FOR BHF USE

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: 0053553

Facility Name: Central Nursing Home

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

County: Cook

Telephone Number: 773-889-1333 **Fax #** 773-889-1516

HFS ID Number:

Date of Initial License for Current Owners: 05/01/2015

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: Mendel Schneider **Telephone Number:** 847-933-1274
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 01/01/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) (Date)
(Print Name and Title) See Accountamt's Report Attached
(Firm Name & Address) Mendel S Schneider & Associates CPA PC
4051 Old Orchard Rd Skokie Illinois 60076
(Telephone) 847-933-1274 Fax # 847-933-1283

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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 _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	245	Skilled (SNF)	245	89,670	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	245	TOTALS	245	89,670	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	70,906	30	4,093	75,029	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	70,906	30	4,093	75,029	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.67%

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 05/01/2015

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 245 and days of care provided 2,763

Medicare Intermediary Wisconsin Physicians Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	330,123	13,732	12,592	356,447		356,447		356,447			1
2	Food Purchase		354,902		354,902	(30,000)	324,902	(163)	324,739			2
3	Housekeeping	377,856	49,314	20,139	447,309		447,309		447,309			3
4	Laundry	19,635	10,191		29,826		29,826		29,826			4
5	Heat and Other Utilities			220,761	220,761		220,761	2,762	223,523			5
6	Maintenance			58,395	58,395		58,395	1,629	60,024			6
7	Other (specify):*											7
8	**TOTAL General Services**	727,614	428,139	311,887	1,467,640	(30,000)	1,437,640	4,228	1,441,868			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,597,861	164,103	277,787	3,039,751		3,039,751	159,625	3,199,376			10
10a	Therapy	76,372			76,372		76,372		76,372			10a
11	Activities	149,474			149,474		149,474		149,474			11
12	Social Services	144,666		6,088	150,754		150,754		150,754			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,968,373	164,103	283,875	3,416,351		3,416,351	159,625	3,575,976			16
	C. General Administration											
17	Administrative			1,356,564	1,356,564		1,356,564	(1,223,825)	132,739			17
18	Directors Fees											18
19	Professional Services			52,929	52,929		52,929	23,949	76,878			19
20	Dues, Fees, Subscriptions & Promotions			2,447	2,447		2,447	(200)	2,247			20
21	Clerical & General Office Expenses	184,944	35,270	185,343	405,557		405,557	188,820	594,377			21
22	Employee Benefits & Payroll Taxes			529,417	529,417	30,000	559,417	39,081	598,498			22
23	Inservice Training & Education											23
24	Travel and Seminar			388	388		388		388			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			224,145	224,145		224,145	141,122	365,267			26
27	Other (specify):*											27
28	**TOTAL General Administration**	184,944	35,270	2,351,233	2,571,447	30,000	2,601,447	(831,053)	1,770,394			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,880,931	627,512	2,946,995	7,455,438		7,455,438	(667,200)	6,788,238			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Central Nursing Home #0053553 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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			154,856	154,856		154,856	80,209	235,065			30
31	Amortization of Pre-Op. & Org.							1,462,824	1,462,824			31
32	Interest							661,915	661,915			32
33	Real Estate Taxes							538,845	538,845			33
34	Rent-Facility & Grounds			1,875,870	1,875,870		1,875,870	(1,875,870)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* **Bad Debt**			66,657	66,657		66,657	(66,657)				36
37	**TOTAL Ownership**			2,097,383	2,097,383		2,097,383	801,266	2,898,649			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			536,379	536,379		536,379		536,379			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			573,161	573,161		573,161		573,161			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			1,109,540	1,109,540		1,109,540		1,109,540			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,880,931	627,512	6,153,918	10,662,361		10,662,361	134,066	10,796,427			45

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

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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 Reference	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	(130,389)	30		9
10	Interest and Other Investment Income	(52,766)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(163)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(945)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(66,657)	36		24
25	Fund Raising, Advertising and Promotional	(200)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(50,055)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (301,175)		$	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)	435,241		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 435,241		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 134,066		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Central Nursing Home

ID# 0053553

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line 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				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	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(163)	0	0	0	0	0	0	0	0	0	0	(163)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,762	0	0	0	0	0	0	0	0	2,762	5
6	Maintenance	0	0	1,629	0	0	0	0	0	0	0	0	1,629	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(163)	0	4,391	0	0	0	0	0	0	0	0	4,228	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	159,625	0	0	0	0	0	0	0	0	159,625	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	159,625	0	0	0	0	0	0	0	0	159,625	16
	C. General Administration													
17	Administrative	0	0	(1,223,825)	0	0	0	0	0	0	0	0	(1,223,825)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,500	15,449	0	0	0	0	0	0	0	0	23,949	19
20	Fees, Subscriptions & Promotions	(200)	0	0	0	0	0	0	0	0	0	0	(200)	20
21	Clerical & General Office Expenses	(51,000)	75	239,745	0	0	0	0	0	0	0	0	188,820	21
22	Employee Benefits & Payroll Taxes	0	0	39,081	0	0	0	0	0	0	0	0	39,081	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	138,110	3,012	0	0	0	0	0	0	0	0	141,122	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(51,200)	146,685	(926,538)	0	0	0	0	0	0	0	0	(831,053)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(51,363)	146,685	(762,522)	0	0	0	0	0	0	0	0	(667,200)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Central Nursing Home **#** 0053553 **Report Period Beginning:** 01/01/2020 **Ending:** 12/31/2020

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	(130,389)	210,598	0	0	0	0	0	0	0	0	0	80,209	30
31	Amortization of Pre-Op. & Org.	0	1,462,824	0	0	0	0	0	0	0	0	0	1,462,824	31
32	Interest	(52,766)	714,681	0	0	0	0	0	0	0	0	0	661,915	32
33	Real Estate Taxes	0	526,321	12,524	0	0	0	0	0	0	0	0	538,845	33
34	Rent-Facility & Grounds	0	(1,875,870)	0	0	0	0	0	0	0	0	0	(1,875,870)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(66,657)	0	0	0	0	0	0	0	0	0	0	(66,657)	36
37	**TOTAL Ownership**	(249,812)	1,038,554	12,524	0	0	0	0	0	0	0	0	801,266	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(301,175)	1,185,239	(749,998)	0	0	0	0	0	0	0	0	134,066	45

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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
Joseph Mermelstein	50	Paul House & Health Care Ctr	Chicago	Novo Investers LLC	Lincolnwood	Bldg Rental
Marvin Mermelstein	50	Winston Manor Nursing Home	Chicago	Nivram Mgmt Inc	Lincolnwood	Mgmt Co
		Balmoral Nursing Home	Chicago			
		Chicago Ridge Nursing Home	Chicago Ridge			

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	34	Rent	$ 1,875,870	Novo Investors LLC	100.00%	$	$ (1,875,870)	1
2	V	30	Depreciation		Novo Investors LLC		210,598	210,598	2
3	V	31	Amortization		Novo Investors LLC		1,462,824	1,462,824	3
4	V	19	Professional Fees		Novo Investors LLC		8,500	8,500	4
5	V	33	Real Estate Tax		Novo Investors LLC		526,321	526,321	5
6	V	32	Interest		Novo Investors LLC		714,681	714,681	6
7	V	26	Insurance		Novo Investors LLC		138,110	138,110	7
8	V	21	Office		Novo Investors LLC		75	75	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,875,870			$ 3,061,109	$ * 1,185,239	14

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

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	17	Management Fees	$ 1,356,564	Nivram Management Inc	100.00%	$	$ (1,356,564)	15
16	V	21	Payroll		Nivram Management Inc		145,544	145,544	16
17	V	22	Payroll Taxes		Nivram Management Inc		39,081	39,081	17
18	V	33	Real Estate Tax		Nivram Management Inc		12,524	12,524	18
19	V	5	Utilities		Nivram Management Inc		2,762	2,762	19
20	V	6	Repairs & Maintenance		Nivram Management Inc		1,629	1,629	20
21	V	26	Insurance		Nivram Management Inc		3,012	3,012	21
22	V	19	Professional Fees		Nivram Management Inc		15,449	15,449	22
23	V	21	Office		Nivram Management Inc		31,935	31,935	23
24	V	17	Marvin Mermelstein		Nivram Management Inc		21,008	21,008	24
25	V	21	Doreen Mermelstein		Nivram Management Inc		2,158	2,158	25
26	V	21	Jacob Mermelstein		Nivram Management Inc		32,533	32,533	26
27	V	21	Joel Mermelstein		Nivram Management Inc		27,575	27,575	27
28	V	10	Don Salary		Nivram Management Inc		159,625	159,625	28
29	V	17	Administrator Salary		Nivram Management Inc		111,731	111,731	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			$ 1,356,564			$ 606,566	$ * (749,998)	39

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

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	Marvin Mermelstein		Adm	50.00	62,938	10	20.00	Salary	$ 21,008	17	1
2	Doreen Mermelstein		Clerical		6,465	10	20.00	Salary	2,158	21	2
3	Jacob Mermelstein		Clerical		97,467	10	20.00	Salary	32,533	21	3
4	Joel Mermelstein		Clerical		82,612	10	20.00	Salary	27,575	21	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 83,274		13

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

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

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Nivram Mgmt Inc
Street Address: 6500 N Hamlin
City / State / Zip Code: Lincolnwood, Il 60712
Phone Number: (847-679-7484
Fax Number: (847-679-7494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Payroll	Resident Beds	979	5	$ 581,580	$ 581,580	245	$ 145,544	1
2	22	Payroll Taxes	Resident Beds	979	5	156,164		245	39,081	2
3	33	Real Estate Tax	Resident Beds	979	5	50,044		245	12,524	3
4	5	Utilities	Resident Beds	979	5	11,038		245	2,762	4
5	6	Repairs & Maintenance	Resident Beds	979	5	6,509		245	1,629	5
6	26	Insurance	Resident Beds	979	5	12,037		245	3,012	6
7	19	Professional Fees	Resident Beds	979	5	61,734		245	15,449	7
8	21	Office	Resident Beds	979	5	127,608	127,608	245	31,935	8
9	17	Marvin Mermelstein	Resident Beds	979	5	83,946	83,946	245	21,008	9
10	21	Doreen Mermelstein	Resident Beds	979	5	8,623	8,623	245	2,158	10
11	21	Jacob Mermelstein	Resident Beds	979	5	130,000	130,000	245	32,533	11
12	21	Joel Mermelstein	Resident Beds	979	5	110,187	110,187	245	27,575	12
13	10	DON Salary				159,625	159,625		159,625	13
14	17	Administrator Salary				111,731	111,731		111,731	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,610,826	$ 1,313,300		$ 606,566	25

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Capital One		X	Mortgage	$153,947.00	05/01/15	$ 21,250,000	$ 17,902,663		3.8500	$ 714,681	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$153,947.00		$ 21,250,000	$ 17,902,663			$ 714,681	9
	B. Non-Facility Related*											
10	Interest Income										(52,766)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (52,766)	14
15	TOTALS (line 9+line14)						$ 21,250,000	$ 17,902,663			$ 661,915	15

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

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

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

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 467,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 491,743	2
3. Under or (over) accrual (line 2 minus line 1).		$ 24,743	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 501,578	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.)**		$ 12,524	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.		$ 538,845	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	397,767	8
	2016	409,231	9
	2017	442,589	10
	2018	458,200	11
	2019	491,743	12

Line 4: 491743 x 1.02

12524 Allocated from Mgmt Co

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Central Nursing Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053553

CONTACT PERSON REGARDING THIS REPORT Robb Strukoff

TELEPHONE 847-715-2522 FAX #: 847-941-0101

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-29-431-013-0000	Facility	$ 27,373.14	$ 27,373.14
2.	13-29-431-014-0000	Facility	$ 67,496.30	$ 67,496.30
3.	13-29-431-015-0000	Facility	$ 67,574.85	$ 67,574.85
4.	13-29-431-016-0000	Facility	$ 67,760.95	$ 67,760.95
5.	13-29-431-017-0000	Facility	$ 67,513.59	$ 67,513.59
6.	13-29-431-018-0000	Facility	$ 67,496.30	$ 67,496.30
7.	13-29-431-019-0000	Facility	$ 67,154.14	$ 67,154.14
8.	13-29-431-020-0000	Facility	$ 53,551.77	$ 53,551.77
9.	13-29-431-021-0000	Facility	$ 2,878.50	$ 2,878.50
10.	13-29-431-022-0000	Facility	$ 2,943.34	$ 2,943.34
		TOTALS	$ 491,742.88	$ 491,742.88

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

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

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

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

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: 14,628,243
2. Number of Years Over Which it is Being Amortized: 10
3. Current Period Amortization: 1,462,824
4. Dates Incurred: 05/01/15

Nature of Costs: Intangibles
(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	30,000	2015	$ 500,000	1
2					2
3	TOTALS	30,000		$ 500,000	3

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	245		2015	1973	$ 6,076,927	$ 155,635	39	$ 155,635	$	$ 882,605	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Cooled Chiller Unit			2015	92,000	13,456	7	13,456		66,341	9
10	Time Clock Reader			2015	2,574	94	27.5	94		516	10
11	HVAC Unit			2015	4,227	632	7	632		3,278	11
12	Compressor			2015	8,500	309	27.5	309		1,648	12
13	Elevator Project			2016	10,840	278	39	278		1,367	13
14	Elevator Pump Motor			2016	3,800	98	39	98		439	14
15	Door Project			2015	5,201	189	27.5	189		961	15
16	Air Handler			2016	6,470	236	27.5	236		1,138	16
17	Main and Lower Floor Flooring			2016	15,078	548	27.5	548		2,581	17
18	Hot Water Heater			2016	10,750	392	27.5	392		1,696	18
19	Sewer Restoration			2016	11,950	890	15	890		3,937	19
20	Boiler			2016	19,500	2,321	7	2,321		13,696	20
21	Boiler			2017	22,500	3,136	7	3,136		12,700	21
22	Security Camera			2017	14,642	1,965	7	1,965		7,765	22
23	Water Heater			2017	5,700	859	7	859		3,554	23
24	Brick Pavers			2017	3,000	237	15	237		867	24
25	Ada Signage			2018	5,227		39	134	134	402	25
26	Installed new electrical panel and relocated c/r from old panel			2018	4,569		39	117	117	351	26
27	New dryer in basement			2018	4,422		5	884	884	2,652	27
28	Repipe and install new spprinkler in coolers,excavate fdc pipe			2019	33,283		15	2,219	2,219	3,328	28
29	excavate and replace underground FDC piping. Installed new fire alarm fi										29
30	Decorate First Floor Resident Rooms			2020	16,588	16,588	15	1,106	(15,482)	1,106	30
31	60 LB Rigid Mount Washer			2020	26,449	26,449	15	1,763	(24,686)	1,763	31
32	Air Condensing Unit Installation			2020	8,037	8,037	15	536	(7,501)	536	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,412,234	$ 232,349		$ 188,034	$ (44,315)	$ 1,015,227	70

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

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,122,085	$ 133,105	$ 47,031	$ (86,074)	7	$ 1,122,085	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,122,085	$ 133,105	$ 47,031	$ (86,074)		$ 1,122,085	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)	$ 8,034,319	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 365,454	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 235,065	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (130,389)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,137,312	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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.	/2021	$
13.	/2022	$
14.	/2023	$

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 Central Nursing Home # 0053553 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			518,295			518,295	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts			18,084			18,084	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$ 536,379	$		$ 536,379	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 Central Nursing Home # 0053553 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (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	$ 6,734,659	$ 6,806,005	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,074,431	3,074,431	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	117,090	212,779	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	77,428	77,428	8
9	Other(specify): Escrows		1,089,572	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 10,003,608	$ 11,260,215	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		500,000	13
14	Buildings, at Historical Cost		6,076,927	14
15	Leasehold Improvements, at Historical Cost	149,953	330,885	15
16	Equipment, at Historical Cost	1,122,084	1,451,597	16
17	Accumulated Depreciation (book methods)	(1,224,785)	(2,522,641)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Goodwill		6,338,906	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 47,252	$ 12,175,674	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 10,050,860	$ 23,435,889	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,253,722	$ 1,253,722	26
27	Officer's Accounts Payable	2,871	80,300	27
28	Accounts Payable-Patient Deposits	150,480	150,480	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	315,576	315,576	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,014	18,014	31
32	Accrued Real Estate Taxes(Sch.IX-B)		501,578	32
33	Accrued Interest Payable		58,870	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,740,663	$ 2,378,540	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		17,902,663	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)**	$	$ 17,902,663	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,740,663	$ 20,281,203	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 8,310,197	$ 3,154,686	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 10,050,860	$ 23,435,889	48

***(See instructions.)**

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,147,512	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,147,512	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	7,362,685	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	(2,200,000)	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)**	$ 5,162,685	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)**	$ 8,310,197	24 *

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

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	$ 15,153,361	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 15,153,361	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	51,734	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 51,734	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Stimulus Income	2,819,951	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,819,951	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 18,025,046	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,467,640	31
32	Health Care	3,416,351	32
33	General Administration	2,571,447	33
	B. Capital Expense		
34	Ownership	2,097,383	34
	C. Ancillary Expense		
35	Special Cost Centers	536,379	35
36	Provider Participation Fee	573,161	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,662,361	40
41	**Income before Income Taxes (line 30 minus line 40)****	7,362,685	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 7,362,685	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 12,503,731	44
45	Private Pay - Net Inpatient Revenue	7,973	45
46	Medicare - Net Inpatient Revenue	2,396,174	46
47	Other-(specify) Veterans	245,483	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 15,153,361	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No,Cash Bas If not, please attach a reconciliation.**

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

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

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing	2,134	2,358	90,148	38.23	2
3	Registered Nurses	32,969	35,539	1,230,548	34.63	3
4	Licensed Practical Nurses	8,970	9,886	295,683	29.91	4
5	CNAs & Orderlies	42,516	45,847	798,232	17.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,803	3,003	76,372	25.43	8
9	Activity Director	2,096	2,368	40,400	17.06	9
10	Activity Assistants	6,675	7,524	109,074	14.50	10
11	Social Service Workers	6,767	7,567	144,666	19.12	11
12	Dietician					12
13	Food Service Supervisor	1,503	1,543	46,467	30.11	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,805	17,712	283,656	16.01	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	21,248	23,300	377,856	16.22	18
19	Laundry	1,169	1,296	19,635	15.15	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,152	13,149	184,944	14.07	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) MDS	5,036	5,511	183,250	33.25	33
34	TOTAL (lines 1 - 33)	161,843	176,603	$ 3,880,931 *	$ 21.98	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	Monthly	$ 12,592	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				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	Monthly	6,088	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 18,680		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,164	$ 69,828	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	6,932	207,959	10-3	52
53	TOTAL (lines 50 - 52)	8,096	$ 277,787		53

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

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

B. Administrative - Other

Description	Amount
Nivram Mgmt-Mgmt Fees	$ 1,356,564
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,356,564
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Mendel Schneider CPA	Accounting	$ 14,000
Richard Peelo	Accounting	4,200
Perfect Staffing Solution	Placement Fee	5,145
Personnel Planners	UC Tax Consultant	1,000
Compliagent	Bus Mgmt Cons	16,200
Govig & Assoc	Placement Fee	6,000
WIPFLI	Accounting	2,175
Gary Weintraub	Legal	4,209
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 52,929

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 53,073
Unemployment Compensation Insurance	17,036
FICA Taxes	315,831
Employee Health Insurance	182,558
Employee Meals	30,000
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 598,498

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Subs-Accurate Biometrics	1,547
Amex	175
License-City of Chicago	450
Sec of State	75
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,247

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Various	388
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 388

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **15**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **20,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **573,161**
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. $ **30,000** Has any meal income been offset against related costs? **No** Indicate the amount. $

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

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.