





Facility Name & ID Number **SKOKIE MEADOWS BEHAVIORAL CEN1** # **0054312** Report Period Beginning: **01/01/2018** Ending: **12/31/2018**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	157,845	19,660	7,896	185,401		185,401		185,401		1
2	Food Purchase		187,637		187,637	(5,749)	181,888		181,888		2
3	Housekeeping	159,614	17,080		176,694		176,694		176,694		3
4	Laundry		13,748		13,748		13,748		13,748		4
5	Heat and Other Utilities			21,068	21,068		21,068		21,068		5
6	Maintenance	23,092	14,443	50,727	88,262		88,262		88,262		6
7	Other (specify):*			8,734	8,734		8,734		8,734		7
8	<b>TOTAL General Services</b>	340,551	252,568	88,425	681,544	(5,749)	675,795		675,795		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,138,547	23,981	54,226	1,216,754		1,216,754		1,216,754		10
10a	Therapy										10a
11	Activities	71,023	6,359	2,544	79,926		79,926		79,926		11
12	Social Services	134,512		3,056	137,568		137,568		137,568		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,344,082	30,340	71,826	1,446,248		1,446,248		1,446,248		16
	<b>C. General Administration</b>										
17	Administrative	73,184		120,000	193,184		193,184		193,184		17
18	Directors Fees										18
19	Professional Services			29,546	29,546		29,546	(75)	29,471		19
20	Dues, Fees, Subscriptions & Promotions			71,197	71,197		71,197	(31,285)	39,912		20
21	Clerical & General Office Expenses	36,614	5,773	8,210	50,597		50,597		50,597		21
22	Employee Benefits & Payroll Taxes			337,307	337,307	5,749	343,056		343,056		22
23	Inservice Training & Education			4,125	4,125		4,125		4,125		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			6,750	6,750		6,750		6,750		25
26	Insurance-Prop.Liab.Malpractice			75,529	75,529		75,529		75,529		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	109,798	5,773	652,664	768,235	5,749	773,984	(31,360)	742,624		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,794,431	288,681	812,915	2,896,027		2,896,027	(31,360)	2,864,667		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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	7,896
	REPAIRS & MAINTENANCE	
		7,896
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	0
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	6,718
	ELECTRICITY	
	WATER	13,842
	CABLE TV - LOBBY	508
		21,068
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	1,090
	PAINTING & DECORATING	
	BUILDING REPAIRS	20,024
	MAINTENANCE TRAVEL	
	EQUIPMENT MAINTENANCE & REPAIR	7,827
	ELEVATOR MAINTENANCE & REPAIR	10,300
	OUTSIDE LABOR	5,433
	EXTERMINATING SERVICE	675
	FIRE SERVICE	5,378
		50,727
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	8,734
	SECURITY SERVICE	
		8,734
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	12,000
		12,000

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	5,386
	PURCHASED SERVICES	18,835
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,600
	PHARMACY CONSULTANT XVIII B 39-2	4,405
	UTILIZATION REVIEW FEES XVIII B __-2	
	PHYSICIANS XVIII B __-2	
	PSYCHIATRIC XVIII B -2	24,000
	RN CONSULTANT XVIII B 38-2	
		54,226
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	
	OCCUPATIONAL THERAPY SERVICES	
	REHABILITATION CONSULTANT XVIII B __-2	
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	
	SPEECH THERAPY CONSULTANT XVIII B 43-2	
		0
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,544
		2,544
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	
	SOCIAL WORKER XVIII B 45-2	3,056
		3,056
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	0
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	120,000
<b>18</b>	<b>DIRECTORS FEES</b>	
	DIRECTORS FEES	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	
	ADMINISTRATIVE CONSULTANTS XIX C	
	PROFESSIONAL FEES XIX C	29,546
		29,546
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	29,325
	EMPLOYEE RECRUITMENT/WANT ADS XIX F	
	CONTRIBUTIONS VI 20 XIX F	1,960
	DUES & SUBSCRIPTIONS XIX F	38,207
	LICENSES & PERMITS XIX F	1,705
	PUBLIC RELATIONS-PATIENT RELATED XIX F	
	ADVERTISING-YELLOW PAGES VI 28 XIX F	
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	
	HEALTH CARE WORKER BACKGROUND CHECKS XIX F	
	PATIENT BACKGROUND CHECKS XIX F	
		71,197
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	116
	EQUIPMENT REPAIR & MAINTENANCE	
	OUTSIDE CLERICAL SERVICES	
	PENALTIES / OVERDRAFT CHARGES VI 18	
	HOME OFFICE EXPENSE	
	THEFT & DAMAGE LOSS	
	TELEPHONE	8,094
	MESSANGER SERVICE	
		8,210

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	132,838
	UNEMPLOYMENT COMPENSATION XIX D	11,079
	WORKERS COMPENSATION INSURANCE XIX D	23,019
	HOSPITALIZATION INSURANCE XIX D	143,808
	EMPLOYEE BENEFITS - OTHER XIX D	26,563
	EMPLOYEE PHYSICAL EXAMS XIX D	
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	
	PENSION/PROFIT SHARING PLANS XIX D	
		337,307
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	4,125
		4,125
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	
	TRAVEL XIX G	
		0
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	6,750
		6,750
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	75,529
		75,529
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	
		0

**GRAND TOTAL COLUMN 3 OTHER 812,915**

**SKOKIE MEADOWS BEHAVIORAL CENTER  
SCHEDULES  
12/31/2018**

**EMPLOYEE MEAL RECLASSIFICATION  
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	187,637	
LESS SALES TAX	<u>0</u>	<b>HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??</b>
NET FOOD	187,637	
TOTAL PATIENT CENSUS	26,902	
TIMES 3 MEALS PER DAY	<u>3</u>	
TOTAL PATIENT MEALS	80,706	
ADD # EMPLOYEE MEALS/DAY	7	
TIMES # DAYS	<u>365</u>	
TOTAL EMPLOYEE MEALS	2,555	
PATIENT MEALS	80,706	
ADD EMPLOYEE MEALS	<u>2,555</u>	
TOTAL MEALS/YEAR	83,261	
NET FOOD	187,637	
DIVIDE TOTAL MEALS/YEAR	<u>83,261</u>	
COST PER MEAL	2.25	
TIMES EMPLOYEE MEALS	<u>2,555</u>	
EMPLOYEE MEAL RECLASSIFIC	<u><u>5,749</u></u>	

Facility Name &amp; ID Number

SKOKIE MEADOWS BEHAVIORAL CENTER

#0054312

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			6,707	6,707		6,707	138,679	145,386			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							140,957	140,957			32
33	Real Estate Taxes			250,952	250,952		250,952		250,952			33
34	Rent-Facility & Grounds			590,065	590,065		590,065	(590,065)				34
35	Rent-Equipment & Vehicles			2,934	2,934		2,934		2,934			35
36	Other (specify):*							34,402	34,402			36
37	<b>TOTAL Ownership</b>			850,658	850,658		850,658	(276,027)	574,631			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		138,038		138,038		138,038		138,038			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		138,038		138,038		138,038		138,038			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	1,794,431	426,719	1,663,573	3,884,723		3,884,723	(307,387)	3,577,336			45

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

**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.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	78,032	30		9
10	Interest and Other Investment Income	(14,865)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(1,960)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(75)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(29,325)	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				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 31,807		\$	30

<b>BHF USE ONLY</b>							
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	2	
		<b>Amount</b>	<b>Reference</b>	
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)	(339,194)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (339,194)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (307,387)		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	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

ID# 0054312

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	ALLIANCE FOR LIVING POLITICAL PORTION	\$	20	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				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	<b>Total</b>	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SKOKIE MEADOWS BEHAVIORAL CENTER

# 0054312

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>8</b>
<b>B. Health Care and Programs</b>														
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
<b>C. General Administration</b>														
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(75)	0	0	0	0	0	0	0	0	0	0	(75)	19
20	Fees, Subscriptions & Promotions	(31,285)	0	0	0	0	0	0	0	0	0	0	(31,285)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(31,360)</b>	<b>0</b>	<b>(31,360)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(31,360)</b>	<b>0</b>	<b>(31,360)</b>	<b>29</b>									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SKOKIE MEADOWS BEHAVIORAL CENTER # 0054312 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	78,032	60,647	0	0	0	0	0	0	0	0	0	138,679	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(14,865)	155,822	0	0	0	0	0	0	0	0	0	140,957	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(590,065)	0	0	0	0	0	0	0	0	0	(590,065)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	34,402	0	0	0	0	0	0	0	0	0	34,402	36
37	<b>TOTAL Ownership</b>	<b>63,167</b>	<b>(339,194)</b>	<b>0</b>	<b>(276,027)</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> <b>(sum of lines 29, 37 &amp; 44)</b>	<b>31,807</b>	<b>(339,194)</b>	<b>0</b>	<b>(307,387)</b>	<b>45</b>								

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
MARC APPEL	50	CAMBRIDGE NURSING REHAB CENTER	SKOKIE	SKOKIE CAMBRIDGE		REAL ESTATE
JOAN WILLEY	50			REALTY LLC	SKOKIE	

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 RENT	\$ 590,065	SKOKIE CAMBRIDGE REALTY, LLC		\$	(590,065)	1
2	V	30 DEPRECIATION				60,647	60,647	2
3	V	32 INTEREST				150,529	150,529	3
4	V	36 MIP INSURANCE				34,402	34,402	4
5	V	32 AMORT OF LOAN COST				5,293	5,293	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 590,065			\$ 250,871	\$ * (339,194)	14

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

Facility Name & ID Number

SKOKIE MEADOWS BEHAVIORAL CENTER

# 0054312

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

**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 BEHAVIORAL CEN # 0054312 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

## 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JOAN WILLEY	CEO	ADMINISTRATIVE	0.50		50	83.33	MGMT FEE	\$ 120,000	17-3	1
2											2
3											3
4	MARK APPEL	CEO	FINANCIAL	0.50	120,000	10	16.66				4
5											5
6					CAMBRIDGE NURSING & REHAB						6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 120,000		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 BEHAVIORAL CENTER # 0054312 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Skokie Cambridge					\$		\$		\$	1									
2	Realty,LLC			MORTGAGE			12/21/12	7,239,800	6,183,642		150,529	2								
3	LOAN COST			Amortized over life of loan				79,398	47,640		5,293	3								
4												4								
5												5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>					\$	7,319,198	\$	6,231,282		\$	155,822	9							
<b>B. Non-Facility Related*</b>																				
10	IRS,IDR,ETC		X	LATE FEES								10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>					\$		\$			\$		14							
15	<b>TOTALS (line 9+line14)</b>					\$	7,319,198	\$	6,231,282		\$	155,822	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 34,402 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.)

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

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2017 report.	\$	<b>233,000</b>	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.)	\$	<b>237,952</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>4,952</b>	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>248,000</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>252,952</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013	<b>218,215</b>	8
	2014	<b>218,695</b>	9
	2015	<b>223,920</b>	10
	2016	<b>224,609</b>	11
	2017	<b>237,952</b>	12

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~105% OF THE PRIOR YEAR REAL ESTATE TAX BILL - THE PAYMENT ON LINE 2 APPLIES TO THE 2016 TAX BILL.**

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2017	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

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

**2017 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME SKOKIE MEADOWS BEHAVIORAL CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0054312

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

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

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>10-10-304-042-0000</u>	<u>NURSING HOME</u>	\$ <u>237,952.00</u>	\$ <u>237,952.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>237,952.00</u></u>	\$ <u><u>237,952.00</u></u>

**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   X   NO

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

**C. Tax Bills**

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

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

Facility Name & ID Number SKOKIE MEADOWS BEHAVIORAL CENTER

# 0054312

Report Period Beginning:

01/01/2018 Ending:

12/31/2018

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? (a) Own the Equipment (X) (b) Rent equipment from a Related Organization. (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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for counts. Row 1: 1, Use, Square Feet, 2007, \$ 275,250, 1. Row 2: 2, 2. Row 3: 3, TOTALS, \$ 275,250, 3.

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	111	2007		\$ 2,365,250	\$	39	\$ 60,647	\$ 60,647	\$ 616,578	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	WALL UNITS		2008	8,200		39	210	210	2,206	9
10	BASEMENT STAIRCASE		2008	4,895		39	126	126	1,322	10
11	INSTALLED REMOTE ANNAUNCIATOR PANEL		2008	6,850		39	176	176	1,848	11
12	INSTALL NEW GUIDES FOR ELEVATOR		2008	3,578		39	92	92	966	12
13	INSTALLED NEW TEKMAR CONTROL FOR BOILERS		2008	2,549		39	65	65	683	13
14	ELECTRICAL SERVICE		2008	2,650		39	68	68	714	14
15	ROOF TOP UNIT		2008	12,800		39	328	328	3,444	15
16	FIRE ALARM SYSTEM DEVICES		2009	29,065		39	745	745	7,416	16
17	SPRINKLER SYSTEM		2009	8,076		39	207	207	2,064	17
18	WALCOVERING CORRIDOR AND LOBBY		2010	9,190		39	236	236	2,114	18
19	SHOWERS ROOMS FLOOR REPLACEMENT		2010	18,730		39	480	480	4,300	19
20	NORT DINING ROOM PARTITION		2010	4,650		39	119	119	1,066	20
21	MAIN DINING ROOM NEW CEILING		2010	7,385		39	189	189	1,693	21
22	DOCTOR OFFICE NEW WALL & CEILING		2010	3,072		39	79	79	708	22
23	NURSING OFFICE WALL COVERING		2010	3,188		39	82	82	734	23
24	BASEMENT FLOORING NEW TILES		2010	15,600		39	400	400	3,583	24
25	FRONT ENTRY WAY WALL COVERING		2010	15,600		39	400	400	3,583	25
26	PAINTING CEILING		2010	26,720		39	685	685	6,137	26
27	DOORS		2010	14,175		39	363	363	3,252	27
28	MOLDED TO RAIL FINISH BLACK PAINT		2010	6,000		39	154	154	1,380	28
29										29
30	RESIDENT ROOM & PART OF HALLWAY FLOORING		2011	12,395		39	317	317	2,545	30
31	CONCRETE WORK		2011	11,880		39	305	305	2,445	31
32	HAT WATER SYSTEM		2011	20,433		39	524	524	4,204	32
33										33
34	REMOVED EXISTING NURSING STATION, COUNTER TOP AND CABINETS									34
35	REPLACE CABINETS AND COUNTERTOPS WITH A NEW DESIGN. TOP COUNTERTOP									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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	BUILT NEW CABINETS MADE FROM 3/4 INCH MELLAMI AND STANDAR		\$	\$		\$	\$	\$	37
38	GRADE LAMINATE. REMOVED EXISTING VINYL TILES FROM THE FLOOR								38
39	ALSO PREPARED THE FLOOR USING POWER GRINDER TO SMOOTH								39
40	THE SURFACE FOR THE NEW WOOD GRAIN 7 X 48 INCH VINYL								40
41	PLANKS. REMOVED EXISTING FORMICA COUNTERTOPS AND VINYL								41
42	TILES FROM THE FLOOR. REMOVED SOME DOOR FROM								42
43	EXISTING CABINETS. REPLACED WITH NEW LAMINATE LOOK.								43
44	BUILT NEW CABINETS FOR THE FAX MACHINE. INSTALLED								44
45	NEW WOOD GRAIN 7 X 48 INCH VINYL PLANK FLOORING,								45
46	TOPS AND NEW SINK. REMOVED AND REPLACED 30 X 80 INCH SOLID								46
47	CORE ENTRY DOOR TO MED ROOM. LAMINATED BOTH SIDES OF THE								47
48	DOOR WITH CHERRY LAMINATE LOOK AND DECORATIVE								48
49	TRIM. INSTALLED QUARTER INCH 12 X 12 CORK TILES BETWEEN								49
50	TOP CABINETS AND COUNTERTOP. INSTALLED 6 INCH C	2012	11,100		39	285	285	1,983	50
51	BASE TO FINISH.								51
52	HAND RAIL	2014	2,800		39	72	72	357	52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63				6,707			(6,707)		63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,626,831	\$ 6,707		\$ 67,354	\$ 60,647	\$ 677,325	70

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

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	\$ 173,854	\$	\$ 17,385	\$ 17,385		\$ 166,825	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 173,854	\$	\$ 17,385	\$ 17,385		\$ 166,825	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)	\$ 3,075,935	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 6,707	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 84,739	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 78,032	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 844,150	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.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: NA

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								5
6								6
7	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 2,934 Description: \_\_\_\_\_

(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			\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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.

**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.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$			\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				138,038		138,038	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY Other (specify):	39-2								13
14	TOTAL			\$		\$	138,038		\$ 138,038	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.

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 1,263,321	\$ 1,263,326	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	524,319	524,319	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		221,727	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,787,640	\$ 2,009,372	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		275,250	13
14	Buildings, at Historical Cost		2,365,250	14
15	Leasehold Improvements, at Historical Cost	261,581	261,581	15
16	Equipment, at Historical Cost	266,541	377,541	16
17	Accumulated Depreciation (book methods)	(309,809)	(1,100,034)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		89,396	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(39,201)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>GOODWILL NET</u>		1,265,953	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 218,313	\$ 3,495,736	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,005,953	\$ 5,505,108	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 42,827	\$ 42,827	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	98,318	98,318	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	248,000	248,000	32
33	Accrued Interest Payable		12,399	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>SKOKIE 1 &amp; 2 ELIMINATION</u>	4,402,993	4,402,993	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 4,792,138	\$ 4,804,537	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,183,642	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 6,183,642	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,792,138	\$ 10,988,179	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (2,786,185)	\$ (5,483,071)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,005,953	\$ 5,505,108	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(2,032,107)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(2,032,107)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(484,078)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	(270,000)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>OUT OF PERIOD EXPENSES</b>		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(754,078)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(2,786,185)</b>	<b>24</b> *

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

Facility Name &amp; ID Number SKOKIE MEADOWS BEHAVIORAL CENTER # 0054312 Report Period Beginning: 01/01/2018

Ending: 12/31/2018

## 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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,382,388	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,382,388	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	14,865	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 14,865	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>VENDING COMMISSIONS</b>	3,392	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 3,392	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,400,645	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	681,544	31
32	Health Care	1,446,248	32
33	General Administration	768,235	33
<b>B. Capital Expense</b>			
34	Ownership	850,658	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	138,038	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,884,723	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(484,078)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (484,078)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,851,534	44
45	Private Pay - Net Inpatient Revenue	91,748	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <b>VETERAN</b>	1,439,106	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 3,382,388	49

\*\*TAX RETURN PREPARED ON CASH BASIS

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? **NO\*\*** 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 BEHAVIORAL CENTER**

# **0054312**

Report Period Beginning: **01/01/2018**

Ending:

**12/31/2018**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,864	2,125	\$ 74,415	\$ 35.02	1
2	Assistant Director of Nursing	1,864	2,125	74,562	35.09	2
3	Registered Nurses	12,945	14,435	426,614	29.55	3
4	Licensed Practical Nurses	180	180	3,602	20.01	4
5	CNAs & Orderlies	33,044	36,328	493,539	13.59	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,898	2,074	27,206	13.12	9
10	Activity Assistants	2,313	2,569	43,817	17.06	10
11	Social Service Workers	5,728	6,214	134,512	21.65	11
12	Dietician					12
13	Food Service Supervisor	1,754	1,952	27,690	14.19	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,926	11,554	130,155	11.26	15
16	Dishwashers					16
17	Maintenance Workers	1,267	1,550	23,092	14.90	17
18	Housekeepers	11,328	12,750	159,614	12.52	18
19	Laundry					19
20	Administrator	1,992	2,080	73,184	35.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,150	2,286	36,614	16.02	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					31
32	Other Health C: CARE PLAN	1,920	2,117	65,815	31.09	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	91,173	100,339	\$ 1,794,431 *	\$ 17.88	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 7,896	1-3	35
36	Medical Director	O	12,000	9-3	36
37	Medical Records Consultant	N	1,600	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	4,405	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,544	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 28,445		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		\$		53



SKOKIE MEADOWS BEHAVIORAL CENTER  
LEGAL EXPENSES  
12/31/2018

DATE	FIRM	INVOICE #	PURPOSE	COST
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Facility Name &amp; ID Number SKOKIE MEADOWS BEHAVIORAL CENTER

# 0054312

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. ALLIANCE FOR LIVING \$14,400
- (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? \_\_\_\_\_
- (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 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line 10-2
- (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. \_\_\_\_\_
- (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.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 0  
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 benefit on Schedule V. \$ 5,749 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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
**g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES  
Attach invoices and a summary of services for all architect and appraisal fees