FOR BHF USE

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

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

I. IDPH License ID Number: 0053827

Facility Name: City View Multicare Center

Address: 5825 West Cermak Rd (Number) Cicero (City) 60804 (Zip Code)

County: Cook

Telephone Number: (708) 656-9120 **Fax #** (708) 656-9128

HFS ID Number:

Date of Initial License for Current Owners: 12/01/15

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Daniel S. Gaafar **Telephone Number:** (317) 237-5500
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 01/01/16 to 12/31/16 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) Flora Reznik
(Title) CFO

Paid Preparer

(Signed) (Date)
(Print Name and Title) Daniel S. Gaafar, Partner
(Firm Name & Address) Bradley Associates, 201 S. Capitol Ave, Suite 700, Indianapolis, IN 46225
(Telephone) (317) 237-5500 Fax # (317) 237-5503

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 City View Multicare Center # 0053827 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	148	Skilled (SNF)	148	54,168	1
2		Skilled Pediatric (SNF/PED)			2
3	337	Intermediate (ICF)	337	123,342	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	485	TOTALS	485	177,510	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	28,725	1	3,581	32,307	8
9	SNF/PED					9
10	ICF	65,408	2	710	66,120	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	94,133	3	4,291	98,427	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.45%

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)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/01/15

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/15 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 148 and days of care provided 3,269

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	501,992		74,963	576,955		576,955	(2,874)	574,081			1
2	Food Purchase		599,096		599,096		599,096	680	599,776			2
3	Housekeeping	380,370	100,224		480,594		480,594	430	481,024			3
4	Laundry	102,119	52,956		155,075		155,075		155,075			4
5	Heat and Other Utilities			265,113	265,113		265,113	581	265,694			5
6	Maintenance	318,987	71,159	151,750	541,896		541,896	721	542,617			6
7	Other (specify):*											7
8	TOTAL General Services	1,303,468	823,435	491,826	2,618,729		2,618,729	(462)	2,618,267			8
	B. Health Care and Programs											
9	Medical Director			20,500	20,500		20,500		20,500			9
10	Nursing and Medical Records	4,148,021	262,403	7,809	4,418,233		4,418,233	9,778	4,428,011			10
10a	Therapy			1,120,794	1,120,794		1,120,794		1,120,794			10a
11	Activities	204,159	35,859		240,018		240,018	2,305	242,323			11
12	Social Services	281,862		27,485	309,347		309,347		309,347			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			26,688	26,688		26,688		26,688			15
16	TOTAL Health Care and Programs	4,634,042	298,262	1,203,276	6,135,580		6,135,580	12,083	6,147,663			16
	C. General Administration											
17	Administrative	186,200			186,200		186,200		186,200			17
18	Directors Fees											18
19	Professional Services			426,861	426,861		426,861	(254,289)	172,572			19
20	Dues, Fees, Subscriptions & Promotions			20,107	20,107		20,107	(426)	19,681			20
21	Clerical & General Office Expenses	246,963	66,289	104,818	418,070		418,070	87,882	505,952			21
22	Employee Benefits & Payroll Taxes			1,406,328	1,406,328		1,406,328	50,398	1,456,726			22
23	Inservice Training & Education											23
24	Travel and Seminar			25,085	25,085		25,085	1,447	26,532			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			627,528	627,528		627,528	355	627,883			26
27	Other (specify):*											27
28	TOTAL General Administration	433,163	66,289	2,610,727	3,110,179		3,110,179	(114,633)	2,995,546			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,370,673	1,187,986	4,305,829	11,864,488		11,864,488	(103,012)	11,761,476			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 City View Multicare Center #0053827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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			159,434	159,434		159,434	610,026	769,460			30
31	Amortization of Pre-Op. & Org.							812,651	812,651			31
32	Interest			24,386	24,386		24,386	724,307	748,693			32
33	Real Estate Taxes			1,158,876	1,158,876		1,158,876		1,158,876			33
34	Rent-Facility & Grounds			1,575,601	1,575,601		1,575,601	(1,569,664)	5,937			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,918,297	2,918,297		2,918,297	577,320	3,495,617			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			170	170		170		170			38
39	Ancillary Service Centers		122,696		122,696		122,696		122,696			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			849,163	849,163		849,163		849,163			42
43	Other (specify):* **Bad Debt Exp**			61,770	61,770		61,770	(61,770)				43
44	**TOTAL Special Cost Centers**		122,696	911,103	1,033,799		1,033,799	(61,770)	972,029			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,370,673	1,310,682	8,135,229	15,816,584		15,816,584	412,538	16,229,122			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 City View Multicare Center # 0053827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	(123,944)	30		9
10	Interest and Other Investment Income	(5,140)	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				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				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(61,770)	43		24
25	Fund Raising, Advertising and Promotional	(7,370)	21		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	(33,496)	various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (231,720)		$	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)	644,258	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 644,258		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 412,538		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

City View Multicare Center

ID# 0053827

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (32,768)	21	1
2	Lobbying Expense	(728)	20	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**	(33,496)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	(2,874)	0	0	0	0	0	0	0	0	0	(2,874)	1
2	Food Purchase	0	0	680	0	0	0	0	0	0	0	0	680	2
3	Housekeeping	0	0	430	0	0	0	0	0	0	0	0	430	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	581	0	0	0	0	0	0	0	0	0	581	5
6	Maintenance	0	721	0	0	0	0	0	0	0	0	0	721	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	(1,572)	1,110	0	0	0	0	0	0	0	0	(462)	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	9,778	0	0	0	0	0	0	0	0	0	9,778	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	2,305	0	0	0	0	0	0	0	0	0	2,305	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	12,083	0	0	0	0	0	0	0	0	0	12,083	16
	C. General Administration													
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	0	(241,508)	(12,781)	0	0	0	0	0	0	0	0	(254,289)	19
20	Fees, Subscriptions & Promotions	(728)	0	302	0	0	0	0	0	0	0	0	(426)	20
21	Clerical & General Office Expenses	(40,138)	127,770	250	0	0	0	0	0	0	0	0	87,882	21
22	Employee Benefits & Payroll Taxes	0	50,398	0	0	0	0	0	0	0	0	0	50,398	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,447	0	0	0	0	0	0	0	0	0	1,447	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	355	0	0	0	0	0	0	0	0	0	355	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(40,866)	(61,538)	(12,229)	0	0	0	0	0	0	0	0	(114,633)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(40,866)	(51,027)	(11,119)	0	0	0	0	0	0	0	0	(103,012)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number City View Multicare Center **#** 0053827 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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	(123,944)	0	733,970	0	0	0	0	0	0	0	0	610,026	30
31	Amortization of Pre-Op. & Org.	0	0	812,651	0	0	0	0	0	0	0	0	812,651	31
32	Interest	(5,140)	0	729,447	0	0	0	0	0	0	0	0	724,307	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	5,936	(1,575,600)	0	0	0	0	0	0	0	0	(1,569,664)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(129,084)	5,936	700,468	0	0	0	0	0	0	0	0	577,320	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):*	(61,770)	0	0	0	0	0	0	0	0	0	0	(61,770)	43
44	**TOTAL Special Cost Centers**	(61,770)	0	0	0	0	0	0	0	0	0	0	(61,770)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(231,720)	(45,091)	689,349	0	0	0	0	0	0	0	0	412,538	45

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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
Michael Blisko	50	Ambassador Nursing & Rehab Center	Chicago	Infinity Healthcare	Hillside	Consulting Co.
Moishe Gubin	50	Belhaven Nursing & Rehab Center	Chicago	Westshire Realty		Realty Co
		Continental Nursing & Rehab Center	Chicago			
		Forest View Rehab & Nursing Center	Itasca			
		Lakeview Nursing & Rehab Center	Chicago			
		Midway Neurological & Rehab Center	Bridgeview			
		Momence Meadows Nursing & Rehab Ctr	Momence			

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	1	Dietary	$ 14,710	Infinity Healthcare Management		$ 11,836	$ (2,874)	1
2	V	10	Nursing Wages	6,607	Infinity Healthcare Management		16,385	9,778	2
3	V	21	Office Wages		Infinity Healthcare Management				3
4	V	5	Utilities		Infinity Healthcare Management		581	581	4
5	V	6	Maintenance	322	Infinity Healthcare Management		1,043	721	5
6	V	19	Professional Services	369,146	Infinity Healthcare Management		127,638	(241,508)	6
7	V	21	Office Expense	96,663	Infinity Healthcare Management		224,433	127,770	7
8	V	22	Employee Benefit		Infinity Healthcare Management		50,398	50,398	8
9	V	24	Auto/Travel Expense	67	Infinity Healthcare Management		1,514	1,447	9
10	V	26	Insurance		Infinity Healthcare Management		355	355	10
11	V	33	Property Tax		Infinity Healthcare Management				11
12	V	34	Rent		Infinity Healthcare Management		5,936	5,936	12
13	V	11	Activities	429	Infinity Healthcare Management		2,734	2,305	13
14	Total			$ 487,944			$ 442,853	$ * (45,091)	14

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

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees	$	Westshire Realty		$ (12,781)	$ (12,781)	15
16	V	21	Office Expense		Westshire Realty		250	250	16
17	V	26	Insurance		Westshire Realty				17
18	V	30	Depreciation		Westshire Realty		733,718	733,718	18
19	V	31	Amortization		Westshire Realty		812,651	812,651	19
20	V	32	Interest		Westshire Realty		726,182	726,182	20
21	V	33	Property Taxes		Westshire Realty				21
22	V	34	Rent	1,575,600	Westshire Realty			(1,575,600)	22
23	V								23
24	V								24
25	V	2	Food Purchases		Infinity Healthcare Management		680	680	25
26	V	3	Housekeeping		Infinity Healthcare Management		430	430	26
27	V	20	Dues, Fees, Subs & Promotions		Infinity Healthcare Management		302	302	27
28	V	30	Depreciation		Infinity Healthcare Management		252	252	28
29	V	32	Interest		Ind		3,265	3,265	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			$ 1,575,600			$ 2,264,949	$ * 689,349	39

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

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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			Niles Nursing & Rehab Center	Niles				1
2			Oak Lawn Respiratory & Rehab Center	Oak Lawn				2
3			Parker Nursing & Rehab Center	Streator				3
4			Parkshore Estates Nursing & Rehab Ctr	Chicago				4
5			Southpoint Nursing & Rehab Center	Chicago				5
6			West Suburban Nursing & Rehab Center	Bloomingdale				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 City View Multicare Center # 0053827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	HUD Loan		X	Mortgage	$97,351.00	7/26/13	$ 18,339,000	$ 18,227,643	3/1/41	3.9400	$ 726,182	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Capital One		X	Working Capital	None	12/1/15	26,000,000	2,352,824	8/31/18	various	24,386	6
7	Infinity	X		Working Capital	None	various	853,380	853,380	various	various	3,265	7
8												8
9	TOTAL Facility Related				$97,351.00		$ 45,192,380	$ 21,433,847			$ 753,833	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 45,192,380	$ 21,433,847			$ 753,833	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ n/a Line # n/a

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

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

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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.**	$		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.)	$	1,199,929	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,199,929	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	(41,053)	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.	$	1,158,876	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011		8
2012		9
2013		10
2014		11
2015	1,199,929	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 City View Multicare Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053827

CONTACT PERSON REGARDING THIS REPORT Daniel S. Gaafar

TELEPHONE (317) 237-5500 FAX #: (317) 237-5503

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.	16-29-202-004-0000	Nursing Facility	$ 168,090.34	$ 168,090.34
2.	16-29-202-005-0000	Nursing Facility	$ 168,090.34	$ 168,090.34
3.	16-29-202-006-0000	Nursing Facility	$ 336,181.03	$ 336,181.03
4.	16-29-202-007-0000	Nursing Facility	$ 191,502.67	$ 191,502.67
5.	16-29-202-008-0000	Nursing Facility	$ 336,064.46	$ 336,064.46
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,199,928.84	$ 1,199,928.84

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 City View Multicare Center # 0053827 Report Period Beginning: 01/01/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 124,020 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 9

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 [ ] (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).

None

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

1. Total Amount Incurred: 9,953 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: 1,991 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2015	$ 305,000	1
2					2
3	TOTALS			$ 305,000	3

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	485		2015		$ 9,700,000	$ 248,718	39	$ 248,718	$ 0	$ 849,784	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Concrete patched to areas rebar was exposed			2015	7,297	187	39	187	(0)	187	9
10											10
11	Renovations to bring building up to HUD compliance including										11
12	new doors, patch walls, drywall, painting on 3rd, 4th, 5th										12
13	6th floors, air conditioning units, wall guards on 6th floor										13
14	bedroom, electrical repairs, bathroom repairs, 3rd floor										14
15	office repairs, dining room repairs, repairs to various resident										15
16	rooms, install fireproof doors throughout building, repair										16
17	ceiling and walls			2016	57,597	1,477	39	1,477	0	1,477	17
18	Room ID signs, Braille signs, Regulatory signs			2016	4,977	128	39	128	0	128	18
19	Terrace Rails for East Side Balcony			2016	5,400	138	39	138	(0)	138	19
20	2 Retractable Elevator Pit Ladders			2016	6,466	166	39	166	0	166	20
21	Terrace Rails for East Side Balcony			2016	7,201	185	39	185	0	185	21
22	Building Facility Sign			2016	16,861	432	39	432	(0)	432	22
23	Paint 1st,2nd,3rd,4th,5ht,6th,7th,8th,9th Floors			2016	3,232	83	39	83	0	83	23
24	Materials for Remodeling Center Stairwell			2016	5,923	152	39	152	0	152	24
25	Rebuild Nurse Station Cabinets			2016	5,775	148	39	148	(0)	148	25
26	Nurse Station Counter Tops			2016	2,922	75	39	75	0	75	26
27	New Generator			2016	6,258	160	39	160	(0)	160	27
28	Pait 3rd Floor Dining Room			2016	2,650	68	39	68	0	68	28
29	Terrace Rails for West Side Balcony			2016	2,900	74	39	74	(0)	74	29
30	15 Ton Compressor			2016	7,450	191	39	191	(0)	191	30
31	Materials for Remodeling Center Stairwell			2016	5,580	143	39	143	(0)	143	31
32	3rd Floor Electrical Work,Clean & Sand 3rd Floor Cabinet Doors			2016	2,700	69	39	69	(0)	69	32
33	3rd Floor Nurse Call System			2016	6,620	170	39	170	0	170	33
34	Flooring			2016	2,646	68	39	68	0	68	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 City View Multicare Center # 0053827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Installation of Door Alamr Systems on 4 Floors	2016	$ 3,615	$ 93	39	$ 93	$ 0	$ 93	37
38	Insulate Emergency Generator Piping/Silencer	2016	3,423	88	39	88	0	88	38
39	Install new Walls by Penthouse Boiler Room	2016	2,851	73	39	73	(0)	73	39
40	Electrical Work for Sign	2016	2,650	68	39	68	0	68	40
41	New Kitchen/Laundry Hot Water Boiler	2016	11,500	295	39	295	0	295	41
42	Fresh Air Room Generator	2016	3,422	88	39	88	0	88	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)		$ 9,887,916	$ 253,536		$ 253,537	$ 1	$ 854,602	70

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

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 2,457,795	$ 518,047	$ 491,559	$ (26,488)	5	$ 1,719,934	71
72	Current Year Purchases	121,821	121,821	24,364	(97,457)	5	121,821	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,579,616	$ 639,868	$ 515,923	$ (123,945)		$ 1,841,755	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)	$ 12,772,532	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 893,404	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 769,460	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (123,944)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,696,358	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 City View Multicare Center # 0053827 Report Period Beginning: 01/01/16 Ending: 12/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								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 ☐ NO Terms: ____ *

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

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

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 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	TOTAL		$	$	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 City View Multicare Center # 0053827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$	4,922	$	334,897	$	4,922	$ 334,897	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		2,633		180,355		2,633	180,355	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10a-3	hrs		4,081		230,540		4,081	230,540	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 prescrpts					118,348		118,348	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify): X-Ray	39-2						893		893	12
13	Other (specify): Lab	39-2						3,455		3,455	13
14	TOTAL			$	11,636	$	745,792	$ 122,696	11,636	$ 868,488	14

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

Facility Name & ID Number City View Multicare Center **#** 0053827 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ 7,843	$ 595,356	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,313,563	4,313,563	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	311,956	311,956	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Escrow Accounts		934,449	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,633,362	$ 6,155,324	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		305,000	13
14	Buildings, at Historical Cost		9,700,000	14
15	Leasehold Improvements, at Historical Cost	187,916	187,916	15
16	Equipment, at Historical Cost	154,616	2,579,616	16
17	Accumulated Depreciation (book methods)	(159,434)	(2,696,357)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		12,189,759	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(2,664,039)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Replacement Reserves	223,171	1,429,370	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 406,269	$ 21,031,265	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,039,631	$ 27,186,589	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,820,718	$ 4,293,400	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,241	23,241	28
29	Short-Term Notes Payable		458,247	29
30	Accrued Salaries Payable	348,209	349,209	30
31	Accrued Taxes Payable (excluding real estate taxes)	144,358	144,358	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		59,847	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Working Capital	2,352,824	2,352,824	36
37	Working Capital		853,380	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,689,350	$ 8,534,506	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		17,769,396	39
40	Mortgage Payable			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)**	$	$ 17,769,396	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,689,350	$ 26,303,902	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 350,281	$ 883,687	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,039,631	$ 27,187,589	48

***(See instructions.)**

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,450	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,450	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	347,831	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 347,831	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)**	$ 350,281	24 *

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

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 14,676,581	1
2	Discounts and Allowances for all Levels	708,787	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 15,385,368	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	659,092	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 659,092	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	80,709	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,982	19
20	Radiology and X-Ray	384	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 84,075	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,112	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,112	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a	**Miscellaneous Revenue**	32,768	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 32,768	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,164,415	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,618,729	31
32	Health Care	6,135,580	32
33	General Administration	3,110,179	33
	B. Capital Expense		
34	Ownership	2,918,297	34
	C. Ancillary Expense		
35	Special Cost Centers	122,696	35
36	Provider Participation Fee	849,163	36
	D. Other Expenses (specify):		
37	**Medically Necessary Transportation**	170	37
38	**Bad Debt Expense**	61,770	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,816,584	40
41	**Income before Income Taxes (line 30 minus line 40)****	347,831	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 347,831	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 13,627,708	44
45	Private Pay - Net Inpatient Revenue	555	45
46	Medicare - Net Inpatient Revenue	1,427,921	46
47	Other-(specify) **Net Inpatient Revenue**	329,184	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 15,385,368	49

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,115	2,217	$ 101,647	$ 45.85	1
2	Assistant Director of Nursing	8,755	9,515	339,924	35.73	2
3	Registered Nurses	8,289	8,916	282,652	31.70	3
4	Licensed Practical Nurses	55,069	57,809	1,606,778	27.79	4
5	CNAs & Orderlies	116,131	125,829	1,653,905	13.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	15,022	16,960	204,159	12.04	9
10	Activity Assistants					10
11	Social Service Workers	16,756	17,593	281,862	16.02	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	36,230	39,793	501,992	12.62	15
16	Dishwashers					16
17	Maintenance Workers	25,368	27,037	318,987	11.80	17
18	Housekeepers	29,569	32,848	380,370	11.58	18
19	Laundry	7,199	7,902	102,119	12.92	19
20	Administrator	4,041	4,276	186,200	43.55	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,956	23,889	378,437	15.84	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,749	1,935	31,641	16.35	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	348,249	376,519	$ 6,370,673 *	$ 16.92	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	377	$ 13,206	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	223	7,809	10-3	38
39	Pharmacist Consultant	534	26,688	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	7,500	375,002	10-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	643	22,500	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	9,277	$ 445,205		49

C. CONTRACT NURSES

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

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michael Perl	Administrator		$ 129,465
Esther Burnett	Administrator		56,735
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 186,200

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Johnson & Goldburg	Accounting	$ 1,000
Capital One	Accounting	12,725
MTS Consulting	Professional	990
Pinnacle Quality Insight	Professional	600
Kopicki Family Funeral	Professional	325
Heatlhcare Recruiting Specialists	Professional	22,500
Infinity Healthcare	Professional/Mgmt	388,721
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 426,861

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 147,109
Unemployment Compensation Insurance	117,934
FICA Taxes	481,758
Employee Health Insurance	613,148
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniform Expense	19,992
Pension Expense	37,750
Employee Expense	39,035
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,456,726

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,739
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
IHCA	12,709
Town of Cicero	2,500
City of Chicago	1,032
Cook County Dept of Revenue	478
Various	1,223
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,681

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage	21,195
Auto Allowance	1,366
Seminar Expense	
Education & Seminars	3,971
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 26,532

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. **Illinois Council on Long Term Care**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **64,787** 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. **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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **849,163**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees