FOR BHF USE

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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, LLC

Address: 5825 West Cermak Road (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 01/01/2018 to 12/31/2018 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, LLC # 0053827 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	54,020	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 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	31,284	54	2,876	34,215	8
9	SNF/PED					9
10	ICF	71,236	124	543	71,902	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	102,520	178	3,419	106,117	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.94%

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 2,638

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: 12/31/18 Fiscal Year: 12/31/18

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

Facility Name & ID Number City View Multicare Center, LLC # 0053827 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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	541,486	52,055	13,686	607,227		607,227	(5)	607,222			1
2	Food Purchase		602,322		602,322		602,322	2,177	604,499			2
3	Housekeeping	473,730	155,368		629,098		629,098	23	629,121			3
4	Laundry	94,173	69,912		164,085		164,085		164,085			4
5	Heat and Other Utilities			325,709	325,709		325,709	(30,497)	295,212			5
6	Maintenance	373,409	67,655	131,190	572,254		572,254	1,972	574,226			6
7	Other (specify):*											7
8	TOTAL General Services	1,482,798	947,312	470,585	2,900,695		2,900,695	(26,330)	2,874,365			8
	B. Health Care and Programs											
9	Medical Director			31,000	31,000		31,000		31,000			9
10	Nursing and Medical Records	5,217,963	249,401	11,705	5,479,069		5,479,069	53,996	5,533,065			10
10a	Therapy			696,641	696,641		696,641		696,641			10a
11	Activities	264,400	56,942		321,342		321,342		321,342			11
12	Social Services	385,052		37,266	422,318		422,318		422,318			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			31,986	31,986		31,986	(685)	31,301			15
16	TOTAL Health Care and Programs	5,867,415	306,343	808,598	6,982,356		6,982,356	53,311	7,035,667			16
	C. General Administration											
17	Administrative	175,338			175,338		175,338		175,338			17
18	Directors Fees											18
19	Professional Services			748,384	748,384		748,384	(637,145)	111,239			19
20	Dues, Fees, Subscriptions & Promotions			10,141	10,141		10,141	(777)	9,364			20
21	Clerical & General Office Expenses	247,024	83,388	209,334	539,746		539,746	210,061	749,807			21
22	Employee Benefits & Payroll Taxes			1,381,252	1,381,252		1,381,252	54,528	1,435,780			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,700	12,700		12,700	4,047	16,747			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			645,534	645,534		645,534	2,528	648,062			26
27	Other (specify):*											27
28	TOTAL General Administration	422,362	83,388	3,007,345	3,513,095		3,513,095	(366,758)	3,146,337			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,772,575	1,337,043	4,286,528	13,396,146		13,396,146	(339,777)	13,056,369			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, LLC #0053827 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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			44,752	44,752		44,752	755,107	799,859			30
31	Amortization of Pre-Op. & Org.							812,651	812,651			31
32	Interest			68,676	68,676		68,676	671,439	740,115			32
33	Real Estate Taxes			772,274	772,274		772,274		772,274			33
34	Rent-Facility & Grounds			1,671,554	1,671,554		1,671,554	(1,664,433)	7,121			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Replacement Tax			5,077	5,077		5,077		5,077			36
37	**TOTAL Ownership**			2,562,333	2,562,333		2,562,333	574,764	3,137,097			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			852	852		852		852			38
39	Ancillary Service Centers		138,341		138,341		138,341	(2,912)	135,429			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			892,642	892,642		892,642		892,642			42
43	Other (specify):* Bad Debt Exp			235,085	235,085		235,085	(235,085)				43
44	**TOTAL Special Cost Centers**		138,341	1,128,579	1,266,920		1,266,920	(237,997)	1,028,923			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,772,575	1,475,384	7,977,440	17,225,399		17,225,399	(3,010)	17,222,389			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, LLC # 0053827 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	253,528	30		9
10	Interest and Other Investment Income	(24,785)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(5)	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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(235,085)	43		24
25	Fund Raising, Advertising and Promotional	(18,855)	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	(41,182)	various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (66,384)		$	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)	63,374	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 63,374		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (3,010)		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, LLC

ID# 0053827

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc Income	$ (34,095)	5	1
2	Misc Income	(749)	10	2
3	Misc Income	(268)	21	3
4	Penalties	(2,200)	21	4
5	Lobbying Expense	(208)	20	5
6	RP Profit	(65)	10	6
7	RP Profit	(685)	15	7
8	RP Profit	(2,912)	39	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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22				22
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28				28
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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**	(41,182)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number City View Multicare Center, LLC # 0053827 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Operating Expenses	PAGES 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	(5)	0	0	0	0	0	0	0	0	0	0	(5)	1
2	Food Purchase	0	2,177	0	0	0	0	0	0	0	0	0	2,177	2
3	Housekeeping	0	23	0	0	0	0	0	0	0	0	0	23	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(34,095)	3,598	0	0	0	0	0	0	0	0	0	(30,497)	5
6	Maintenance	0	1,972	0	0	0	0	0	0	0	0	0	1,972	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(34,100)	7,770	0	0	0	0	0	0	0	0	0	(26,330)	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	(814)	54,810	0	0	0	0	0	0	0	0	0	53,996	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):*	(685)	0	0	0	0	0	0	0	0	0	0	(685)	15
16	**TOTAL Health Care and Programs**	(1,499)	54,810	0	0	0	0	0	0	0	0	0	53,311	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	(640,845)	3,700	0	0	0	0	0	0	0	0	(637,145)	19
20	Fees, Subscriptions & Promotions	(208)	(569)	0	0	0	0	0	0	0	0	0	(777)	20
21	Clerical & General Office Expenses	(21,323)	231,256	128	0	0	0	0	0	0	0	0	210,061	21
22	Employee Benefits & Payroll Taxes	0	54,528	0	0	0	0	0	0	0	0	0	54,528	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	4,047	0	0	0	0	0	0	0	0	0	4,047	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	1,920	608	0	0	0	0	0	0	0	0	2,528	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(21,531)	(349,663)	4,436	0	0	0	0	0	0	0	0	(366,758)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(57,130)	(287,083)	4,436	0	0	0	0	0	0	0	0	(339,777)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number City View Multicare Center, LLC # 0053827 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	253,528	0	501,579	0	0	0	0	0	0	0	0	755,107	30
31	Amortization of Pre-Op. & Org.	0	0	812,651	0	0	0	0	0	0	0	0	812,651	31
32	Interest	(24,785)	0	696,224	0	0	0	0	0	0	0	0	671,439	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(1,664,433)	0	0	0	0	0	0	0	0	(1,664,433)	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**	228,743	0	346,021	0	0	0	0	0	0	0	0	574,764	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	(2,912)	0	0	0	0	0	0	0	0	0	0	(2,912)	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):*	(235,085)	0	0	0	0	0	0	0	0	0	0	(235,085)	43
44	**TOTAL Special Cost Centers**	(237,997)	0	0	0	0	0	0	0	0	0	0	(237,997)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(66,384)	(287,083)	350,457	0	0	0	0	0	0	0	0	(3,010)	45

Facility Name & ID Number City View Multicare Center, LLC # 0053827 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	Itasca			
		Lakeview Nursing & Rehab Center	Chicago			
		Midway Neurological & Rehab Center	Bridgeview			
		Momence Meadows Nursing & Rehab Center	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	$	Infinity Healthcare Management		$	$	1
2	V	2	Food Purchases		Infinity Healthcare Management		2,177	2,177	2
3	V	3	Housekeeping		Infinity Healthcare Management		23	23	3
4	V	5	Utilities		Infinity Healthcare Management		3,598	3,598	4
5	V	6	Maintenance		Infinity Healthcare Management		1,972	1,972	5
6	V	10	Nursing	12,018	Infinity Healthcare Management		66,828	54,810	6
7	V	11	Activities		Infinity Healthcare Management				7
8	V	19	Professional Fees	643,894	Infinity Healthcare Management		3,049	(640,845)	8
9	V	20	Dues, Fees Subs & Promotions	780	Infinity Healthcare Management		211	(569)	9
10	V	21	Clerical & Office Expense	141,592	Infinity Healthcare Management		372,848	231,256	10
11	V	22	Employee Benefits	2,228	Infinity Healthcare Management		56,756	54,528	11
12	V	24	Travel & Seminar	2,703	Infinity Healthcare Management		6,750	4,047	12
13	V	26	Insurance		Infinity Healthcare Management		1,920	1,920	13
14	Total			$ 803,215			$ 516,132	$ * (287,083)	14

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

Facility Name & ID Number City View Multicare Center, LLC # 0053827 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	30	Depreciation	$	Infinity Healthcare Management		$	$	15
16	V	32	Interest		Infinity Healthcare Management		6,222	6,222	16
17	V	34	Rent		Infinity Healthcare Management		7,121	7,121	17
18	V								18
19	V								19
20	V								20
21	V	19	Professional Fees		Westshire Realty		3,700	3,700	21
22	V	21	Office Expense		Westshire Realty		128	128	22
23	V	26	Insurance		Westshire Realty		608	608	23
24	V	30	Depreciation		Westshire Realty		501,579	501,579	24
25	V	31	Amortization		Westshire Realty		812,651	812,651	25
26	V	32	Interest		Westshire Realty		690,002	690,002	26
27	V	33	Property Taxes		Westshire Realty				27
28	V	34	Rent	1,671,554	Westshire Realty			(1,671,554)	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			$ 1,671,554			$ 2,022,011	$ * 350,457	39

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

Facility Name & ID Number City View Multicare Center, LLC # 0053827 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			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			Landmark of Des Plaines Rehab Center	Des Plaines				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, LLC # 0053827 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	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, LLC # 0053827 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [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, LLC # 0053827 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HUD Loan		X	Mortgage	$97,351.00	7/26/13	$ 17,769,000	$ 17,292,736	3/1/41	3.9400	$ 690,002	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Capital One		X	Working Capital	None	12/1/15	26,000,000	145,004	8/31/19	various	7,934	6
7	Infinity Funding	X		Working Capital	various	various	various		various	various	66,965	7
8												8
9	TOTAL Facility Related				$97,351.00		$ 43,769,000	$ 17,437,740			$ 764,901	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	$ 17,437,740			$ 764,901	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 608 Line # 26

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

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

Facility Name & ID Number City View Multicare Center, LLC # 0053827 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 26,984	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.)		$ 1,008,126	2
3. Under or (over) accrual (line 2 minus line 1).		$ 981,142	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ (208,868)	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.		$ 772,274	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2013		8
2014		9
2015	1,199,929	10
2016	1,141,086	11
2017	1,008,126	12

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

NOTES:

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-29-202-004-0000	Nursing Facility	$ 141,240.35	$ 141,240.35
2.	16-29-202-005-0000	Nursing Facility	$ 141,238.50	$ 141,238.50
3.	16-29-202-006-0000	Nursing Facility	$ 282,477.93	$ 282,477.93
4.	16-29-202-007-0000	Nursing Facility	$ 160,809.17	$ 160,809.17
5.	16-29-202-008-0000	Nursing Facility	$ 282,359.93	$ 282,359.93
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,008,125.88	$ 1,008,125.88

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

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

C. **Tax Bills**

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

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

Facility Name & ID Number City View Multicare Center, LLC # 0053827 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 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, LLC # 0053827 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$	$ 1,347,220	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		561	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		4,431	17
18	Room ID signs, Braille signs, Regulatory signs			2016	4,977	128	39	128		383	18
19	Terrace Rails for East Side Balcony			2016	5,400	138	39	138		415	19
20	2 Retractable Elevator Pit Ladders			2016	6,466	166	39	166		497	20
21	Terrace Rails for East Side Balcony			2016	7,201	185	39	185		554	21
22	Building Facility Sign			2016	16,861	432	39	432		1,297	22
23	Paint 1st,2nd,3rd,4th,5ht,6th,7th,8th,9th Floors			2016	3,232	83	39	83		249	23
24	Materials for Remodeling Center Stairwell			2016	5,923	152	39	152		456	24
25	Rebuild Nurse Station Cabinets			2016	5,775	148	39	148		444	25
26	Nurse Station Counter Tops			2016	2,922	75	39	75		225	26
27	New Generator			2016	6,258	160	39	160		481	27
28	Pait 3rd Floor Dining Room			2016	2,650	68	39	68		204	28
29	Terrace Rails for West Side Balcony			2016	2,900	74	39	74		223	29
30	15 Ton Compressor			2016	7,450	191	39	191		573	30
31	Materials for Remodeling Center Stairwell			2016	5,580	143	39	143		429	31
32	3rd Floor Electrical Work,Clean & Sand 3rd Floor Cabinet Doors			2016	2,700	69	39	69		208	32
33	3rd Floor Nurse Call System			2016	6,620	170	39	170		509	33
34	Flooring			2016	2,646	68	39	68		204	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, LLC # 0053827 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$	$ 278	37
38	Insulate Emergency Generator Piping/Silencer	2016	3,423	88	39	88		263	38
39	Install new Walls by Penthouse Boiler Room	2016	2,851	73	39	73		219	39
40	Electrical Work for Sign	2016	2,650	68	39	68		204	40
41	New Kitchen/Laundry Hot Water Boiler	2016	11,500	295	39	295		885	41
42	Fresh Air Room Generator	2016	3,422	88	39	88		263	42
43									43
44	Facility Wide Surveillance Cameras	2017	2,769	72	39	72		108	44
45	New Boiler (down payment)	2017	8,000	205	39	205		308	45
46	New Boiler (final payment)	2017	9,500	244	39	244		366	46
47	Welded Couplings on Boiler	2017	435	11	39	11		17	47
48	Elevator Modernization - Three Traction Elevators	2017	389,521	9,988	39	9,988		14,981	48
49	New Laundry Sink for 3rd Floor	2017	1,580	41	39	41	(0)	61	49
50	Vent Pipe for 3rd Floor Laundry Room	2017	1,925	49	39	49	0	74	50
51	3rd Floor Air Conditioners	2017	4,721	121	39	121		182	51
52	Clear & Unclog Pipe on East & North side of Building.								52
53	New outlet Boxes	2017	3,420	88	39	88		132	53
54	Upgrade to Nurse Station & Dining Room A/C Units	2017	56,850	1,458	39	1,458		2,186	54
55	7th FL Men's Bath Replace Tile, New Concrete,								55
56	Replace Drywall, New Shower	2017	13,600	349	39	349		522	56
57	Facility Wide Sprinkler System Modifications	2017	4,459	114	39	114		171	57
58	7th Floor Air Conditioners	2017	4,690	120	39	120		180	58
59	Seal Coat Roof	2017	2,650	68	39	68		102	59
60	New Tile for 7th Floor Mens Shower Room	2017	4,996	128	39	128		192	60
61	Permit Drawings for 6th Floor Dialysis Room	2017	4,000	103	39	103		154	61
62	Permit Drawings for 1st Floor Dialysis Room	2017	7,000	179	39	179		269	62
63	New Condensor for 4th Floor HVAC	2017	4,132	106	39	106		159	63
64	New Flooring for 1st Floor Conference Room								64
65	& Administrator's Office	2017	2,827	72	39	72		108	65
66									66
67	New Sliding Doors for Lobby	2017	6,685	171	39	171		257	67
68	New Flooring for 1st Floor Business Office								68
69	& Asst Administrator's Office	2017	2,827	72	39	72		108	69
70	TOTAL (lines 4 thru 69)		$ 10,424,503	$ 267,296		$ 267,296	$ 0	$ 1,382,312	70

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

Facility Name & ID Number City View Multicare Center, LLC # 0053827 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 10,424,503	$ 267,296		$ 267,296	$	$ 1,382,312	1
2									2
3	New LVT flooring in conference room, new countertops 4th floor	2018	4,750	61	39	61		61	3
4	Install new pressure detector assembly sprinkler system	2018	8,240	106	39	106		106	4
5	New electrical & lighting for floors 3, 5 and 7	2018	17,540	225	39	225		225	5
6	New flooring for 3 offices on 1st and 2nd floor	2018	5,283	68	39	68		68	6
7	Double fire doors for 2nd floor dining room	2018	3,050	39	39	39		39	7
8	Replace fire pump motor	2018	6,959	89	39	89		89	8
9	Replace 7th floor central stairwell door	2018	3,966	51	39	51		51	9
10	New air conditioners in patients rooms	2018	3,020	39	39	39		39	10
11	New air conditioners in patients rooms	2018	3,619	46	39	46		46	11
12	New air conditioners in patients rooms	2018	3,020	39	39	39		39	12
13	New sill for elevator	2018	3,840	49	39	49		49	13
14	Install new fire door	2018	2,971	38	39	38		38	14
15	New doors for rooms 904,908,medical room, dining room	2018	3,635	47	39	47		47	15
16	New air conditioners in patients rooms	2018	5,416	69	39	69		69	16
17	New walls, flooring, electrical, fixtures for 8th floor bathroom	2018	13,900	178	39	178		178	17
18	8th floor bathroom renovation supplies, etc	2018	5,564	71	39	71		71	18
19	Paint 5th floor hallway & dining room	2018	4,500	58	39	58		58	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,523,775	$ 268,569		$ 268,569	$	$ 1,383,585	34

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

Facility Name & ID Number City View Multicare Center, LLC # 0053827 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 252,861	$ 485,000	$ 232,139	5	$ 2,425,000	71
72	Current Year Purchases	24,902	24,902	4,980	(19,922)	5	24,902	72
73	Fully Depreciated Assets	206,549		41,310	41,310	5	206,549	73
74								74
75	TOTALS	$ 2,656,451	$ 277,763	$ 531,290	$ 253,527		$ 2,656,451	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)	$ 13,485,226	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 546,332	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 799,859	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 253,527	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,040,036	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, LLC # 0053827 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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.	/2019	$
13.	/2020	$
14.	/2021	$

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, LLC # 0053827 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$	4,208	$ 307,205	$	4,208	$ 307,205	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		2,119	146,316		2,119	146,316	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		5,168	243,120		5,168	243,120	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				136,071		136,071	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-2					2,270		2,270	12
13	Other (specify): Lab	39-2					0			13
14	TOTAL			$	11,495	$ 696,641	$ 138,341	11,495	$ 834,982	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.

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XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018 (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	$ (200,228)	$ 62,614	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,961,802	2,961,802	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	380,606	380,606	6
7	Other Prepaid Expenses	235,821	235,821	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Escrow Accounts		733,160	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,378,001	$ 4,374,003	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	823,775	823,775	15
16	Equipment, at Historical Cost	231,451	2,656,451	16
17	Accumulated Depreciation (book methods)	(290,547)	(4,062,767)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		12,189,759	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(4,289,341)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Replacement Reserves	532	712,314	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 765,211	$ 18,035,191	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,143,212	$ 22,409,194	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,519,475	$ 3,797,602	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,556	13,556	28
29	Short-Term Notes Payable		495,755	29
30	Accrued Salaries Payable	510,628	510,628	30
31	Accrued Taxes Payable (excluding real estate taxes)	100,770	100,770	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		56,778	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Working Capital	145,004	145,004	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,289,433	$ 5,120,093	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		16,796,981	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)**	$	$ 16,796,981	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,289,433	$ 21,917,074	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,853,779	$ 492,120	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,143,212	$ 22,409,194	48

***(See instructions.)**

Facility Name & ID Number City View Multicare Center, LLC # 0053827 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,024,584	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,024,584	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	829,196	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) **Rounding**	(1)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 829,195	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)**	$ 1,853,779	24 *

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

Facility Name & ID Number City View Multicare Center, LLC # 0053827 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 16,485,925	1
2	Discounts and Allowances for all Levels	999,712	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 17,485,637	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	481,379	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 481,379	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	47,820	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,242	19
20	Radiology and X-Ray	1,610	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 51,672	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	23,526	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 23,526	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a	Miscellaneous Revenue	35,112	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 35,112	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 18,077,326	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,900,695	31
32	Health Care	6,982,356	32
33	General Administration	3,513,095	33
	B. Capital Expense		
34	Ownership	2,585,064	34
	C. Ancillary Expense		
35	Special Cost Centers	138,341	35
36	Provider Participation Fee	892,642	36
	D. Other Expenses (specify):		
37	Medically Necessary Transportation	852	37
38	Bad Debt Expense	235,085	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,248,130	40
41	**Income before Income Taxes (line 30 minus line 40)****	829,196	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 829,196	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 15,789,230	44
45	Private Pay - Net Inpatient Revenue	32,620	45
46	Medicare - Net Inpatient Revenue	1,462,052	46
47	Other-(specify) Net Inpatient Revenue	201,735	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 17,485,637	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	2,018	2,188	$ 115,888	$ 52.97	1
2	Assistant Director of Nursing	8,037	8,825	353,997	40.11	2
3	Registered Nurses	8,995	9,781	372,871	38.12	3
4	Licensed Practical Nurses	63,317	68,798	2,233,178	32.46	4
5	CNAs & Orderlies	116,167	126,976	2,041,473	16.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	17,532	19,614	264,400	13.48	9
10	Activity Assistants					10
11	Social Service Workers	20,887	22,257	385,052	17.30	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	37,658	40,785	541,486	13.28	15
16	Dishwashers					16
17	Maintenance Workers	25,017	27,084	373,409	13.79	17
18	Housekeepers	34,246	37,858	473,730	12.51	18
19	Laundry	6,148	6,907	94,173	13.63	19
20	Administrator	3,844	4,079	175,338	42.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,788	18,323	313,027	17.08	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	2,053	2,221	34,553	15.56	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	362,707	395,696	$ 7,772,575 *	$ 19.64	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	391	$ 13,686	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	334	11,705	10-3	38
39	Pharmacist Consultant	640	31,986	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	(640)	(32,000)	10a-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	878	30,746	12-3	45
46	Other(specify)				46
47	HR CORP COMPLIANCE	310	15,517	21-3	47
48					48
49	TOTAL (lines 35 - 48)	1,913	$ 71,640		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michael Perl	Administrator		$ 24,397
Esther Burnett	Administrator		98,907
Tamara Dobbins	Administrator		18,149
Chandra Crawford	Administrator		33,885
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 175,338

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	$ 12,000
Wilson, Elser, Moskowitz	Legal	(5,296)
Infinity Funding / Sedgwick	Legal	93,079
MTS Consulting	Professional	(7,582)
Genex Services, Inc	Professional	30
Central Survey	Professional	700
Capital One Field Exam	Professional	192
Infinity Healthcare Mgmt	Professional	28,337
Infinity Healthcare Mgmt	Mgmt	608,424
Michael Blisko	Mgmt	6,500
Empire Risk	Mgmt	12,000
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 748,384

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 207,574
Unemployment Compensation Insurance	120,617
FICA Taxes	605,301
Employee Health Insurance	443,710
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniform Expense	8,465
Employee Background Checks	10,861
Pension	25,031
Employee Expense	14,221
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,435,780

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	$ 4,039
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
IHCA	3,068
Town of Cicero	1,857
Various	400
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,364

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage	16,280
Seminar Expense	
Education	467
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,747

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number City View Multicare Center, LLC # 0053827 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **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. $ **55,817** 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. $ **892,642**
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. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees