		FOR BHF USE			

LL1

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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) 237-550
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 01/01/2017 to 12/31/2017 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)	Paresh Vipani
	(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: 01/01/2017 Ending: 12/31/2017

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	148	Skilled (SNF)	148	54,020	1
2		Skilled Pediatric (SNF/PED)			2
3	337	Intermediate (ICF)	337	123,005	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	485	TOTALS	485	177,025	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	29,232	29	4,025	33,285	8
9	SNF/PED					9
10	ICF	66,562	65	2,214	68,842	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	95,794	94	6,239	102,127	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.69%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 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 3,052

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: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	526,960	48,866	15,179	591,005		591,005	(869)	590,136			1
2	Food Purchase		590,179		590,179		590,179	1,562	591,741			2
3	Housekeeping	399,173	125,261		524,434		524,434	472	524,906			3
4	Laundry	112,496	58,043		170,539		170,539		170,539			4
5	Heat and Other Utilities			280,790	280,790		280,790	637	281,427			5
6	Maintenance	351,940	82,039	112,484	546,463		546,463	536	546,999			6
7	Other (specify):*											7
8	TOTAL General Services	1,390,569	904,388	408,453	2,703,410		2,703,410	2,338	2,705,748			8
	B. Health Care and Programs											
9	Medical Director			25,750	25,750		25,750		25,750			9
10	Nursing and Medical Records	4,640,178	189,337	11,705	4,841,220		4,841,220	40,135	4,881,355			10
10a	Therapy			756,634	756,634		756,634		756,634			10a
11	Activities	250,552	44,008		294,560		294,560		294,560			11
12	Social Services	342,940		20,094	363,034		363,034		363,034			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			30,258	30,258		30,258	(147)	30,111			15
16	TOTAL Health Care and Programs	5,233,670	233,345	844,441	6,311,456		6,311,456	39,988	6,351,444			16
	C. General Administration											
17	Administrative	200,992			200,992		200,992		200,992			17
18	Directors Fees											18
19	Professional Services			534,463	534,463		534,463	(208,006)	326,457			19
20	Dues, Fees, Subscriptions & Promotions			26,781	26,781		26,781	(319)	26,462			20
21	Clerical & General Office Expenses	285,565	76,300	166,718	528,583		528,583	100,910	629,493			21
22	Employee Benefits & Payroll Taxes			1,196,399	1,196,399		1,196,399	37,425	1,233,824			22
23	Inservice Training & Education											23
24	Travel and Seminar			27,665	27,665		27,665	4,574	32,239			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			767,367	767,367		767,367	768	768,135			26
27	Other (specify):*											27
28	TOTAL General Administration	486,557	76,300	2,719,393	3,282,250		3,282,250	(64,648)	3,217,602			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,110,796	1,214,033	3,972,287	12,297,116		12,297,116	(22,322)	12,274,794			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: 01/01/2017 Ending: 12/31/2017

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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			63,630	63,630		63,630	723,096	786,726			30
31	Amortization of Pre-Op. & Org.							812,651	812,651			31
32	Interest			52,014	52,014		52,014	622,512	674,526			32
33	Real Estate Taxes			1,209,123	1,209,123		1,209,123		1,209,123			33
34	Rent-Facility & Grounds			1,622,868	1,622,868		1,622,868	(1,616,798)	6,070			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Replacement Tax			2,594	2,594		2,594		2,594			36
37	**TOTAL Ownership**			2,950,229	2,950,229		2,950,229	541,461	3,491,690			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			222	222		222		222			38
39	Ancillary Service Centers		118,822		118,822		118,822	(1,213)	117,609			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			866,260	866,260		866,260		866,260			42
43	Other (specify):* Bad Dept Exp			476,477	476,477		476,477	(476,477)				43
44	**TOTAL Special Cost Centers**		118,822	1,342,959	1,461,781		1,461,781	(477,690)	984,091			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,110,796	1,332,855	8,265,475	16,709,126		16,709,126	41,449	16,750,575			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: 01/01/2017 Ending: 12/31/2017

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	(10,791)	30		9
10	Interest and Other Investment Income	(85,954)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3)	1		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	(7,142)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(476,477)	43		24
25	Fund Raising, Advertising and Promotional	(13,021)	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	(42,012)	various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (635,400)		$	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)	676,849	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 676,849		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 41,449		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

STATE OF ILLINOIS

City View Multicare Center

ID# 0053827

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (36,173)	21	1
2	Lobbying Expense	(1,144)	20	2
3	RP Profit	(32)	10	3
4	RP Profit	(147)	15	4
5	RP Profit	(1,213)	39	5
6	Med Records	(1,913)	10	6
7	Penalties	(1,390)	21	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**	(42,012)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	(3)	(866)	0	0	0	0	0	0	0	0	0	(869)	1
2	Food Purchase	0	1,562	0	0	0	0	0	0	0	0	0	1,562	2
3	Housekeeping	0	472	0	0	0	0	0	0	0	0	0	472	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	637	0	0	0	0	0	0	0	0	0	637	5
6	Maintenance	0	536	0	0	0	0	0	0	0	0	0	536	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3)	2,341	0	0	0	0	0	0	0	0	0	2,338	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	(1,945)	42,080	0	0	0	0	0	0	0	0	0	40,135	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):*	(147)	0	0	0	0	0	0	0	0	0	0	(147)	15
16	TOTAL Health Care and Programs	(2,092)	42,080	0	0	0	0	0	0	0	0	0	39,988	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	(211,706)	3,700	0	0	0	0	0	0	0	0	(208,006)	19
20	Fees, Subscriptions & Promotions	(1,144)	825	0	0	0	0	0	0	0	0	0	(319)	20
21	Clerical & General Office Expenses	(57,726)	158,386	250	0	0	0	0	0	0	0	0	100,910	21
22	Employee Benefits & Payroll Taxes	0	37,425	0	0	0	0	0	0	0	0	0	37,425	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	4,574	0	0	0	0	0	0	0	0	0	4,574	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	768	0	0	0	0	0	0	0	0	0	768	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(58,870)	(9,728)	3,950	0	0	0	0	0	0	0	0	(64,648)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(60,965)	34,693	3,950	0	0	0	0	0	0	0	0	(22,322)	29

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(10,791)	0	733,887	0	0	0	0	0	0	0	0	723,096	30
31	Amortization of Pre-Op. & Org.	0	0	812,651	0	0	0	0	0	0	0	0	812,651	31
32	Interest	(85,954)	0	708,466	0	0	0	0	0	0	0	0	622,512	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(1,616,798)	0	0	0	0	0	0	0	0	(1,616,798)	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	(96,745)	0	638,206	0	0	0	0	0	0	0	0	541,461	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	(1,213)	0	0	0	0	0	0	0	0	0	0	(1,213)	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):*	(476,477)	0	0	0	0	0	0	0	0	0	0	(476,477)	43
44	TOTAL Special Cost Centers	(477,690)	0	0	0	0	0	0	0	0	0	0	(477,690)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(635,400)	34,693	642,156	0	0	0	0	0	0	0	0	41,449	45

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 3,899	Infinity Healthcare Management		$ 3,033	$ (866)	1
2	V	2	Food Purchase		Infinity Healthcare Management		1,562	1,562	2
3	V	3	Housekeeping		Infinity Healthcare Management		472	472	3
4	V	5	Utilities		Infinity Healthcare Management		637	637	4
5	V	6	Maintenance		Infinity Healthcare Management		536	536	5
6	V	10	Nursing	11,705	Infinity Healthcare Management		53,785	42,080	6
7	V	11	Activities		Infinity Healthcare Management				7
8	V	19	Professional Fees	350,066	Infinity Healthcare Management		138,360	(211,706)	8
9	V	20	Dues, Fees, Subs & Promotions		Infinity Healthcare Management		825	825	9
10	V	21	Clerical & Office Expenses	116,564	Infinity Healthcare Management		274,950	158,386	10
11	V	22	Employee Benefits		Infinity Healthcare Management		37,425	37,425	11
12	V	24	Travel & Seminar		Infinity Healthcare Management		4,574	4,574	12
13	V	26	Insurance		Infinity Healthcare Management		768	768	13
14	Total			$ 482,234			$ 516,927	$ * 34,693	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: 01/01/2017 Ending: 12/31/2017

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Infinity Healthcare Management		$ 169	$ 169	15
16	V	32	Interest		Infinity Healthcare Management		18	18	16
17	V	34	Rent		Infinity Healthcare Management		6,070	6,070	17
18	V								18
19	V								19
20	V	19	Professional Fees		Westshire Realty		3,700	3,700	20
21	V	21	Office Expense		Westshire Realty		250	250	21
22	V	26	Insurance		Westshire Realty				22
23	V	30	Depreciation		Westshire Realty		733,718	733,718	23
24	V	31	Amortization		Westshire Realty		812,651	812,651	24
25	V	32	Interest		Westshire Realty		708,448	708,448	25
26	V	33	Property Taxes		Westshire Realty				26
27	V	34	Rent	1,622,868	Westshire Realty			(1,622,868)	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			$ 1,622,868			$ 2,265,024	$ * 642,156	39

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

STATE OF ILLINOIS

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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: 01/01/2017 Ending: 12/31/2017

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
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: 01/01/2017 Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

	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: 01/01/2017 Ending: 12/31/2017

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	$ 17,769,000	$ 17,769,382	3/1/41	3.9400	$ 708,448	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Capital One		X	Working Capital	None	12/1/15	26,000,000	39,827	8/31/18	various	159	6
7												7
8												8
9	TOTAL Facility Related				$97,351.00		$ 43,769,000	$ 17,809,209			$ 708,607	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 43,769,000	$ 17,809,209			$ 708,607	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: 01/01/2017 Ending: 12/31/2017

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

B. Real Estate Taxes

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

Description		Amount	Line
1. Real Estate Tax accrual used on 2016 report.	$	(41,053)	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.)	$	1,141,086	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,182,139	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	26,984	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.	$	1,209,123	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2012		8
2013		9
2014		10
2015	1,199,929	11
2016	1,141,086	12

Line	FOR BHF USE ONLY		Line
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 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 2016 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 2016.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	16-29-202-004-0000	Nursing Facility	$ 159,853.28	$ 159,853.28
2.	16-29-202-005-0000	Nursing Facility	$ 159,853.28	$ 159,853.28
3.	16-29-202-006-0000	Nursing Facility	$ 319,707.43	$ 319,707.43
4.	16-29-202-007-0000	Nursing Facility	$ 182,082.31	$ 182,082.31
5.	16-29-202-008-0000	Nursing Facility	$ 319,589.48	$ 319,589.48
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,141,085.78	$ 1,141,085.78

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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.

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

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

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

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: 664 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	2	3	4	
	Use	Square Feet	Year Acquired	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: 01/01/2017 Ending: 12/31/2017

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	$	$ 1,098,502	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		374	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		2,954	17
18	Room ID signs, Braille signs, Regulatory signs			2016	4,977	128	39	128		255	18
19	Terrace Rails for East Side Balcony			2016	5,400	138	39	138		277	19
20	2 Retractable Elevator Pit Ladders			2016	6,466	166	39	166		332	20
21	Terrace Rails for East Side Balcony			2016	7,201	185	39	185		369	21
22	Building Facility Sign			2016	16,861	432	39	432		865	22
23	Paint 1st,2nd,3rd,4th,5ht,6th,7th,8th,9th Floors			2016	3,232	83	39	83		166	23
24	Materials for Remodeling Center Stairwell			2016	5,923	152	39	152		304	24
25	Rebuild Nurse Station Cabinets			2016	5,775	148	39	148		296	25
26	Nurse Station Counter Tops			2016	2,922	75	39	75		150	26
27	New Generator			2016	6,258	160	39	160		321	27
28	Pait 3rd Floor Dining Room			2016	2,650	68	39	68		136	28
29	Terrace Rails for West Side Balcony			2016	2,900	74	39	74		149	29
30	15 Ton Compressor			2016	7,450	191	39	191		382	30
31	Materials for Remodeling Center Stairwell			2016	5,580	143	39	143		286	31
32	3rd Floor Electrical Work,Clean & Sand 3rd Floor Cabinet Doors			2016	2,700	69	39	69		138	32
33	3rd Floor Nurse Call System			2016	6,620	170	39	170		339	33
34	Flooring			2016	2,646	68	39	68		136	34
35											35
36	2 Retractable Elevator Pit Ladders										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: 01/01/2017 Ending: 12/31/2017

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	$	$ 185	37
38	Insulate Emergency Generator Piping/Silencer	2016	3,423	88	39	88		176	38
39	Install new Walls by Penthouse Boiler Room	2016	2,851	73	39	73		146	39
40	Electrical Work for Sign	2016	2,650	68	39	68		136	40
41	New Kitchen/Laundry Hot Water Boiler	2016	11,500	295	39	295		590	41
42	Fresh Air Room Generator	2016	3,422	88	39	88		176	42
43									43
44	Facility Wide Surveillance Cameras	2017	2,769	36	39	36		36	44
45	New Boiler (down payment)	2017	8,000	103	39	103		103	45
46	New Boiler (final payment)	2017	9,500	122	39	122		122	46
47	Welded Couplings on Boiler	2017	435	6	39	6		6	47
48	Elevator Modernization - Three Traction Elevators	2017	389,521	4,993	39	4,993		4,993	48
49	New Laundry Sink for 3rd Floor	2017	1,580	20	39	20		20	49
50	Vent Pipe for 3rd Floor Laundry Room	2017	1,925	25	39	25		25	50
51	3rd Floor Air Conditioners	2017	4,721	61	39	61		61	51
52	Clear & Unclog Pipe on East & North side of Building.								52
53	New outlet Boxes	2017	3,420	44	39	44		44	53
54	Upgrade to Nurse Station & Dining Room A/C Units	2017	56,850	728	39	728		728	54
55	7th FL Men's Bath Replace Tile, New Concrete,								55
56	Replace Drywall, New Shower	2017	13,600	173	39	174	1	174	56
57	Facility Wide Sprinkler System Modifications	2017	4,459	57	39	57		57	57
58	7th Floor Air Conditioners	2017	4,690	60	39	60		60	58
59	Seal Coat Roof	2017	2,650	34	39	34		34	59
60	New Tile for 7th Floor Mens Shower Room	2017	4,996	64	39	64		64	60
61	Permit Drawings for 6th Floor Dialysis Room	2017	4,000	51	39	51		51	61
62	Permit Drawings for 1st Floor Dialysis Room	2017	7,000	90	39	90		90	62
63	New Condensor for 4th Floor HVAC	2017	4,132	53	39	53		53	63
64	New Flooring for 1st Floor Conference Room								64
65	& Administrator's Office	2017	2,827	36	39	36		36	65
66									66
67	New Sliding Doors for Lobby	2017	6,685	86	39	86		86	67
68	New Flooring for 1st Floor Business Office								68
69	& Asst Administrator's Office	2017	2,827	36	39	36		36	69
70	TOTAL (lines 4 thru 69)		$ 10,424,503	$ 260,415		$ 260,416	$ 1	$ 1,115,017	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: 01/01/2017 Ending: 12/31/2017

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	$ 2,425,000	$ 485,169	$ 485,000	$ (169)	5	$ 2,326,755	71
72	Current Year Purchases	51,933	51,933	10,387	(41,546)	5	51,933	72
73	Fully Depreciated Assets	154,617		30,923	30,923			73
74								74
75	TOTALS	$ 2,631,550	$ 537,102	$ 526,310	$ (10,792)		$ 2,378,688	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)	$ 13,361,053	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 797,517	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 786,726	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (10,791)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,493,706	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: 01/01/2017 Ending: 12/31/2017

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: 01/01/2017 Ending: 12/31/2017

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	$	5,021	$ 342,044	$	5,021	$ 342,044	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		2,119	161,941		2,119	161,941	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		4,625	252,650		4,625	252,650	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				113,726		113,726	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-2					3,740		3,740	12
13	Other (specify): Lab	39-2					1,356		1,356	13
14	TOTAL			$	11,765	$ 756,634	$ 118,822	11,765	$ 875,457	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: 01/01/2017 Ending: 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2017 (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	$ (256,471)	$ 194,710	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,517,827	2,517,827	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	416,545	416,545	6
7	Other Prepaid Expenses	1,627	1,627	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Escrow Accounts		916,550	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,679,528	$ 4,047,259	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	724,503	724,503	15
16	Equipment, at Historical Cost	206,550	2,631,550	16
17	Accumulated Depreciation (book methods)	(223,064)	(3,493,705)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		12,189,759	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(3,476,690)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Replacement Reserves	223,171	933,693	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 931,160	$ 19,514,110	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,610,688	$ 23,561,369	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,954,823	$ 4,495,543	26
27	Officer's Accounts Payable	-	-	27
28	Accounts Payable-Patient Deposits	25,615	25,615	28
29	Short-Term Notes Payable	-	476,632	29
30	Accrued Salaries Payable	423,661	423,661	30
31	Accrued Taxes Payable (excluding real estate taxes)	142,178	142,178	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		58,343	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Working Capital	39,827	39,827	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,586,104	$ 5,661,799	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		17,292,750	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)**	$	$ 17,292,750	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,586,104	$ 22,954,549	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,024,584	$ 606,821	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,610,688	$ 23,561,370	48

*(See instructions.)

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 350,281	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 350,281	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	674,303	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)**	$ 674,303	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,024,584	24 *

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

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 15,346,621	1
2	Discounts and Allowances for all Levels	1,082,560	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 16,429,181	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	611,325	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 611,325	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	70,482	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,342	19
20	Radiology and X-Ray	2,690	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 81,514	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	84,395	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 84,395	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a	Miscellaneous Revenue	177,011	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 177,011	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,383,426	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,703,408	31
32	Health Care	6,311,456	32
33	General Administration	3,282,249	33
	B. Capital Expense		
34	Ownership	2,950,229	34
	C. Ancillary Expense		
35	Special Cost Centers	118,822	35
36	Provider Participation Fee	866,260	36
	D. Other Expenses (specify):		
37	Medically Necessary Transportation	222	37
38	Bad Debt Expense	476,477	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,709,123	40
41	**Income before Income Taxes (line 30 minus line 40)****	674,303	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 674,303	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 14,405,702	44
45	Private Pay - Net Inpatient Revenue	17,390	45
46	Medicare - Net Inpatient Revenue	1,648,590	46
47	Other-(specify) Net Inpatient Revenue	357,499	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 16,429,181	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.

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,214	2,317	$ 108,491	$ 46.82	1
2	Assistant Director of Nursing	10,122	11,118	424,523	38.18	2
3	Registered Nurses	10,781	11,692	378,501	32.37	3
4	Licensed Practical Nurses	66,204	70,618	2,023,160	28.65	4
5	CNAs & Orderlies	105,995	117,134	1,625,151	13.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	17,877	19,942	250,552	12.56	9
10	Activity Assistants					10
11	Social Service Workers	19,403	20,737	342,940	16.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	38,550	41,805	526,960	12.61	15
16	Dishwashers					16
17	Maintenance Workers	25,925	28,183	351,940	12.49	17
18	Housekeepers	31,114	35,402	399,173	11.28	18
19	Laundry	7,336	8,351	112,496	13.47	19
20	Administrator	4,440	4,385	200,992	45.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,256	20,896	331,928	15.88	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	2,261	2,331	33,989	14.58	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	361,478	394,911	$ 7,110,796 *	$ 18.01	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	434	$ 15,179	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	334	11,705	10-3	38
39	Pharmacist Consultant	605	30,258	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	434	15,184	12-3	45
46	Other(specify)				46
47	HR CORP COMPLIANCE	310	15,517	21-3	47
48					48
49	TOTAL (lines 35 - 48)	2,117	$ 87,843		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	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: 01/01/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michael Perl	Administrator		$ 137,852
Esther Burnett	Administrator		63,140
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 200,992

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
Bradley & Associates	Accounting	$ 11,472
Johnson & Goldburg	Accounting	3,900
Healthcare Recruiting Specialists - Re	Professional	(7,500)
MTS Consulting, Inc	Professional	9,690
MTS Consulting, Inc. - Reversed	Professional	(714)
Pinnacle Quality Insight	Professional	300
Allen A. Lefkowitz & Associates, PC	Legal	5,800
Dec AP Accruals - Reversing Entry	Legal	(5,800)
Infinity Funding / Sedgwick	Legal	62,342
Reclassify to Legal Service - Abbey R	Legal	43,974
Wilson Elser Moskowitz Edelman & I	Legal	9,933
Infinity Healthcare	Management	401,066
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 534,463

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 175,303
Unemployment Compensation Insurance	111,949
FICA Taxes	524,301
Employee Health Insurance	374,197
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniform Expense	2,554
Pension Expense	24,478
Employee Expense	21,042
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,233,824

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed)	
IHCA	18,315
IHCA PAC	1,144
Town of Cicero	1,725
IL Dept of Public Health	1,990
IL Dept of Revenue	1,813
Various	1,475
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,462

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage	24,874
Seminar Expense	
Education & Seminars	2,791
H.O. Seminar	4,574
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 32,239

**See instructions.

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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. $ **60,211** 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. $ **866,260**
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