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: 0053827

Facility Name: City View Multicare Center

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

County: Cook

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Aaron Mauer **Telephone Number:** 773-747-4506
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 1/1/20 to 12/31/20 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) 3/5/2021 (Date)
(Print Name and Title) Aaron Mauer, President
(Firm Name & Address) GGM Associates, Inc., 6101 Nimtz Parkway South Bend IN 46628
(Telephone) 773-747-4506 Fax # 773-747-4725

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

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 NA

	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	31,519	0	7,477	38,996	8
9	SNF/PED					9
10	ICF	71,768	0	605	72,373	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	103,287		8,082	111,369	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.91%

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 7,211

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: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	689,877	110,461	18,000	818,338		818,338		818,338			1
2	Food Purchase		650,734		650,734		650,734		650,734			2
3	Housekeeping	709,348	244,379		953,727		953,727		953,727			3
4	Laundry	118,668	86,552		205,220		205,220		205,220			4
5	Heat and Other Utilities			350,149	350,149		350,149	4,689	354,838			5
6	Maintenance	695,922	181,885	148,208	1,026,015		1,026,015	(3,798)	1,022,217			6
7	Other (specify):*											7
8	TOTAL General Services	2,213,815	1,274,011	516,357	4,004,183		4,004,183	891	4,005,074			8
	B. Health Care and Programs											
9	Medical Director			26,000	26,000		26,000		26,000			9
10	Nursing and Medical Records	6,886,509	468,823	184,185	7,539,517		7,539,517	98,939	7,638,456			10
10a	Therapy			1,001,837	1,001,837		1,001,837		1,001,837			10a
11	Activities	601,854	109,743		711,597		711,597		711,597			11
12	Social Services	392,966		7,981	400,947		400,947		400,947			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			33,109	33,109		33,109	(799)	32,310			15
16	TOTAL Health Care and Programs	7,881,329	578,566	1,253,112	9,713,007		9,713,007	98,140	9,811,147			16
	C. General Administration											
17	Administrative	125,826		11,958	137,784		137,784	(1,260,724)	(1,122,940)			17
18	Directors Fees											18
19	Professional Services			1,380,436	1,380,436		1,380,436	1,114,702	2,495,138			19
20	Dues, Fees, Subscriptions & Promotions			7,996	7,996		7,996	334	8,330			20
21	Clerical & General Office Expenses	278,346	81,911	989,048	1,349,305		1,349,305	345,875	1,695,180			21
22	Employee Benefits & Payroll Taxes			1,721,567	1,721,567		1,721,567	93,651	1,815,218			22
23	Inservice Training & Education											23
24	Travel and Seminar			24,580	24,580		24,580	30,345	54,925			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			1,971,511	1,971,511		1,971,511	50,869	2,022,380			26
27	Other (specify):*											27
28	TOTAL General Administration	404,172	81,911	6,107,096	6,593,179		6,593,179	375,051	6,968,230			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	10,499,316	1,934,488	7,876,565	20,310,369		20,310,369	474,082	20,784,451			29

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

Facility Name & ID Number City View Multicare Center #0053827 Report Period Beginning: 1/1/20 Ending: 12/31/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			131,312	131,312		131,312	179,644	310,956			30
31	Amortization of Pre-Op. & Org.			13,638	13,638		13,638	812,651	826,289			31
32	Interest			(43,680)	(43,680)		(43,680)	531,537	487,857			32
33	Real Estate Taxes			1,079,894	1,079,894		1,079,894		1,079,894			33
34	Rent-Facility & Grounds			1,773,352	1,773,352		1,773,352	(1,762,017)	11,335			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			2,954,516	2,954,516		2,954,516	(238,185)	2,716,331			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			320	320		320		320			38
39	Ancillary Service Centers		355,576		355,576		355,576	(2,839)	352,737			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			897,346	897,346		897,346		897,346			42
43	Other (specify):*			392,874	392,874		392,874	(392,874)				43
44	TOTAL Special Cost Centers		355,576	1,290,540	1,646,116		1,646,116	(395,713)	1,250,403			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	10,499,316	2,290,064	12,121,621	24,911,001		24,911,001	(159,816)	24,751,185			45

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

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	(69,223)	30		9
10	Interest and Other Investment Income	(34,852)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(7,950)	21		18
19	Entertainment				19
20	Contributions	(4,850)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(392,874)	43		24
25	Fund Raising, Advertising and Promotional	(14,093)	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	(11,208)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (535,050)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 375,234	Various	36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (159,816)		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

City View Multicare Center

ID# 0053827

Report Period Beginning: 1/1/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	RP Profit	$ (125)	10	1
2	RP Profit	(799)	15	2
3	RP Profit	(2,839)	39	3
4	Misc Income - Vendor Rebate	(6,466)	6	4
5	Misc Income - Med Records	(979)	10	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**	(11,208)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	4,689	0	0	0	0	0	0	0	0	0	4,689	5
6	Maintenance	(6,466)	2,668	0	0	0	0	0	0	0	0	0	(3,798)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,466)	7,357	0	0	0	0	0	0	0	0	0	891	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,104)	100,042	0	0	0	0	0	0	0	0	0	98,939	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):*	(799)	0	0	0	0	0	0	0	0	0	0	(799)	15
16	**TOTAL Health Care and Programs**	(1,903)	100,042	0	0	0	0	0	0	0	0	0	98,140	16
	C. General Administration													
17	Administrative	0	(1,260,724)	0	0	0	0	0	0	0	0	0	(1,260,724)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,031,535	83,167	0	0	0	0	0	0	0	0	1,114,702	19
20	Fees, Subscriptions & Promotions	0	334	0	0	0	0	0	0	0	0	0	334	20
21	Clerical & General Office Expenses	(26,893)	372,768	0	0	0	0	0	0	0	0	0	345,875	21
22	Employee Benefits & Payroll Taxes	0	93,651	0	0	0	0	0	0	0	0	0	93,651	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	30,345	0	0	0	0	0	0	0	0	0	30,345	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	4,971	45,898	0	0	0	0	0	0	0	0	50,869	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(26,893)	272,879	129,065	0	0	0	0	0	0	0	0	375,051	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(35,262)	380,279	129,065	0	0	0	0	0	0	0	0	474,082	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number City View Multicare Center **#** 0053827 **Report Period Beginning:** 1/1/20 **Ending:** 12/31/20

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	(69,223)	149	248,718	0	0	0	0	0	0	0	0	179,644	30
31	Amortization of Pre-Op. & Org.	0	0	812,651	0	0	0	0	0	0	0	0	812,651	31
32	Interest	(34,852)	12,484	553,905	0	0	0	0	0	0	0	0	531,537	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	11,335	(1,773,352)	0	0	0	0	0	0	0	0	(1,762,017)	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	(104,075)	23,968	(158,078)	0	0	0	0	0	0	0	0	(238,185)	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	(2,839)	0	0	0	0	0	0	0	0	0	0	(2,839)	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):*	(392,874)	0	0	0	0	0	0	0	0	0	0	(392,874)	43
44	TOTAL Special Cost Centers	(395,713)	0	0	0	0	0	0	0	0	0	0	(395,713)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(535,050)	404,246	(29,013)	0	0	0	0	0	0	0	0	(159,816)	45

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	Colsulting Co.
GELP	50	Belhaven Nursing & Rehab Center	Chicago	Westshire Realty		Realty Co.
		Continental Nursing & Rehab Center	Chicago			
		Forest View Nursing & Rehab Center	Itasca			
		Lakeview Nursing & Rehab Center	Chicago			
		Midway Neurological & Rehab Center	Bridgeview			

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	5	Heat and Other Utilities	$	Infinity Healthcare Management of IL LLC		$ 4,689	$ 4,689	1
2	V	6	Maintenance	1	Infinity Healthcare Management of IL LLC		2,669	2,668	2
3	V	10	Nursing and Medical Records	36,881	Infinity Healthcare Management of IL LLC		136,923	100,042	3
4	V	17	Administrative	1,390,517	Infinity Healthcare Management of IL LLC		129,793	(1,260,724)	4
5	V	19	Professional Services	363,098	Infinity Healthcare Management of IL LLC		1,394,633	1,031,535	5
6	V	20	Dues, Fees, Subscriptions & Promotions		Infinity Healthcare Management of IL LLC		334	334	6
7	V	21	Clerical & General Office Expenses	106,053	Infinity Healthcare Management of IL LLC		478,821	372,768	7
8	V	22	Employee Benefits & Payroll Taxes	9	Infinity Healthcare Management of IL LLC		93,660	93,651	8
9	V	24	Travel and Seminar	1,803	Infinity Healthcare Management of IL LLC		32,148	30,345	9
10	V	26	Insurance-Prop.Liab.Malpractice		Infinity Healthcare Management of IL LLC		4,971	4,971	10
11	V	30	Depreciation		Infinity Healthcare Management of IL LLC		149	149	11
12	V	32	Interest		Infinity Healthcare Management of IL LLC		12,484	12,484	12
13	V	34	Rent-Facility & Grounds		Infinity Healthcare Management of IL LLC		11,335	11,335	13
14	Total			$ 1,898,362			$ 2,302,608	$ * 404,246	14

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

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 1/1/20 Ending: 12/31/20

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. ☐ YES ☐ NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rent	$ 1,773,352	Westshire Realty		$	$ (1,773,352)	15
16	V	31	Amortization		Westshire Realty		812,651	812,651	16
17	V	30	Depreciation		Westshire Realty		248,718	248,718	17
18	V	26	Insurance		Westshire Realty		45,898	45,898	18
19	V	19	Professional Services		Westshire Realty		83,167	83,167	19
20	V	32	Interest		Westshire Realty		553,905	553,905	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,773,352			$ 1,744,339	$ * (29,013)	39

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

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 1/1/20 Ending: 12/31/20

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			Momence Meadows Nrusing & Rehab Ctr	Momence				1
2			Niles Nursing & Rehab Center	Niles				2
3			Oak Lawn Respiratory & Rehab Center	Oak Lawn				3
4			Parker Nursing & Rehab Center	Streater				4
5			Parkshore Estates Nursing & Rehab Ctr	Chicago				5
6			Southpoint Nursing & Rehab Center	Chicago				6
7			West Suburban Nursing & Rehab Center	Bloomington				7
8			Landmark of Des Plaines	Des Plaines				8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 ☐

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

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

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

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 1/1/20 Ending: 12/31/20

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		X	Mortgage	$92,357.00	7/26/13	$ 17,769,000	$ 16,279,549	3/1/41	3.3500	$ 555,448	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Infinity H Funding	X		Working Capital	None	Various	Various	Various	None	Various	974	6
7												7
8												8
9	TOTAL Facility Related				$92,357.00		$ 17,769,000	$ 16,279,549			$ 556,422	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 17,769,000	$ 16,279,549			$ 556,422	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 45,899 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 # 0053827 Report Period Beginning: 1/1/20 Ending: 12/31/20

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.**	$ (315,045)	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.)		$ 1,075,112	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,390,157	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ (310,262)	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 1,079,894	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	1,199,929	8
	2016	1,141,086	9
	2017	1,008,126	10
	2018	1,047,573	11
	2019	1,075,112	12

	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 City View Multicare Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053827

CONTACT PERSON REGARDING THIS REPORT Aaron Mauer

TELEPHONE 773-747-4506 FAX #: 773-747-4725

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.	16-29-202-004-0000	Nursing Home	$ 150,623.84	$ 150,623.84
2.	16-29-202-005-0000	Nursing Home	$ 150,623.34	$ 150,623.34
3.	16-29-202-006-0000	Nursing Home	$ 301,247.85	$ 301,247.85
4.	16-29-202-007-0000	Nursing Home	$ 171,494.76	$ 171,494.76
5.	16-29-202-008-0000	Nursing Home	$ 301,121.86	$ 301,121.86
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,075,111.65	$ 1,075,111.65

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 City View Multicare Center # 0053827 Report Period Beginning: 1/1/20 Ending: 12/31/20

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		7/7/1905	$ 305,000	1
2					2
3	TOTALS			$ 305,000	3

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$	$ 1,595,938	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		748	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		7,385	17
18	Room ID signs, Braille signs, Regulatory signs			2016	4,977	128	39	128		638	18
19	Terrace Rails for East Side Balcony			2016	5,400	138	39	138		692	19
20	2 Retractable Elevator Pit Ladders			2016	6,466	166	39	166		829	20
21	Terrace Rails for East Side Balcony			2016	7,201	185	39	185		923	21
22	Building Facility Sign			2016	16,861	432	39	432		2,162	22
23	Paint 1st,2nd,3rd,4th,5ht,6th,7th,8th,9th Floors			2016	3,232	83	39	83		415	23
24	Materials for Remodeling Center Stairwell			2016	5,923	152	39	152		760	24
25	Rebuild Nurse Station Cabinets			2016	5,775	148	39	148		740	25
26	Nurse Station Counter Tops			2016	2,922	75	39	75		375	26
27	New Generator			2016	6,258	160	39	160		802	27
28	Pait 3rd Floor Dining Room			2016	2,650	68	39	68		340	28
29	Terrace Rails for West Side Balcony			2016	2,900	74	39	74		372	29
30	15 Ton Compressor			2016	7,450	191	39	191		955	30
31	Materials for Remodeling Center Stairwell			2016	5,580	143	39	143		715	31
32	3rd Floor Electrical Work,Clean & Sand 3rd Floor Cabinet Doors			2016	2,700	69	39	69		346	32
33	3rd Floor Nurse Call System			2016	6,620	170	39	170		848	33
34	Flooring			2016	2,646	68	39	68		340	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$	$ 463	37
38	Insulate Emergency Generator Piping/Silencer	2016	3,423	88	39	88		439	38
39	Install new Walls by Penthouse Boiler Room	2016	2,851	73	39	73		365	39
40	Electrical Work for Sign	2016	2,650	68	39	68		340	40
41	New Kitchen/Laundry Hot Water Boiler	2016	11,500	295	39	295		1,475	41
42	Fresh Air Room Generator	2016	3,422	88	39	88		438	42
43									43
44	Facility Wide Surveillance Cameras	2017	2,769	71	39	71		250	44
45	New Boiler (down payment)	2017	8,000	205	39	205		718	45
46	New Boiler (final payment)	2017	9,500	244	39	244		853	46
47	Welded Couplings on Boiler	2017	435	11	39	11		39	47
48	Elevator Modernization - Three Traction Elevators	2017	389,521	9,988	39	9,988		34,956	48
49	New Laundry Sink for 3rd Floor	2017	1,580	41	39	41		142	49
50	Vent Pipe for 3rd Floor Laundry Room	2017	1,925	49	39	49		173	50
51	3rd Floor Air Conditioners	2017	4,721	121	39	121		424	51
52	Clear & Unclog Pipe on East & North side of Building.								52
53	New outlet Boxes	2017	3,420	88	39	88		307	53
54	Upgrade to Nurse Station & Dining Room A/C Units	2017	56,850	1,458	39	1,458		5,101	54
55	7th FL Men's Bath Replace Tile, New Concrete								55
56	Replace Drywall, New Shower	2017	13,600	349	39	349		1,219	56
57	Facility Wide Sprinkler System Modifications	2017	4,459	114	39	114		400	57
58	7th Floor Air Conditioners	2017	4,690	120	39	120		421	58
59	Seal Coat Roof	2017	2,650	68	39	68		238	59
60	New Tile for 7th Floor Mens Shower Room	2017	4,996	128	39	128		448	60
61	Permit Drawings for 6th Floor Dialysis Room	2017	4,000	103	39	103		359	61
62	Permit Drawings for 1st Floor Dialysis Room	2017	7,000	179	39	179		628	62
63	New Condensor for 4th Floor HVAC	2017	4,132	106	39	106		371	63
64	New Flooring for 1st Floor Conference Room								64
65	& Administrator's Office	2017	2,827	72	39	72		253	65
66									66
67	New Sliding Doors for Lobby	2017	6,685	171	39	171		600	67
68	New Flooring for 1st Floor Business Office								68
69	& Asst Administrator's Office	2017	2,827	72	39	72		253	69
70	TOTAL (lines 4 thru 69)		$ 10,424,503	$ 267,295		$ 267,295	$	$ 1,667,997	70

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

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$ 267,295		$ 267,295	$	$ 1,667,997	1
2	New LVT flooring in conference room, new countertops 4th floor	2018	4,750	122	39	122		305	2
3	Install new pressure detector assembly sprinkler system	2018	8,240	211	39	211		529	3
4	New electrical & lighting for floors 3, 5 and 7	2018	17,540	450	39	450		1,124	4
5	New flooring for 3 offices on 1st and 2nd floor	2018	5,283	135	39	135		339	5
6	Double fire doors for 2nd floor dining room	2018	3,050	78	39	78		195	6
7	Replace fire pump motor	2018	6,959	178	39	178		446	7
8	Replace 7th floor central stairwell door	2018	3,966	102	39	102		254	8
9	New air conditioners in patients rooms	2018	3,020	77	39	77		194	9
10	New air conditioners in patients rooms	2018	3,619	93	39	93		232	10
11	New air conditioners in patients rooms	2018	3,020	77	39	77		194	11
12	New sill for elevator	2018	3,840	98	39	98		246	12
13	Install new fire door	2018	2,971	76	39	76		190	13
14	New doors for rooms 904,908,medical room, dining room	2018	3,635	93	39	93		233	14
15	New air conditioners in patients rooms	2018	5,416	139	39	139		347	15
16	New walls, flooring, electrical, fixtures for 8th floor bathroom	2018	13,900	356	39	356		891	16
17	8th floor bathroom renovation supplies, etc	2018	5,564	143	39	143		356	17
18	Paint 5th floor hallway & dining room	2018	4,500	115	39	115		289	18
19									19
20	Replace Doors on Rooms 908, 904, Medical Room & 3rd floor Din	2019	2,649	38	39	38		76	20
21	Replace Hinges on Walk-in Cooler	2019	2,496	34	39	34		68	21
22	Paint Doors & Frames, Hallway, Nurse's Station, Dining Room on	2019	4,800	103	39	103		206	22
23	New Dry Wall in 4th Floor Women's Bathroom	2019	2,975	76	39	76		153	23
24	New Plumbing & Fixtures for Bathroom (down payment)	2019	9,450	222	39	222		445	24
25	Tile for 8th Floor Men's Bathroom	2019	4,549	117	39	117		233	25
26	Paint 6th Floor Hall, Doors & Nurse's Station	2019	4,000	103	39	103		205	26
27	New Air Conditioners	2019	3,760	96	39	96		193	27
28	Tile for 8th Floor Men's Bathroom	2019	4,253	109	39	109		209	28
29	New Plumbing & Fixtures for Bathroom (final payment)	2019	9,450	222	39	222		424	29
30	New Fixtures for 8th Floor Bathroom	2019	2,583	66	39	66		127	30
31	Paint Lobby Hallway	2019	2,800	72	39	72		138	31
32	Doors for 7th Floor Men's Shower Room, 8th Floor Men's Shower	2019	12,121	291	39	291		556	32
33	2 New Rebuilt Circulating Heating Pumps	2019	4,769	122	39	122		234	33
34	TOTAL (lines 1 thru 33)		$ 10,594,430	$ 271,512		$ 271,512	$	$ 1,677,627	34

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

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 12B, Carried Forward		$ 10,594,430	$ 271,512		$ 271,512	$	$ 1,677,627	1
2	Urinals for 8th Floor Bathroom	2019	2,676	69	39	69		126	2
3	New Butterfly Valve for Circulating Pump	2019	2,373	61	39	61		112	3
4	Fire Exit Crossbar for Lobby Elevator; New Doors for 5th Floor M	2019	6,781	154	39	154		264	4
5	New Door Sill for Elevator	2019	3,975	102	39	102		178	5
6	Install New Vibrator Isolator on Heating System	2019	2,304	59	39	59		103	6
7	New Flooring for 8th Floor Men's Communal shower, Bath & Tul	2019	6,426	165	39	165		275	7
8	Repairs to 9th Floor Boiler per Inspection Report	2019	3,763	96	39	96		153	8
9	Rewire Lights Over Resident's Beds on 8th Floor	2019	2,900	74	39	74		118	9
10	New Emergency Shutoff Button for Boiler	2019	3,411	87	39	87		138	10
11	Replace coolant & Water Temperatur Gauge Sending Unit on Ger	2019	1,208	31	39	31		49	11
12	Install New Doors on 3rd Floor Bio Hazard Room, Men Women's	2019	13,301	341	39	341		512	12
13	Four Hour Load Bank on Generator 1	2019	1,314	34	39	34		51	13
14	Paint Rooms 509-514, Rooms 609-614, Rooms 709-714	2019	1,575	40	39	40		61	14
15	Run Ductwork from Kitchen Dietary Area to Kitchen	2019	2,273	58	39	58		87	15
16	Two Supply Lines for Kitchen	2019	2,619	67	39	67		101	16
17	Air Conditioners	2019	3,345	86	39	86		129	17
18	Air Conditioners	2019	4,671	120	39	120		180	18
19	Install Overhead Lights in Rooms 804, 805, 806, 807, 808, 810, 811	2019	1,862	48	39	48		72	19
20	Paint Rooms 409-414; Paint 2nd Floor Hallway; Repair Wall in R	2019	4,200	108	39	108		162	20
21	Doors for 2nd Floor Activity Room; 5th Floor Washroom; 8th Flo	2019	3,126	80	39	80		120	21
22	Install New Floor Tile on 4th Floor Women's Bathroom	2019	4,820	124	39	124		175	22
23	Paint & Patch 7th Floor Laundry Room; 7th floor Dining Room; 3	2019	3,950	101	39	101		143	23
24	Flooring for 4th floor Bathroom	2019	3,243	83	39	83		118	24
25	New Air Conditioners	2019	4,008	103	39	103		146	25
26	Retrofit Engine Start Battery for Generator 1	2019	2,206	57	39	57		80	26
27	Replace Large Domestic Hot Water Pump on Boiler #1	2019	4,491	115	39	115		154	27
28	Ductwork & Add a Push Through Louver to Generator Exhaust	2019	3,637	93	39	93		124	28
29	LVP Flooring for Rooms 704, 705, 706, 707, 708, 709, 710, 711, 712	2019	3,243	83	39	83		111	29
30	Paint Dining Room on 4th Floor, 4th Floor Hallway, 5th Floor Ha	2019	4,875	125	39	125		167	30
31	Chemically Clean Domestic Hot Water Boiler #1 (right hand side)	2019	1,984	51	39	51		68	31
32	Chemically Clean Domestic Hot Water Boiler (left hand side)	2019	2,624	67	39	67		90	32
33	Install New Thermostats, and Various Parts to Cooling System Ge	2019	3,058	78	39	78		98	33
34	TOTAL (lines 1 thru 33)		$ 10,710,673	$ 274,473		$ 274,473	$	$ 1,682,089	34

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

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 12C, Carried Forward		$ 10,710,673	$ 274,473		$ 274,473	$	$ 1,682,089	1
2	Clean Right Hand Heating Boiler. Replace Door Gasket	2019	3,842	99	39	99		123	2
3	Install New Floors on Rooms 809, 810, 808, 812, 813, 814	2019	2,970	76	39	76		95	3
4	Install New Floors on Rooms 805, 811, 806, 807	2019	1,700	44	39	44		54	4
5	New Updated Controller for Boiler 1	2019	2,669	68	39	68		86	5
6	Flooring	2019	3,228	83	39	83		103	6
7	Install New Floors on Rooms 801, 802, 803, 804, 806, 807, 808	2019	2,200	56	39	56		71	7
8	Clean Gaskets, Boiler Tubes & Burners on Left-Hand Boiler	2019	5,994	154	39	154		192	8
9	New Camera system for 3rd Floor	2019	3,808	98	39	98		122	9
10	Clean Boilers & Broken Bolts on Left-Hand Boiler	2019	2,607	67	39	67		84	10
11	Finish Cleaning Left-Hand Boiler	2019	3,370	86	39	86		101	11
12	Smooth New bolts on Left-Hand Boiler, Install New Gasket	2019	2,645	68	39	68		79	12
13	Bleed Excess Air on 2nd Floor Convectors	2019	2,812	72	39	72		84	13
14	Vinyl Plank Flooring	2019	3,228	83	39	83		97	14
15	Repair 5th Floor Shower Stalls	2019	4,985	128	39	128		149	15
16	Replace 5th floor Dining Room HVAC	2019	8,750	224	39	224		262	16
17	Remodel 8th FloorWomen's Shower Room; New Steel Studs, Cem	2019	14,975	384	39	384		448	17
18	Install New Vinyl Planks in Rooms 817, 818, 819, 820	2019	2,350	60	39	60		70	18
19	Demolition of 8th Floor Women's Shower Room	2019	2,395	61	39	61		72	19
20	Install LVT Plank Flooring in 2nd Floor Conference Room	2019	1,985	51	39	51		59	20
21	Install Over Bed Lighting on 8th Floor	2019	2,420	62	39	62		72	21
22	Flooring for Rooms 820, 821	2019	3,228	83	39	83		90	22
23	Prime, Patch & Paint 2nd Floor Therapy Room. Prime, Patch & P	2019	2,960	76	39	76		82	23
24	Paint & Patch Walls in Rooms 819, 820, 821. Install New flooring	2019	1,990	51	39	51		55	24
25									25
26	Materials for Remodel of 3rd floor Dining Room	2020	1,888	48	39	48		48	26
27	Materials for Remodel of 5th floor Dining Room	2020	1,888	48	39	48		48	27
28	Materials for Remodel of 7th floor Dining Room	2020	2,101	54	39	54		54	28
29	Remove Old Flooring, Repair Concrete Floor, Prep& Install New	2020	2,495	64	39	64		64	29
30	Glass Replacement in Group Rooms, 7th Floor Office & 8th Floor	2020	6,249	160	39	160		160	30
31	Install Custom Cabinets in 2nd Floor Therapy Room	2020	2,375	61	39	61		61	31
32	Install New 100 Amp 3-Phase Feeder from New Distribution Panel	2020	14,185	364	39	364		364	32
33	Replace Door on Walk-In Freezer # 1	2020	4,016	103	39	103		103	33
34	TOTAL (lines 1 thru 33)		$ 10,832,980	$ 277,609		$ 277,609	$	$ 1,685,642	34

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

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 12D, Carried Forward		$ 10,832,980	$ 277,609		$ 277,609	$	$ 1,685,642	1
2	Replace Door on Walk-In Freezer # 2	2020	4,016	103		103		103	2
3	Install Upper & Lower Cabinets, Counters & Sink in 8th Floor Tr	2020	3,975	102		102		102	3
4	LVT Flooring for Therapy Room	2020	2,747	70		70		70	4
5	Repair, Sand, Patch & Paint, Install New LVT Flooring in Rooms	2020	3,850	99		99		99	5
6	Paint & Repair Walls & Doors on 8th Floor Corridor	2020	1,975	51		46	(4)	51	6
7	Replace Entire Refrigerating for Walk-In Cooler #2	2020	6,884	177		162	(15)	177	7
8	Install New IT Cabling Throughout Building	2020	23,750	609		558	(51)	609	8
9	LVT Flooring for 8th floor Hallway Corridor & Dining Room	2020	9,799	251		209	(42)	251	9
10	Install LVT Flooring in 8th Floor East & Center Hallway	2020	4,900	126		105	(21)	126	10
11	New Doors for Facility Common Areas	2020	5,535	142		106	(35)	142	11
12	New Exhaust Fan for 6th & 7th floor Smoking Area	2020	8,900	228		152	(76)	228	12
13	Replace Motor and Control on Patio Door	2020	2,658	68		51	(17)	68	13
14	Install Backing Support Inside Laundry Wall. Install New Faucets	2020	4,185	107		72	(36)	107	14
15	New Exhaust Fan for 4th floor Smoking Area	2020	4,500	115		77	(38)	115	15
16	New Exhaust Fan for 8th floor Smoking Area	2020	4,500	115		77	(38)	115	16
17	New Exhaust Fan for 3rd floor Smoking Area	2020	4,500	115		77	(38)	115	17
18	Fully Service Entire Cooling System Throughout Building	2020	3,937	101		67	(34)	101	18
19	New Air Conditioners	2020	3,466	89		59	(30)	89	19
20	New Air Conditioners	2020	3,466	89		52	(37)	89	20
21	New Exhaust Fan for 5th floor Smoking Area	2020	4,500	115		67	(48)	115	21
22	Install New Tiles and Re-Grout Entire Dish Room. Repair and Re	2020	2,345	60		35	(25)	60	22
23	Chemically Clean Condensor Coil for 1st floor A/C Unit	2020	3,141	81		47	(34)	81	23
24	Install New Plank Tiles in 8th Floor Nursing Station & Alcoves an	2020	1,495	38		22	(16)	38	24
25	Replace Hanger Rollers, Pick Up Rollers, Closers, Cables and Doo	2020	8,000	205		120	(85)	205	25
26	New Trane Condensor for 1st Floor Dining Room/Kitchen	2020	9,250	237		119	(119)	237	26
27	New Air Conditioners	2020	3,120	80		7	(73)	80	27
28	Chris George Architects	2020	(2,750)	(71)		(71)		(71)	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,969,625	$ 281,112		$ 280,200	$ (913)	$ 1,689,146	34

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

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$ 112,941	$ 20,146	$ 22,588	$ 2,442	5	$ 32,493	71
72	Current Year Purchases	78,614	78,614	7,861	(70,753)	5	78,614	72
73	Fully Depreciated Assets	2,679,182				5	2,679,182	73
74								74
75	TOTALS	$ 2,870,737	$ 98,760	$ 30,450	$ (68,310)		$ 2,790,289	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)	$ 14,145,362	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 379,872	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 310,649	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (69,223)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,479,435	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 City View Multicare Center # 0053827 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$	4,591	$ 390,529	$	4,591	$ 390,529	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		2,050	152,743		2,050	152,743	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		5,907	458,561		5,907	458,561	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				117,722		117,722	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-2					4,425		4,425	12
13	Other (specify): Lab	39-2					233,430		233,430	13
14	TOTAL			$	12,548	$ 1,001,834	$ 355,576	12,548	$ 1,357,410	14

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

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 1/1/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (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	$ (312,597)	$ (16,488)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,290,232	2,290,232	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	408,754	408,754	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		652,514	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,386,389	$ 3,335,012	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	1,269,625	1,269,625	15
16	Equipment, at Historical Cost	445,737	12,625,543	16
17	Accumulated Depreciation (book methods)	(458,841)	(8,213,216)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	40,913	50,866	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(25,003)	(29,928)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	651,668	651,668	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,924,099	$ 16,359,558	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,310,488	$ 19,694,570	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,685,527	$ 2,073,911	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,009	16,009	28
29	Short-Term Notes Payable		530,044	29
30	Accrued Salaries Payable	356,470	356,470	30
31	Accrued Taxes Payable (excluding real estate taxes)	36,135	36,135	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			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)**	$ 2,094,141	$ 3,012,569	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		15,749,505	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)**	$	$ 15,749,505	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,094,141	$ 18,762,074	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,216,347	$ 932,496	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,310,488	$ 19,694,570	48

***(See instructions.)**

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 1/1/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,821,437	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,821,437	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	394,910	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 Error**	(1)	15
16	Other (describe) **Rounding**	1	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 394,910	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)**	$ 2,216,347	24 *

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

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$ 21,343,007	1
2	Discounts and Allowances for all Levels	(40,371)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 21,302,636	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	472,501	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 472,501	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	3,404,427	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	2,382	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	33,972	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,440,781	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	34,852	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 34,852	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Misc Income	55,141	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 55,141	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 25,305,911	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	4,004,183	31
32	Health Care	9,713,007	32
33	General Administration	6,593,179	33
	B. Capital Expense		
34	Ownership	2,954,516	34
	C. Ancillary Expense		
35	Special Cost Centers	1,646,116	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 24,911,001	40
41	**Income before Income Taxes (line 30 minus line 40)****	394,910	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 394,910	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 17,056,877	44
45	Private Pay - Net Inpatient Revenue	5,550	45
46	Medicare - Net Inpatient Revenue	3,982,669	46
47	Other-(specify) Net Patient Revenue	257,540	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 21,302,636	49

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

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

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

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

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	2,032	2,120	$ 149,669	$ 70.60	1
2	Assistant Director of Nursing	8,267	9,019	445,267	49.37	2
3	Registered Nurses	8,726	10,709	391,678	36.57	3
4	Licensed Practical Nurses	56,018	73,899	3,003,063	40.64	4
5	CNAs & Orderlies	113,793	145,827	2,752,034	18.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	26,797	30,260	601,854	19.89	10
11	Social Service Workers	16,563	17,936	392,966	21.91	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	37,979	42,597	689,877	16.20	15
16	Dishwashers					16
17	Maintenance Workers	36,069	41,134	695,922	16.92	17
18	Housekeepers	34,268	40,827	658,322	16.12	18
19	Laundry	6,076	7,457	118,668	15.91	19
20	Administrator	2,532	2,709	125,826	46.45	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,570	13,669	278,346	20.36	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	6,689	7,437	195,823	26.33	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	367,379	445,600	$ 10,499,315 *	$ 23.56	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	375	$ 18,000	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	2,076	110,843	10-3	38
39	Pharmacist Consultant	662	33,109	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	104	6,751	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,217	$ 168,703		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	419	73,342	10-2	52
53	TOTAL (lines 50 - 52)	419	$ 73,342		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Moore, Jami R	Administrator	0	$ 43,519
Rudolph, Ladwina	Administrator	0	20,069
Ishola, Hamed A	Administrator	0	47,506
Gautam, Shubam	Administrator	0	14,731
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 125,826

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
Infinity Healthcare Management of I	Management fees	$ 1,090,575
Empire Risk Management Services, I	Management fees	1,000
Infinity Healthcare Management of I	Legal	392
Klauke Law Group LLC	Legal	2,186
McGuire Woods - 10/12/20	Legal	2,099
POLSINELLI	Legal	216,932
RES PUBLICA GROUP	Legal	17,818
GGM	Accounting	6,000
Johnson and Goldburg	Accounting	3,000
See attached schedule		40,434
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 1,380,436

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 166,604
Unemployment Compensation Insurance	50,679
FICA Taxes	869,835
Employee Health Insurance	593,110
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	87,973
Unfifoms	17,096
Employee backround check	4,420
Other Employee Benefits	25,501
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,815,218

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

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Town of Cicero	2,930
Anderson Elevator	945
Secretary of State	102
Other License and dues	2,363
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,330

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Travel Reimbursement	848
In-State Travel	
Travel Reimbursement	15,336
Travel Reimbursement	30,345
Seminar Expense	
Education and Seminars	8,396
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 54,925

* Attach copy of IMRF notifications

**See instructions.

C. Professional Services

Vendor/Payee	Type	Amount
Abbey Road Tax Consultants	Professional Fees	367
Empire Risk Management Services, L	Professional Fees	11,000
Genex Services, LLC.	Professional Fees	16
Global Fiscal Midwest LLC	Professional Fees	1,619
Infinity Healthcare Management of Il	Professional Fees	1,743
THE MERRITT SEARCH GROUP I	Professional Fees	18,750
USA Risk Management Inc	Professional Fees	3,812
Infinity H Funding	Professional Fees	423
People Powered LLC	Professional Fees	2,000
Premier Destine	Professional Fees	704
See attached schedule		
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		**$ 40,434**

Facility Name & ID Number City View Multicare Center # 0053827 Report Period Beginning: 1/1/20 Ending: 12/31/20

XX. GENERAL INFORMATION:

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

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

(3) Did the nursing home make political contributions or payments to a political action organization? _____ 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 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **48,541** 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. **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. $ **897,346**
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 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.