)	16
	C. General Administration													
17	Administrative			(119,659)									(119,659)	17
18	Directors Fees													18
19	Professional Services	(2,533)	2,533	175									175	19
20	Fees, Subscriptions & Promotions	(15,759)		944									(14,815)	20
21	Clerical & General Office Expenses	(44,896)	175	91,043									46,322	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			28									28	24
25	Other Admin. Staff Transportation			1,690									1,690	25
26	Insurance-Prop.Liab.Malpractice			2,122									2,122	26
27	Other (specify):*			24,558									24,558	27
28	**TOTAL General Administration**	(63,188)	2,708	902									(59,578)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(154,584)	2,708	77,112	131								(74,633)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Skokie Meadows # 0055996 **Report Period Beginning:** 02/01/20 **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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	175,996		1,558	1,063								178,617	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(327)	99,313	1,566	3,198								103,750	32
33	Real Estate Taxes		179,227		4,385								183,612	33
34	Rent-Facility & Grounds		(372,953)	14,268	(4,822)								(363,507)	34
35	Rent-Equipment & Vehicles			9,712									9,712	35
36	Other (specify):*		27,238										27,238	36
37	**TOTAL Ownership**	175,669	(67,175)	27,104	3,824								139,421	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(39,996)											(39,996)	43
44	**TOTAL Special Cost Centers**	(39,996)											(39,996)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(18,911)	(64,467)	104,216	3,955								24,792	45

Facility Name & ID Number Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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	Rental Income	$ 372,953	Golf Knox Properties LLC		$	$ (372,953)	1
2	V	32	HUD Mortgage Interest	15	Golf Knox Properties LLC		99,328	99,313	2
3	V	36	MIP Insurance		Golf Knox Properties LLC		27,238	27,238	3
4	V	21	Bank Charges & Fees		Golf Knox Properties LLC		175	175	4
5	V	19	Legal & Professional Services		Golf Knox Properties LLC		2,533	2,533	5
6	V	33	Real Estate Tax Expense		Golf Knox Properties LLC		179,227	179,227	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 372,968			$ 308,501	$ * (64,467)	14

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

Facility Name & ID Number Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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	Jonathan Aaron	27.04%	AMBERWOOD CARE CENTER	ROCKFORD, IL	GOLF KNOX PROPERTIES, LLC		BUILDING COMPANY	1
2	Kenneth Ripstein	27.04%	WARREN PARK HEALTH AND LIVING CENTER	CHICAGO, IL	DAMEN HEALTHCARE GROUP	SKOKIE, IL	BOOKKEEPING	2
3	Stern Family Investment Trust U/A/D 06/11/15	4.99%	CITADEL CARE CENTER-KANKAKEE LLC	KANKAKEE, IL	3755 CHASE, LLC	SKOKIE	BUILDING COMPANY	3
4	Raphaela Stern	4.99%	CITADEL CARE CENTER-ELGIN LLC	ELGIN, IL	BILTMORE INC. CELL	BURLINGTON, VT	INSURANCE	4
5	Berger Family Trust U/A/D 06/25/14	4.99%	CITADEL CARE CENTER-WILMETTE LLC	WILMETTE, IL	INTEGRA HEALTHCARE EQUI	ELMHURST	DME	5
6	Menachem Berger	4.99%	THE WATERFORD CARE CENTER LLC	CHICAGO, IL	LIFELINE AMBULANCE	SKOKIE	AMBULANCE	6
7	Israel Family Investment Trust U/A/D 05/20/15	4.99%	CITADEL CARE CENTER-STERLING LLC	STERLING, IL				7
8	Israel Family Trust U/A/D 06/18/15	4.99%	THE CITADEL OF NORTHBROOK LLC	NORTHBROOK, IL				8
9	Leonard Weiss	2.50%	PA PETERSON AT THE CITADEL LLC	ROCKFORD, IL				9
10	Jonah Bruck	2.50%	THE CITADEL OF GLENVIEW LLC	GLENVIEW, IL				10
11	Ilana Teller	4.99%	THE CITADEL OF BOURBONNAIS LLC	BOURBONNAIS				11
12	Marcella Graf	2.00%	THE CITADEL OF SKOKIE LLC	SKOKIE, IL				12
13	Lisa Trudeau	2.00%						13
14	Yakov Kohen	2.00%						14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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	3	Housekeeping	$	Damen Healthcare Group, LLC		$ 945	$ 945	15
16	V	5	Utilities		Damen Healthcare Group, LLC		782	782	16
17	V	6	Maintenance Salary		Damen Healthcare Group, LLC		7,393	7,393	17
18	V	6	Maintenance	1,518	Damen Healthcare Group, LLC		972	(546)	18
19	V	7	Maintenance Benefits		Damen Healthcare Group, LLC		1,571	1,571	19
20	V	10	Nursing	10,800	Damen Healthcare Group, LLC		63,642	52,842	20
21	V	15	Nursing Benefits		Damen Healthcare Group, LLC		13,224	13,224	21
22	V	17	Administrative	170,795	Damen Healthcare Group, LLC		16,402	(154,393)	22
23	V	19	Professional Fees		Damen Healthcare Group, LLC		175	175	23
24	V	20	Dues, Fees, Subscriptions		Damen Healthcare Group, LLC		944	944	24
25	V	21	Office Expense - Salaries		Damen Healthcare Group, LLC		92,035	92,035	25
26	V	21	Office Expense - Other	7,684	Damen Healthcare Group, LLC		6,692	(992)	26
27	V	24	Seminars & Education		Damen Healthcare Group, LLC		28	28	27
28	V	25	Auto Expense		Damen Healthcare Group, LLC		1,690	1,690	28
29	V	26	Insurance		Damen Healthcare Group, LLC		2,122	2,122	29
30	V	27	Employee Ben. - Gen. Admin.		Damen Healthcare Group, LLC		24,558	24,558	30
31	V	30	Depreciation		Damen Healthcare Group, LLC		1,558	1,558	31
32	V	32	Interest Expense		Damen Healthcare Group, LLC		1,566	1,566	32
33	V	34	Rent-Unrelated		Damen Healthcare Group, LLC		9,446	9,446	33
34	V	34	Rent-3755 W. Chase		Damen Healthcare Group, LLC		4,822	4,822	34
35	V	35	Equipment Rental		Damen Healthcare Group, LLC		522	522	35
36	V	35	Auto Lease		Damen Healthcare Group, LLC		9,190	9,190	36
37	V	17	Admin Fees-J Aaron		Damen Healthcare Group, LLC		18,333	18,333	37
38	V	17	Admin Fees-K Ripstein		Damen Healthcare Group, LLC		16,402	16,402	38
39	Total			$ 190,796			$ 295,012	$ * 104,216	39

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

Facility Name & ID Number Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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	6	Maintenance	$	3755 W Chase, LLC		$ 131	$ 131	15
16	V	30	Depreciation		3755 W Chase, LLC		1,063	1,063	16
17	V	32	Interest Expense		3755 W Chase, LLC		3,198	3,198	17
18	V	33	Real Estate Taxes		3755 W Chase, LLC		3,728	3,728	18
19	V	33	Real Estate Tax Protest Fees		3755 W Chase, LLC		657	657	19
20	V								20
21	V	34	Rent	4,822	3755 W Chase, LLC			(4,822)	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			$ 4,822			$ 8,777	$ * 3,955	39

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

Facility Name & ID Number Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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	26	Insurance	$ 131,303	Biltmore Incorporated Cell		$ 131,303	$	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			$ 131,303			$ 131,303	$ *	39

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

Facility Name & ID Number Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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 Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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 Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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 Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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 Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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 Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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 Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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	Jonathan Aaron	Owner	Administrative	27.04%	See Attached	2.93	7.33%	Alloc Mgt Fee	$ 18,333	17-7	1
2	Kenneth Ripstein	Administrative	Administrative	27.04%	See Attached	2.62	6.55%	Alloc Mgt Fee	16,402	17-7	2
3	Yakov Kohen	Clerical	Clerical	2.00%	See Attached	2.62	6.55%	Alloc Salary	8,995	21-7	3
4	Marcella Graf	Administrative	Administrative	2.00%	See Attached	2.62	6.55%	Alloc Salary	16,402	17-7	4
5	Lisa Trudeau	VP Clinical Op.	Nsg Admin	2.00%	See Attached	2.62	6.55%	Alloc Salary	19,017	10-7	5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 79,149		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 Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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 Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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: Damen Healthcare Group, LLC
Street Address: 3755 W. Chase Ave.
City / State / Zip Code: Skokie, IL 60076
Phone Number: (224) 470-2044
Fax Number: (224) 470-2952

	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	3	Housekeeping	Patient Days	396,623	14	$ 14,400	$	26,021	$ 945	1
2	5	Utilities	Patient Days	396,623	14	11,913		26,021	782	2
3	6	Maintenance Salary	Patient Days	396,623	14	112,690	112,690	26,021	7,393	3
4	6	Maintenance	Patient Days	396,623	14	14,821		26,021	972	4
5	7	Maintenance Benefits	Patient Days	396,623	14	23,951		26,021	1,571	5
6	10	Nursing	Patient Days	396,623	14	970,057	948,342	26,021	63,642	6
7	15	Nursing Benefits	Patient Days	396,623	14	201,561		26,021	13,224	7
8	17	Administrative	Patient Days	396,623	14	250,000	250,000	26,021	16,402	8
9	19	Professional Fees	Patient Days	396,623	14	2,669		26,021	175	9
10	20	Dues, Fees, Subscriptions	Patient Days	396,623	14	14,390		26,021	944	10
11	21	Office Expense - Salaries	Patient Days	396,623	14	1,402,841	1,402,841	26,021	92,035	11
12	21	Office Expense - Other	Patient Days	396,623	14	101,995		26,021	6,692	12
13	24	Seminars & Education	Patient Days	396,623	14	431		26,021	28	13
14	25	Auto Expense	Patient Days	396,623	14	25,762		26,021	1,690	14
15	26	Insurance	Patient Days	396,623	14	32,350		26,021	2,122	15
16	27	Employee Ben. - Gen. Admin.	Patient Days	396,623	14	374,325		26,021	24,558	16
17	30	Depreciation	Patient Days	396,623	14	23,745		26,021	1,558	17
18	32	Interest Expense	Patient Days	396,623	14	23,867		26,021	1,566	18
19	34	Rent-Unrelated	Patient Days	396,623	14	143,975		26,021	9,446	19
20	34	Rent-3755 W. Chase	Patient Days	396,623	14	73,500		26,021	4,822	20
21	35	Equipment Rental	Patient Days	396,623	14	7,954		26,021	522	21
22	35	Auto Lease	Patient Days	396,623	14	140,073		26,021	9,190	22
23	17	Admin Fees-J Aaron	Patient Days	354,845	13	250,000		26,021	18,333	23
24	17	Admin Fees-K Ripstein	Patient Days	396,623	14	250,000		26,021	16,402	24
25	TOTALS					$ 4,467,270	$ 2,713,873		$ 295,012	25

Facility Name & ID Number Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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: 3755 W Chase, LLC
Street Address: 3755 W. Chase Ave.
City / State / Zip Code: Skokie, IL 60076
Phone Number: (224) 470-2044
Fax Number: (224) 470-2952

	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	6	Maintenance	Patient Days	396,623	14	$ 2,000	$	26,021	$ 131	1
2	30	Depreciation	Patient Days	396,623	14	16,199		26,021	1,063	2
3	32	Interest Expense	Patient Days	396,623	14	48,746		26,021	3,198	3
4	33	Real Estate Taxes	Patient Days	396,623	14	56,831		26,021	3,728	4
5	33	Real Estate Tax Protest Fees	Patient Days	396,623	14	10,020		26,021	657	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					$ 133,796	$		$ 8,777	25

Facility Name & ID Number Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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: Biltmore Incorporated Cell
Street Address: 30 Main street, Suite 330
City / State / Zip Code: Burlington, Vermont 05401
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	26	Insurance	Direct Allocation			$	$		$ 131,303	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
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14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 131,303	25

Facility Name & ID Number Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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 Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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 Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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 Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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 Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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 Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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	Cambridge Realty Capital Ltd of IL		X	Mortgage			$	$ 4,889,206			$ 99,328	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CIBC		X	Line of Credit				575,000				6
7												7
8												8
9	TOTAL Facility Related						$	$ 5,464,206			$ 99,328	9
	B. Non-Facility Related*											
10	Interest Income		X								(327)	10
11	Allocated from Damen HC	X									1,566	11
12	Allocated from 3755 Chase	X									3,198	12
13	Interest Income - Bldg Co		X								(15)	13
14	TOTAL Non-Facility Related						$	$			$ 4,422	14
15	TOTALS (line 9+line14)						$	$ 5,464,206			$ 103,750	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 27,238 Line # 36

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

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

Facility Name & ID Number Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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.**	$ 215,993	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.)		$ 174,047	2
3. Under or (over) accrual (line 2 minus line 1).		$ (41,946)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 225,558	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.)**		$ 16,957	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.		$ 200,569	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	223,920	8
	2016	224,609	9
	2017	237,952	10
	2018	236,242	11
	2019	169,662	12

2020 Accrual = $169,662 x 1.32 = $225,558
Allocated from 3755 Chase $3,728
Beginning Accrual Adjusted

	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 Skokie Meadows COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0055996

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.	10-10-304-042-0000	Long Term Care Property	$ 169,661.92	$ 169,661.92
2.	10-26-318-023-0000	Allocated from Home Office	$ 172,792.10	$ 11,336.26
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 342,454.02	$ 180,998.18

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 Skokie Meadows COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0055996

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 Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,213 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

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			$ 584,156	1
2	Allocated from3755 W Chase		2019	44,101	2
3	TOTALS			$ 628,257	3

Facility Name & ID Number Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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	89		2020	1977	$ 5,636,288	$	35	$ 147,617	$ 147,617	$ 147,617	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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)		6,015			301	301	301	67
68	Related Party Allocations (Pages 12H & 12I)		249,903	1,628		1,424	(204)	11,008	68
69	Financial Statement Depreciation			5,913			(5,913)		69
70	TOTAL (lines 4 thru 69)		$ 5,892,206	$ 7,541		$ 149,342	$ 141,801	$ 158,925	70

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

Facility Name & ID Number Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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		$ 5,892,206	$ 7,541		$ 149,342	$ 141,801	$ 158,925	1
2	Total Elevator Service - Replace Door Operator Package	2020	22,301		20				2
3	Paragon Mechanical, Inc. - Roof Top Unit Installation-18651-1865	2020	21,129		20				3
4	Paragon Mechanical, Inc. - Roof Top Unit Installation-#19299	2020	9,823		20				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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,945,459	$ 7,541		$ 149,342	$ 141,801	$ 158,925	34

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

Facility Name & ID Number Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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		$ 5,945,459	$ 7,541		$ 149,342	$ 141,801	$ 158,925	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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19									19
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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)		$ 5,945,459	$ 7,541		$ 149,342	$ 141,801	$ 158,925	34

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

Facility Name & ID Number Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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		$ 5,945,459	$ 7,541		$ 149,342	$ 141,801	$ 158,925	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)		$ 5,945,459	$ 7,541		$ 149,342	$ 141,801	$ 158,925	34

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

Facility Name & ID Number Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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		$ 5,945,459	$ 7,541		$ 149,342	$ 141,801	$ 158,925	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,945,459	$ 7,541		$ 149,342	$ 141,801	$ 158,925	34

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

Facility Name & ID Number Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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	Install of RTU 03 Cooling Rooftop Unit (14,249)	2020	6,015		20	301	301	301	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)		$ 6,015	$		$ 301	$ 301	$ 301	34

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

Facility Name & ID Number Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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		$ 6,015	$		$ 301	$ 301	$ 301	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)		$ 6,015	$		$ 301	$ 301	$ 301	34

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

Facility Name & ID Number Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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 3737 Chase	2019	249,903	1,063	35	1,424	361	11,008	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Damen Management	2015		565			(565)		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)		$ 249,903	$ 1,628		$ 1,424	$ (204)	$ 11,008	34

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

Facility Name & ID Number Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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		$ 249,903	$ 1,628		$ 1,424	$ (204)	$ 11,008	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
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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)		$ 249,903	$ 1,628		$ 1,424	$ (204)	$ 11,008	34

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

Facility Name & ID Number Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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	$ 5,835	$ 539	$ 539	$	10	$ 3,075	71
72	Current Year Purchases	387,859	366	34,561	34,195	10	34,561	72
73	Fully Depreciated Assets	745	87	87		10	745	73
74								74
75	TOTALS	$ 394,438	$ 993	$ 35,187	$ 34,195		$ 38,380	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)	$ 6,968,154	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 8,534	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 184,529	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 175,996	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 197,306	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 Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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 Damen HC				9,446			5
6								6
7	TOTAL				$ 9,446 **			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: $ 2,670 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 Damen HC		$	$ 9,190	17
18					18
19					19
20					20
21	TOTAL		$	$ 9,190	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 Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							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				1,377		1,377	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					8,151			8,151	13
14	TOTAL			$		$ 8,151	$ 1,377		$ 9,528	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 Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 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	$ 884,143	$ 884,143	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	430,408	430,408	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	53,016	53,016	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	1,200	212,752	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,368,767	$ 1,580,319	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		584,156	13
14	Buildings, at Historical Cost		5,636,288	14
15	Leasehold Improvements, at Historical Cost	53,253	59,268	15
16	Equipment, at Historical Cost	33,646	406,678	16
17	Accumulated Depreciation (book methods)	(5,914)	(5,914)	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		67,783	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 80,985	$ 6,748,259	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,449,752	$ 8,328,578	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 143,986	$ 143,986	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	575,000	575,000	29
30	Accrued Salaries Payable	136,895	136,895	30
31	Accrued Taxes Payable (excluding real estate taxes)	105,827	105,827	31
32	Accrued Real Estate Taxes(Sch.IX-B)		225,558	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	732,335	732,335	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,694,043	$ 1,919,601	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,889,206	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached		147,497	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,036,703	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,694,043	$ 6,956,304	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (244,291)	$ 1,372,274	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,449,752	$ 8,328,578	48

***(See instructions.)**

Facility Name & ID Number Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(244,291)	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)**	$ (244,291)	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)**	$ (244,291)	24 *

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

Facility Name & ID Number Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 Ending: 12/31/20

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	$ 3,415,894	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,415,894	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	327	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 327	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,416,221	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	666,472	31
32	Health Care	1,674,713	32
33	General Administration	888,789	33
	B. Capital Expense		
34	Ownership	381,014	34
	C. Ancillary Expense		
35	Special Cost Centers	49,524	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,660,512	40
41	**Income before Income Taxes (line 30 minus line 40)****	(244,291)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (244,291)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,207,150	44
45	Private Pay - Net Inpatient Revenue	29,363	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Veterans	1,179,381	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,415,894	49

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

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

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

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

Facility Name & ID Number Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 Ending: 12/31/20

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,928	2,142	$ 70,700	$ 33.01	1
2	Assistant Director of Nursing	2,118	2,353	70,530	29.97	2
3	Registered Nurses	12,200	13,556	404,241	29.82	3
4	Licensed Practical Nurses	2,688	2,986	99,000	33.15	4
5	CNAs & Orderlies	30,282	33,647	569,306	16.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,427	2,697	55,996	20.76	10
11	Social Service Workers	3,999	4,443	108,339	24.38	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	9,666	10,740	176,042	16.39	15
16	Dishwashers					16
17	Maintenance Workers	1,655	1,839	37,688	20.49	17
18	Housekeepers	10,227	11,364	197,910	17.42	18
19	Laundry					19
20	Administrator	1,656	1,840	114,727	62.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,613	1,792	37,626	21.00	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	399	443	16,547	37.35	33
34	TOTAL (lines 1 - 33)	80,858	89,842	$ 1,958,652 *	$ 21.80	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	98	$ 4,606	01-03	35
36	Medical Director	Monthly	32,980	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Per Visit	228	10-03	38
39	Pharmacist Consultant	Monthly	10,929	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				44
45	Social Service Consultant	88	5,824	12-03	45
46	Other(specify)				46
47	Psychiatric	Monthly	6,570	12-03	47
48					48
49	TOTAL (lines 35 - 48)	186	$ 61,137		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

Facility Name & ID Number Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joan Willey	Administrator	0	$ 114,727
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 114,727

B. Administrative - Other

Description	Amount
Management Fees - Damen Healthcare Group, LLC	$ 170,795
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 170,795

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 5,062
ProPay HR	Payroll Services	13,097
eSolutions, Inc.	Data Processing	1,065
IIT/SourceTech	Data Processing	459
National Datacare Corporation	Data Processing	2,266
PointClickCare Technologies	Data Processing	27,856
Reside Admissions	Data Processing	2,614
Madison Specs	Cost Segregation Study	1,800
Pendulum, LLC	Liability Risk Assessments	3,750
Personnel Planners	Unemployment Consultant	278
See Attached	Legal	21,301
See Supplemental Schedule		6,864
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 86,412

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 12,099
Unemployment Compensation Insurance	27,227
FICA Taxes	149,837
Employee Health Insurance	102,698
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	2,772
Dental / Vision Insurance	5
Employee Benefits - Other	5,984
Holiday Expense	1,176
401K Employer Match Expense	6,219
Pension Expense	16,576
TOTAL (agree to Schedule V, line 22, col.8)	$ 324,593

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,075
Health Care Worker Background Check	
(Indicate # of checks performed 11)	838
Patient Background Checks 107	1,076
Dues & Subscriptions	9,418
Licenses & Fees	8,279
See Supplemental Schedule	944
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,630

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	886
See Supplemental Schedule	28
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 914

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Skokie Meadows # 0055996 Report Period Beginning: 02/01/20 Ending: 12/31/20

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Alliance for Living $13,200**

(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. $ **0** Line **N/A**

(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. $
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? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
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 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.