		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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0053553

Facility Name: Central Nursing Home

Address: 2450 N Central Ave (Number) Chicago (City) 60639 (Zip Code)

County: Cook

Telephone Number: (773) 889-1333 **Fax #** (847) 889-1516

HFS ID Number:

Date of Initial License for Current Owners:

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Sanford B. Alper **Telephone Number:** (847) 580-4100
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2016 to 12/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Sanford B. Alper, Director
(Firm Name & Address) Kessler, Orlean, Silver & Company, P.C., 1101 Lake Cook Road, Suite C, Deerfied IL 60015
(Telephone) (847) 580-4100 Fax # (847) 580-4199

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 Central Nursing Home # 0053553 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 245

	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	245	Skilled (SNF)	245	89,670	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	245	TOTALS	245	89,670	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	77,331	482	4,700	82,513	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	77,331	482	4,700	82,513	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.02%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

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 05/01/2015

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/2015 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 245 and days of care provided 3,624

Medicare Intermediary Wisconsin Physicans Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	262,991	20,200	14,857	298,048		298,048		298,048			1
2	Food Purchase		299,107		299,107	(28,403)	270,704	(51)	270,653			2
3	Housekeeping	257,556	28,893		286,449		286,449		286,449			3
4	Laundry		11,919		11,919		11,919		11,919			4
5	Heat and Other Utilities			174,600	174,600		174,600	5,750	180,350			5
6	Maintenance	42,532	69,670	2,632	114,834		114,834	38,109	152,943			6
7	Other (specify):* Attached Schedule			82,766	82,766		82,766	175	82,941			7
8	TOTAL General Services	563,079	429,789	274,855	1,267,723	(28,403)	1,239,320	43,983	1,283,303			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,101,925	137,416	351,240	2,590,581		2,590,581		2,590,581			10
10a	Therapy	64,596		626,572	691,168		691,168		691,168			10a
11	Activities	103,816		33,561	137,377		137,377		137,377			11
12	Social Services	121,101		11,773	132,874		132,874		132,874			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,391,438	137,416	1,023,146	3,552,000		3,552,000		3,552,000			16
	C. General Administration											
17	Administrative			747,674	747,674		747,674	(623,149)	124,525			17
18	Directors Fees											18
19	Professional Services			147,875	147,875		147,875	14,404	162,279			19
20	Dues, Fees, Subscriptions & Promotions			17,745	17,745		17,745	2,685	20,430			20
21	Clerical & General Office Expenses	95,501		228,126	323,627		323,627	326,263	649,890			21
22	Employee Benefits & Payroll Taxes			541,608	541,608	28,403	570,011	59,477	629,488			22
23	Inservice Training & Education											23
24	Travel and Seminar			569	569		569	1,095	1,664			24
25	Other Admin. Staff Transportation			198	198		198	171	369			25
26	Insurance-Prop.Liab.Malpractice			237,481	237,481		237,481	139,144	376,625			26
27	Other (specify):*											27
28	TOTAL General Administration	95,501		1,921,276	2,016,777	28,403	2,045,180	(79,910)	1,965,270			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,050,018	567,205	3,219,277	6,836,500		6,836,500	(35,927)	6,800,573			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 Central Nursing Home #0053553 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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			223,052	223,052		223,052	235,782	458,834			30
31	Amortization of Pre-Op. & Org.							1,462,824	1,462,824			31
32	Interest							766,728	766,728			32
33	Real Estate Taxes							454,231	454,231			33
34	Rent-Facility & Grounds			1,838,578	1,838,578		1,838,578	(1,838,578)				34
35	Rent-Equipment & Vehicles			11,443	11,443		11,443	319	11,762			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,073,073	2,073,073		2,073,073	1,081,306	3,154,379			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			611,886	611,886		611,886		611,886			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			611,886	611,886		611,886		611,886			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,050,018	567,205	5,904,236	9,521,459		9,521,459	1,045,379	10,566,838			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 Central Nursing Home # 0053553 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(33,785)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(285)	2		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	(600)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(163,960)	21		24
25	Fund Raising, Advertising and Promotional				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	(234)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (198,864)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,244,243		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,244,243		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 1,045,379		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

Central Nursing Home

ID# 0053553

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sales Taxes (Management Company)	$ (234)	21	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	**Total**	(234)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(285)	0	234	0	0	0	0	0	0	0	0	(51)	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	5,750	0	0	0	0	0	0	0	0	0	5,750	5
6	Maintenance	0	2,522	35,587	0	0	0	0	0	0	0	0	38,109	6
7	Other (specify):*	0	175	0	0	0	0	0	0	0	0	0	175	7
8	TOTAL General Services	(285)	8,447	35,821	0	0	0	0	0	0	0	0	43,983	8
	B. Health Care and Programs													
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	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(623,149)	0	0	0	0	0	0	0	0	(623,149)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	6,671	7,733	0	0	0	0	0	0	0	14,404	19
20	Fees, Subscriptions & Promotions	0	2,513	172	0	0	0	0	0	0	0	0	2,685	20
21	Clerical & General Office Expenses	(164,794)	18,774	472,033	250	0	0	0	0	0	0	0	326,263	21
22	Employee Benefits & Payroll Taxes	0	59,477	0	0	0	0	0	0	0	0	0	59,477	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,095	0	0	0	0	0	0	0	0	1,095	24
25	Other Admin. Staff Transportation	0	140	31	0	0	0	0	0	0	0	0	171	25
26	Insurance-Prop.Liab.Malpractice	0	2,582	0	136,562	0	0	0	0	0	0	0	139,144	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(164,794)	83,486	(143,147)	144,545	0	0	0	0	0	0	0	(79,910)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(165,079)	91,933	(107,326)	144,545	0	0	0	0	0	0	0	(35,927)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Central Nursing Home # 0053553 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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	0	0	6,355	229,427	0	0	0	0	0	0	0	235,782	30
31	Amortization of Pre-Op. & Org.	0	0	0	1,462,824	0	0	0	0	0	0	0	1,462,824	31
32	Interest	(33,785)	0	(3)	800,516	0	0	0	0	0	0	0	766,728	32
33	Real Estate Taxes	0	0	11,464	442,767	0	0	0	0	0	0	0	454,231	33
34	Rent-Facility & Grounds	0	16,916	(16,916)	(1,838,578)	0	0	0	0	0	0	0	(1,838,578)	34
35	Rent-Equipment & Vehicles	0	0	319	0	0	0	0	0	0	0	0	319	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(33,785)	16,916	1,219	1,096,956	0	0	0	0	0	0	0	1,081,306	37
	Ancillary Expense													
	E. Special Cost Centers													
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	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(198,864)	108,849	(106,107)	1,241,501	0	0	0	0	0	0	0	1,045,379	45

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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
Marvin Mermelstein	5.00	Winston Manor Nursing Home	Chicago	Nivram Mng, Inc.	Lincolnwood	Management
Joseph Mermelstein	5.00	Balmoral Home, Inc.	Chicago			
Marvin Mermelstein Family Trust	45.00	Chicago Ridge Nursing Central	Chicago Ridge			
Joseph Mermelstein Family Trust	45.00					

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	25	Auto Expense	$	Nivram Management, Inc.	100.00%	$ 140	$ 140	1
2	V	20	Advertising		Nivram Management, Inc.	100.00%	304	304	2
3	V	21	Bank Charges		Nivram Management, Inc.	100.00%	123	123	3
4	V	6	Repairs & Maintenance		Nivram Management, Inc.	100.00%	2,522	2,522	4
5	V	5	Utilities		Nivram Management, Inc.	100.00%	5,750	5,750	5
6	V	21	Office Expense		Nivram Management, Inc.	100.00%	18,469	18,469	6
7	V	20	Dues & Subscriptions		Nivram Management, Inc.	100.00%	2,209	2,209	7
8	V	21	Taxes - Other		Nivram Management, Inc.	100.00%	182	182	8
9	V	22	Payroll Taxes		Nivram Management, Inc.	100.00%	41,436	41,436	9
10	V	34	Rent		Nivram Management, Inc.	100.00%	16,916	16,916	10
11	V	26	Insurance		Nivram Management, Inc.	100.00%	2,582	2,582	11
12	V	22	Health Insurance		Nivram Management, Inc.	100.00%	18,041	18,041	12
13	V	7	Scavenger		Nivram Management, Inc.	100.00%	175	175	13
14	Total			$			$ 108,849	$ * 108,849	14

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

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Rental Equipment	$	Nivram Management, Inc.	100.00%	$ 319	$ 319	15
16	V	21	Miscellaneous		Nivram Management, Inc.	100.00%	1,362	1,362	16
17	V	21	Postage		Nivram Management, Inc.	100.00%	1,077	1,077	17
18	V	2	Sales Expense		Nivram Management, Inc.	100.00%	234	234	18
19	V	20	Licenses & Permits		Nivram Management, Inc.	100.00%	172	172	19
20	V	25	Travel		Nivram Management, Inc.	100.00%	31	31	20
21	V	30	Depreciation		Nivram Management, Inc.	100.00%	343	343	21
22	V	21	Data Processing		Nivram Management, Inc.	100.00%	1,626	1,626	22
23	V	19	Outside Services		Nivram Management, Inc.	100.00%	1,319	1,319	23
24	V	24	Seminars		Nivram Management, Inc.	100.00%	1,095	1,095	24
25	V	19	Professional Services		Nivram Management, Inc.	100.00%	3,274	3,274	25
26	V	6	Plant Supervisor Salary		Nivram Management, Inc.	100.00%	35,587	35,587	26
27	V	17	Asst. Administrator Salary		Nivram Management, Inc.	100.00%	53,380	53,380	27
28	V	21	Office Manager Salary		Nivram Management, Inc.	100.00%	28,640	28,640	28
29	V	17	Administrative Salaries		Nivram Management, Inc.	100.00%	71,145	71,145	29
30	V	21	Clerical Salaries		Nivram Management, Inc.	100.00%	439,220	439,220	30
31	V	17	Management Fees	747,674	Nivram Management, Inc.			(747,674)	31
32	V					100.00%			32
33	V	34	Rental Income	16,916	Hamlin Arthur Building Partnership	100.00%		(16,916)	33
34	V	32	Interest Income	3	Hamlin Arthur Building Partnership	100.00%		(3)	34
35	V	21	Bank Fees		Hamlin Arthur Building Partnership	100.00%	108	108	35
36	V	30	Depreciation		Hamlin Arthur Building Partnership	100.00%	6,012	6,012	36
37	V	19	Legal Fees		Hamlin Arthur Building Partnership	100.00%	2,078	2,078	37
38	V	33	Real Estate Taxes		Hamlin Arthur Building Partnership	100.00%	11,464	11,464	38
39	Total			$ 764,593			$ 658,486	$ * (106,107)	39

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

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	34	Rental Income	$ 1,838,578	Novo Investors, LLC	100.00%	$	$ (1,838,578)	15
16	V	32	Interest Income	602	Novo Investors, LLC	100.00%		(602)	16
17	V	33	Real Esate Taxes		Novo Investors, LLC	100.00%	442,767	442,767	17
18	V	26	Insurance Expense		Novo Investors, LLC	100.00%	136,562	136,562	18
19	V	32	Interest Expense		Novo Investors, LLC	100.00%	801,118	801,118	19
20	V	30	Depreciation Expense		Novo Investors, LLC	100.00%	229,427	229,427	20
21	V	31	Amortization Expense		Novo Investors, LLC	100.00%	1,462,824	1,462,824	21
22	V	19	Professional Services		Novo Investors, LLC	100.00%	7,733	7,733	22
23	V	21	Taxes - Other		Novo Investors, LLC	100.00%	250	250	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			$ 1,839,180			$ 3,080,681	$ * 1,241,501	39

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

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 Central Nursing Home # 0053553 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	Henry Mermelstein	Administrative Asst	Administrative	0.00	150,000	10	25.00	Salary	$ 50,000	17-7	1
2	Daniel Mermelstein	Clerical	Clerical	0.00	2,872	2	28.00	Salary	1,128	21-7	2
3	Marvin Mermelstein	Plant Supervisor	Support	50.00	90,638	5	28.00	Salary	35,587	6-7	3
4	Doreen Mermelstein	Office Manager	Administrative	0.00	85,920	10	25.00	Salary	28,640	21-7	4
5	Gavriel Mermelstein	Clerical	Clerical	0.00	2,872	2	28.00	Salary	1,128	21-7	5
6	Marvin Mermelstein	Administrative Asst	Administrative	See Above	135,957	8	28.00	Salary	53,380	17-7	6
7	Joseph Mermelstein	Owner	Administrative	50.00	53,855	3	28.00	Salary	21,145	17-7	7
8	Jacob Mermelstein	Clerical	Clerical	0.00	0	40	100.00	Salary	89,741	21-7	8
9	Joshua Mermelstein	Clerical	Clerical	0.00	6,786	3	28.00	Salary	2,664	21-7	9
10											10
11											11
12											12
13								TOTAL	$ 283,413		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 Central Nursing Home # 0053553 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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: Nivram Management, Inc.
Street Address: 6500 N. Hamlin Avenue
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: (847) 679-7484
Fax Number: (847) 679-7494

	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	25	Auto Expense	Resident Beds	869	4	$ 496	$	245	$ 140	1
2	20	Advertising	Resident Beds	869	4	1,081		245	305	2
3	21	Bank Charges	Resident Beds	869	4	438		245	123	3
4	6	Repairs & Maintenance	Resident Beds	869	4	8,945		245	2,522	4
5	5	Utilities	Resident Beds	869	4	20,395		245	5,750	5
6	21	Office Expense	Resident Beds	869	4	65,510		245	18,469	6
7	20	Dues & Subscriptions	Resident Beds	869	4	7,837		245	2,210	7
8	21	Taxes - Other	Resident Beds	869	4	645		245	182	8
9	22	Payroll Taxes	Resident Beds	869	4	146,971		245	41,436	9
10	34	Rent	Resident Beds	869	4	60,000		245	16,916	10
11	26	Insurance	Resident Beds	869	4	9,159		245	2,582	11
12	22	Health Insurance	Resident Beds	869	4	63,991		245	18,041	12
13	7	Scavenger	Resident Beds	869	4	619		245	175	13
14	35	Rental Equipment	Resident Beds	869	4	1,130		245	319	14
15	21	Miscellaneous	Resident Beds	869	4	4,832		245	1,362	15
16	21	Postage	Resident Beds	869	4	3,820		245	1,077	16
17	2	Sales Expense	Resident Beds	869	4	828		245	233	17
18	20	Licenses & Permits	Resident Beds	869	4	608		245	171	18
19	25	Travel	Resident Beds	869	4	111		245	31	19
20	30	Depreciation	Resident Beds	869	4	1,215		245	343	20
21	21	Data Processing	Resident Beds	869	4	5,768		245	1,626	21
22	19	Outside Services	Resident Beds	869	4	4,680		245	1,319	22
23	24	Seminars	Resident Beds	869	4	3,883		245	1,095	23
24	19	Professional Services	Resident Beds	869	4	11,614		245	3,274	24
25	TOTALS					$ 424,576	$		$ 119,701	25

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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: Nivram Management, Inc.
Street Address: 6500 N. Hamlin Avenue
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: ((847) 679-7484
Fax Number: ((847) 679-7494

	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	Plant Supervisor Salary	Direct Cost	1	1	$ 35,587	$ 35,587	1	$ 35,587	1
2	17	Asst. Administrator Salary	Direct Cost	1	1	53,380	53,380	1	53,380	2
3	21	Office Manager Salary	Direct Cost	1	1	28,640	28,640	1	28,640	3
4	17	Administrative Salaries	Direct Cost	1	1	71,145	71,145	1	71,145	4
5	21	Clerical Salaries	Direct Cost	1	1	439,220	439,220	1	439,220	5
6	21	Bank Fees	Resident Beds	869	4	383		245	108	6
7	30	Depreciation	Resident Beds	869	4	21,325		245	6,012	7
8	19	Legal Fees	Resident Beds	869	4	7,372		245	2,078	8
9	33	Real Estate Taxes	Resident Beds	869	4	40,663		245	11,464	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					$ 697,715	$ 627,972		$ 647,634	25

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Capital One Commercial		x	Mortgage	$100,282.00	05/01/15	$ 20,711,110	$ 20,102,284		3.8500	$ 801,118	1
2	Central Nursing and Rehab		x	Purchase - Finance	N/A	05/01/15	861,758			6.0000		2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$100,282.00		$ 21,572,868	$ 20,102,284			$ 801,118	9
	B. Non-Facility Related*											
10	Interest Income										(33,785)	10
11	Interest Income Mgmt Co										(3)	11
12	Interest Income Mgmt Co										(602)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (34,390)	14
15	TOTALS (line 9+line14)						$ 21,572,868	$ 20,102,284			$ 766,728	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 136,562 Line # 26

*** 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 Central Nursing Home # 0053553 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 375,000	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.)		$ 409,231	2
3. Under or (over) accrual (line 2 minus line 1).		$ 34,231	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 420,000	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.)		$	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.		$ 454,231	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	333,386	8
	2012	369,186	9
	2013	345,745	10
	2014	352,710	11
	2015	397,767	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Central Nursing Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053553

CONTACT PERSON REGARDING THIS REPORT Sanford B. Alper

TELEPHONE (847) 580-4100 FAX #: (847) 580-4199

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.	Attached Schedule	Nursing Home	$ 397,767.41	$ 397,767.41
2.	10-35-325-029-0000	Management Company	$ 4,426.35	$ 1,073.22
3.	10-35-325-015-0000	Management Company	$ 42,856.70	$ 10,391.15
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 445,050.46	$ 409,231.78

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 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 Central Nursing Home # 0053553 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 86,088 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

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).

N/A

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	Nursing Home	30,000	2015	$ 500,000	1
2					2
3	TOTALS	30,000		$ 500,000	3

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	245		2015	1973	$ 6,076,927	$ 155,819	39	$ 155,819	$	$ 259,698	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Cooled Chiller Unit			2015	92,000	13,143	7	13,143		18,619	9
10	Time Clock Reader			2015	2,574	94	27.5	94		140	10
11	HVAC Unit			2015	4,227	604	7	604		805	11
12	Compressor			2015	8,500	309	27.5	309		412	12
13	Elevator Project			2016	10,840	255	39	255		255	13
14	Elevator Pump Motor			2016	3,800	49	39	49		49	14
15	Door Project			2015	5,201	189	27.5	189		205	15
16	Air Handler			2016	6,470	196	27.5	196		196	16
17	Flooring			2016	15,078	388	27.5	388		388	17
18	Hot Water Heater			2016	10,750	130	27.5	130		130	18
19	Sewer Restoration			2016	11,950	465	15	465		465	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 Central Nursing Home # 0053553 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,248,317	$ 171,641		$ 171,641	$	$ 281,362	70

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

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,106,000	$ 227,210	$ 227,210	$	5-7	$ 373,877	71
72	Current Year Purchases	4,273	285	285		5	285	72
73	Fully Depreciated Assets							73
74	Novo Investments		59,698	59,698		5-7		74
75	TOTALS	$ 1,110,273	$ 287,193	$ 287,193	$		$ 374,162	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)	$ 7,858,590	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 458,834	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 458,834	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 655,524	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 Central Nursing Home # 0053553 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Novo Investors, LLC

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 [X] 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	TOTAL				$ **			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 [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 05/01/2015
Ending 05/01/2035

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2017	$ 1,768,446
13.	12/31/2018	$ 1,768,446
14.	12/31/2019	$ 1,768,446

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: $ 5,566 Description: Ice Maker - $1,243; Postal Machine - $379; Copoer - $1,283; A/C unit - $2,342; Mgmt Co - $319
(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	Administrative	2015 Toyota	$ 563.00	$ 6,196	17
18					18
19					19
20					20
21	TOTAL		$ 563.00	$ 6,196	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 Central Nursing Home # 0053553 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

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

STATE OF ILLINOIS

Facility Name & ID Number Central Nursing Home **#** 0053553 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2016 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,703,388	$ 1,775,634	1
2	Cash-Patient Deposits	46,104	46,104	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,513,056	3,513,056	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	86,894	195,709	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	72,658	72,520	8
9	Other(specify): Attached Schedule		647,827	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,422,100	$ 6,250,850	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		500,000	13
14	Buildings, at Historical Cost		6,076,927	14
15	Leasehold Improvements, at Historical Cost	52,799	171,389	15
16	Equipment, at Historical Cost	1,110,273	1,415,491	16
17	Accumulated Depreciation (book methods)	(370,086)	(746,964)	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 (spe Goodwill		12,190,203	22
23	Other(specify): Deposits	22,500	22,500	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 815,486	$ 19,629,546	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,237,586	$ 25,880,396	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 346,279	$ 347,874	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	52,945	52,945	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	121,228	121,228	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		420,000	32
33	Accrued Interest Payable		64,495	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Attached Schedule	1,091,535	1,091,535	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,611,987	$ 2,098,077	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		20,102,284	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 20,102,284	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,611,987	$ 22,200,361	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,625,599	$ 3,680,035	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,237,586	$ 25,880,396	48

***(See instructions.)**

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,286,307	1
2	Restatements (describe):		2
3	Rounding	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,286,309	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,628,178	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	(1,288,888)	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)**	$ 2,339,290	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)**	$ 4,625,599	24 *

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

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 12,692,532	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,692,532	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	415,129	6
7	Oxygen	1,926	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 417,055	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***	33,785	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 33,785	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	8,642	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,642	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,152,014	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,267,723	31
32	Health Care	3,552,000	32
33	General Administration	2,016,777	33
	B. Capital Expense		
34	Ownership	2,073,073	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	611,886	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,521,459	40
41	**Income before Income Taxes (line 30 minus line 40)****	3,630,555	41
42	**Income Taxes**	(2,377)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 3,628,178	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	49

* **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 Central Nursing Home # 0053553 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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
2	Assistant Director of Nursing	2,098	2,178	73,583	33.78	2
3	Registered Nurses	35,970	38,286	1,090,863	28.49	3
4	Licensed Practical Nurses	6,080	6,765	141,622	20.93	4
5	CNAs & Orderlies	56,897	60,476	696,649	11.52	5
6	CNA Trainees					6
7	Licensed Therapist	2,010	2,098	64,596	30.79	7
8	Rehab/Therapy Aides	5,343	5,989	68,851	11.50	8
9	Activity Director	2,028	2,129	33,763	15.86	9
10	Activity Assistants	6,487	6,765	70,053	10.36	10
11	Social Service Workers	6,373	6,694	121,101	18.09	11
12	Dietician					12
13	Food Service Supervisor	2,063	2,611	64,060	24.53	13
14	Head Cook	2,582	2,806	53,150	18.94	14
15	Cook Helpers/Assistants	13,110	14,251	145,781	10.23	15
16	Dishwashers					16
17	Maintenance Workers	2,350	2,648	42,532	16.06	17
18	Housekeepers	20,536	22,146	257,556	11.63	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,210	7,614	95,501	12.54	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,617	2,662	30,357	11.40	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	173,754	186,118	$ 3,050,018 *	$ 16.39	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		$ 14,857	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		80,320	10-3	39
40	Physical Therapy Consultant		626,572	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		33,561	11-3	44
45	Social Service Consultant		11,773	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 767,083		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 270,920	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$ 270,920		53

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

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

B. Administrative - Other

Description	Amount
Management Fees	$ 747,674
TOTAL (agree to Schedule V, line 17, col. 3)	$ 747,674
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
Attached Schedule		147,875
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 147,875

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 63,914
Unemployment Compensation Insurance	44,068
FICA Taxes	228,789
Employee Health Insurance	178,727
Employee Meals	28,403
Illinois Municipal Retirement Fund (IMRF)*	
Employee Union Pension	24,773
Other Employee Benefits	1,337
Allocation from Management Company	59,477
TOTAL (agree to Schedule V, line 22, col.8)	$ 629,488

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	1,263
Health Care Worker Background Check	
(Indicate # of checks performed 37)	2,507
Patient Background Checks 243	7,800
Dues & Subscriptions	2,592
Licenses & Permits	3,583
Allocation from Management Company	2,685
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,430

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	569
Allocation from Management Company	1,095
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,664

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(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? **5-7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** 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. $ **611,886**
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? **Yes** 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? **N/A**

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **N/A** 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? **N/A**
d. Have vehicle usage logs been maintained? **Yes**
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? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees