		FOR BHF USE				

LL1

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.

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

I. IDPH License ID Number: 0054643

Facility Name: Little Village Nrsg Rhb Ctr

Address: 2320 S Lawndale Ave (Number) Chicago (City) 60623 (Zip Code)

County: Cook

Telephone Number: (773) 522-0400 **Fax #** (773) 522-1692

HFS ID Number:

Date of Initial License for Current Owners: 8/1/2017

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	

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)	
	(Title)	
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	Denise A Leonard, CPA Partner
	(Firm Name & Address)	Plante & Moran, PLLC 1111 Superior Ave, Suite 1250 Cleveland, OH 44114
	(Telephone)	(216) 274-6514 Fax # (248) 233-7349

In the event there are further questions about this report, please contact:
Name: Joshua S. Banach Telephone Number: (847) 628 - 8784
Email Address:

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 Little Village Nrsg Rhb Ctr # 0054643 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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	14	Skilled (SNF)	14	5,124	1
2		Skilled Pediatric (SNF/PED)			2
3	92	Intermediate (ICF)	92	33,672	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,796	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	1,114	83	3,041	4,238	8
9	SNF/PED					9
10	ICF	27,673		152	27,825	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,787	83	3,193	32,063	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.65%

D. How many bed reserve days during this year were paid by the Department?
None (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)
N/A

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 08/01/2017

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/01/2017 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 14 and days of care provided 3,041

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Little Village Nrsg Rhb Ctr # 0054643 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	319,331	27,908	8,488	355,727		355,727		355,727			1
2	Food Purchase		168,146		168,146		168,146		168,146			2
3	Housekeeping	252,639	33,444		286,083		286,083		286,083			3
4	Laundry	69,821	8,508		78,329		78,329		78,329			4
5	Heat and Other Utilities			140,628	140,628		140,628	(11,864)	128,764			5
6	Maintenance	89,174	112,880	7,450	209,504		209,504	(13,655)	195,849			6
7	Other (specify):*	123,363		18,612	141,975		141,975		141,975			7
8	**TOTAL General Services**	854,328	350,886	175,178	1,380,392		1,380,392	(25,519)	1,354,873			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,778,390	158,434	77,680	2,014,504		2,014,504	(636)	2,013,868			10
10a	Therapy	121,216		528,035	649,251		649,251		649,251			10a
11	Activities	161,136	(230)		160,906		160,906		160,906			11
12	Social Services	222,085	9,054	15,923	247,062		247,062		247,062			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,282,827	167,258	633,638	3,083,723		3,083,723	(636)	3,083,087			16
	C. General Administration											
17	Administrative	118,427			118,427		118,427		118,427			17
18	Directors Fees											18
19	Professional Services			606,734	606,734		606,734	(261,772)	344,962			19
20	Dues, Fees, Subscriptions & Promotions			48,158	48,158		48,158	(8,258)	39,900			20
21	Clerical & General Office Expenses	228,604	35,694	27,627	291,925		291,925	(35,811)	256,114			21
22	Employee Benefits & Payroll Taxes			533,099	533,099		533,099		533,099			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,908	2,908		2,908		2,908			24
25	Other Admin. Staff Transportation			23,576	23,576		23,576	(17,706)	5,870			25
26	Insurance-Prop.Liab.Malpractice			260,122	260,122		260,122		260,122			26
27	Other (specify):*			11,492	11,492		11,492	(11,492)				27
28	**TOTAL General Administration**	347,031	35,694	1,513,716	1,896,441		1,896,441	(335,039)	1,561,402			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,484,186	553,838	2,322,532	6,360,556		6,360,556	(361,194)	5,999,362			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.

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			19,115	19,115		19,115	25,606	44,721			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,610	38,610		38,610	166,023	204,633			32
33	Real Estate Taxes			180,426	180,426		180,426	(32,279)	148,147			33
34	Rent-Facility & Grounds			548,250	548,250		548,250	(543,114)	5,136			34
35	Rent-Equipment & Vehicles			22,388	22,388		22,388		22,388			35
36	Other (specify):*											36
37	TOTAL Ownership			808,789	808,789		808,789	(383,764)	425,025			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		4,535	62,190	66,725		66,725		66,725			39
40	Barber and Beauty Shops		109		109		109	(109)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			239,142	239,142		239,142		239,142			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		4,644	301,332	305,976		305,976	(109)	305,867			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,484,186	558,482	3,432,653	7,475,321		7,475,321	(745,067)	6,730,254			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 Little Village Nrsg Rhb Ctr # 0054643 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 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(11,864)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	25,606	30		9
10	Interest and Other Investment Income	(1,154)	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	(14,911)	21		18
19	Entertainment				19
20	Contributions	(2,517)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(8,975)	27		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	(133,218)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (147,033)		$	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)	(598,034)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (598,034)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (745,067)		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

Little Village Nrsg Rhb Ctr

ID# 0054643

Report Period Beginning: 1/1/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	2320 S. Lawndale LLC- Management Fees	$ (7,950)	17	1
2	2320 S. Lawndale LLC- Fees & Taxes	(75)	21	2
3	2320 S. Lawndale LLC- Amortization	(7,304)	31	3
4	2320 S. Lawndale LLC- Professional Fees	(12,426)	19	4
5	Jury Duty Income	(17)	10	5
6	Patient Clothing	(619)	10	6
7	Barber & Beauty Expenses	(109)	40	7
8	Bank Charges	(886)	21	8
9	Forgiveness of Receivables	(18,228)	21	9
10	Miscellaneous Income	(22)	21	10
11	Non-Allowable Interest	(9,516)	32	11
12	Non-Allowable Travel	(17,706)	25	12
13	PAC Dues	(8,258)	20	13
14	Capitalized R&M	(13,655)	06	14
15	Non-Allowable Legal	(34,340)	19	15
16	Non-Allowable Expense	(2,107)	21	16
17		0		17
18		0		18
19		0		19
20		0		20
21		0		21
22		0		22
23		0		23
24		0		24
25		0		25
26		0		26
27		0		27
28		0		28
29		0		29
30		0		30
31		0		31
32		0		32
33		0		33
34		0		34
35		0		35
36		0		36
37		0		37
38		0		38
39		0		39
40		0		40
41		0		41
42		0		42
43		0		43
44		0		44
45		0		45
46		0		46
47		0		47
48		0		48
49	**Total**	(133,218)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Little Village Nrsg Rhb Ctr # 0054643 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	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	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	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(13,655)	0	0	0	0	0	0	0	0	0	0	(13,655)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(13,655)	0	0	0	0	0	0	0	0	0	0	(13,655)	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	(636)	0	0	0	0	0	0	0	0	0	0	(636)	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**	(636)	0	0	0	0	0	0	0	0	0	0	(636)	16
	C. General Administration													
17	Administrative	(7,950)	7,950	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(46,766)	12,426	(227,432)	0	0	0	0	0	0	0	0	(261,772)	19
20	Fees, Subscriptions & Promotions	(8,258)	0	0	0	0	0	0	0	0	0	0	(8,258)	20
21	Clerical & General Office Expenses	(21,318)	75	343	0	0	0	0	0	0	0	0	(20,900)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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	(17,706)	0	0	0	0	0	0	0	0	0	0	(17,706)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(101,998)	20,451	(227,089)	0	0	0	0	0	0	0	0	(308,636)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(116,289)	20,451	(227,089)	0	0	0	0	0	0	0	0	(322,927)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Little Village Nrsg Rhb Ctr # 0054643 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	25,606	0	0	0	0	0	0	0	0	0	0	25,606	30
31	Amortization of Pre-Op. & Org.	(7,304)	7,304	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,516)	176,693	0	0	0	0	0	0	0	0	0	167,177	32
33	Real Estate Taxes	0	(32,279)	0	0	0	0	0	0	0	0	0	(32,279)	33
34	Rent-Facility & Grounds	0	(540,000)	(3,114)	0	0	0	0	0	0	0	0	(543,114)	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**	8,786	(388,282)	(3,114)	0	0	0	0	0	0	0	0	(382,610)	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	(109)	0	0	0	0	0	0	0	0	0	0	(109)	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**	(109)	0	0	0	0	0	0	0	0	0	0	(109)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(107,612)	(367,831)	(230,203)	0	0	0	0	0	0	0	0	(705,646)	45

Facility Name & ID Number Little Village Nrsg Rhb Ctr # 0054643 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
See Page 6 - Supp		See Page 6 - Supp		See Page 6 - Supp		

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	Rental Income	$ 540,000	2320 S Lawndale, LLC	100.00%	$	$ (540,000)	1
2	V	33	RE Taxes	164,402	2320 S Lawndale, LLC	100.00%	132,123	(32,279)	2
3	V	32	Interest	37,927	2320 S Lawndale, LLC	100.00%	214,620	176,693	3
4	V	17	Management Fees		2320 S Lawndale, LLC	100.00%	7,950	7,950	4
5	V	19	Legal Expense		2320 S Lawndale, LLC	100.00%	12,426	12,426	5
6	V	21	Fees and Taxes		2320 S Lawndale, LLC	100.00%	75	75	6
7	V	31	Amortization		2320 S Lawndale, LLC	100.00%	7,304	7,304	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 742,329			$ 374,498	$ * (367,831)	14

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

Facility Name & ID Number Little Village Nrsg Rhb Ctr # 0054643 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	Rita Lipshitz	20.00%	Sheridan Village Nursing & Rehab	Chicago, IL	Jade Financial	Chicago, IL	Mgmt Company	1
2	David Mashiach	40.00%	Tri-State Village Nursing & Rehab	Lansing, IL	2320 S Lawndale, LLC	Chicago, IL	Building Co	2
3	Jake Mashiach	40.00%	Wheaton Village Nursing & Rehab	Wheaton, IL				3
4			Kensington Place Nursing & Rehab	Chicago, IL				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 Little Village Nrsg Rhb Ctr # 0054643 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. [X] YES [ ] NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	A&G Expenses	$	Jade Financial	100.00%	$ 343	$ 343	15
16	V	19	Professional Fees	227,821	Jade Financial	100.00%	389	(227,432)	16
17	V	34	Rent Expense	8,250	Jade Financial	100.00%	5,136	(3,114)	17
18	V								18
19	V								19
20	V								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			$ 236,071			$ 5,868	$ * (230,203)	39

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

Facility Name & ID Number Little Village Nrsg Rhb Ctr # 0054643 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	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Yechiel Mashiash	Owner	Administrative	40.00%	See Attached	0.88	2.20%	Salary	$ 4,393	17-1	1
2	Yaacov Mashiash	Owner	Admin/Admission	40.00%	See Attached	5.23	13.07%	Salary	14,140	17-1; 12-1	2
3	Rita Lipshitz	Owner	Administrative	20.00%	None	40	100.00%	Cons. Fees	52,000	19-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 70,533		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 Little Village Nrsg Rhb Ctr # 0054643 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 [X]

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

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

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

Facility Name & ID Number Little Village Nrsg Rhb Ctr # 0054643 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 [X] NO [ ]

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

Name of Related Organization: Jade Financial Services LLC
Street Address: 2320 South Lawndale Avenue
City / State / Zip Code: Chicago, IL 60623
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	21	A&G Expenses	Resident Days	200,733	5	$ 2,146	$	32,063	$ 343	1
2	19	Professional Fees	Resident Days	200,733	5	2,435		32,063	389	2
3	34	Rent Expense	Resident Days	200,733	5	32,153		32,063	5,136	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
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20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 36,734	$		$ 5,868	25

Facility Name & ID Number Little Village Nrsg Rhb Ctr # 0054643 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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Providence Bank		X	Mortgage			$	$ 3,770,079			$ 214,620	1
2												2
3												3
4												4
5												5
	Working Capital											
6	HFG		X	Line of Credit							29,094	6
7	Shareholder Loan	X		Working Capital				180,000			9,516	7
8												8
9	TOTAL Facility Related						$	$ 3,950,079			$ 253,230	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,154)	10
11	Non-Allowable Interest	X									(9,516)	11
12	Interest Income- Building		X								(37,927)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (48,597)	14
15	TOTALS (line 9+line14)						$	$ 3,950,079			$ 204,633	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

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

Facility Name & ID Number Little Village Nrsg Rhb Ctr # 0054643 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

B. Real Estate Taxes

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

Description		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$	175,945	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.)	$	139,492	2
3. Under or (over) accrual (line 2 minus line 1).	$	(36,453)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	178,955	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.)**	$	5,645	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** $ 21,669 **For** '17 **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.	$	148,147	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		Line
2015		8
2016		9
2017	169,488	10
2018	167,567	11
2019	170,433	12

2020 Accrual = $170,433 X 1.05 = $178,955

FOR BHF USE ONLY

Line	Description		Line
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 Little Village Nrsg Rhb Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054643

CONTACT PERSON REGARDING THIS REPORT Joshua S. Banach

TELEPHONE (847) 628 - 8784 FAX #: ( )

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)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.	16-26-105-075-0000	Long Term Care Property	$ 30,541.72	$ 30,541.72
2.	16-26-105-079-0000	Long Term Care Property	$ 69,879.76	$ 69,879.76
3.	16-26-105-080-0000	Long Term Care Property	$ 70,011.56	$ 70,011.56
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 170,433.04	$ 170,433.04

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,849 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

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

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

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

None

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2018	$ 40,650	1
2					2
3	TOTALS			$ 40,650	3

Facility Name & ID Number Little Village Nrsg Rhb Ctr # 0054643 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	106		2018		$ 1,020,720	$	40	$ 25,518	$ 25,518	$ 76,554	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Doors(Rear Exit to Parking Lot / South Stairwell)		2018		11,610		20	581	581	1,742	9
10	Replacement Of Front Door		2019		3,063		20	153	153	306	10
11	Installation Of Sink 2nd Floor Dining Area		2019		3,800		20	190	190	380	11
12	Painted 1st Floor And Basement		2019		16,850		20	843	843	1,685	12
13	Replaced Door To Courtyard		2019		6,488		20	324	324	649	13
14	Electrical/Wiring/Cable-Call Light System-All Resident Rooms		2019		30,818		20	1,541	1,541	3,082	14
15	Built In Pumps/Transformer, Amp, Limit switch-Water Damage		2019		16,800		20	840	840	1,680	15
16	Copper Water Piping From Basement- Mixing Valves 1st Floor		2019		33,000		20	1,650	1,650	3,300	16
17	Signage for the Corridors		2019		2,925		20	146	146	293	17
18	Drywall and Tiling Patching for 7 Resident Units		2019		3,500		20	175	175	350	18
19	Install New Ejector Pump/Mixing Valve/Piping for 1st Fl Shower		2019		3,300		20	165	165	330	19
20	Repairs to Cabeling for the Passenger Elevator		2019		2,935		20	147	147	294	20
21	Metal Pedestrian Door w/Frame & Hardware-Courtyard Entrance		2020		3,681		20	184	184	184	21
22	Flowline/Backflow Precenter-Plumbing System Throughout Faciltiy		2020		22,225		20	1,111	1,111	1,111	22
23	Fire Alarm Systems, Devices, Panels - Basement		2020		24,820		20	1,241	1,241	1,241	23
24	Fire Alarm System- Tamper Panel Replacement Through Facility		2020		4,025		20	201	201	201	24
25	Boiler Installation - Ejector Pit, Piping, Gaskets- Boiler Room		2020		66,549		20	3,327	3,327	3,327	25
26	45 Feet of Handrails- Exterior Walkways		2020		2,500		20	125	125	125	26
27	Ejector Pit Lids and Piping Repairs- Sump System		2020		3,186		20	159	159	159	27
28	Concrete Work and Piping/Hub Couplings- Sump System		2020		2,691		20	135	135	135	28
29	Pump and Motor Replacement On Elevator		2020		5,279		20	264	264	264	29
30	Replacement of Boiler-Boiler Room		2020		20,337		20	1,017	1,017	1,017	30
31											31
32											32
33	Financial Statement Depreciation- Little Village Nursing & Rehab					19,115			(19,115)		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 Little Village Nrsg Rhb Ctr # 0054643 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			$	$		$	$	$	37
38									38
39									39
40									40
41	2320 S. Lawndale LLC								41
42	Various	1989	17,739		20			17,739	42
43	Various	1990	11,700		20			11,700	43
44	Various	1991	17,413		20			17,413	44
45	Various	1992	51,998		20			51,998	45
46	Various	1993	24,657		20			24,657	46
47	Various	1994	1,742		20			1,742	47
48	Various	1989	4,204		20			4,204	48
49	Various	1992	3,140		20			3,140	49
50	Various	1992	3,400		20			3,400	50
51	Various	1995	1,500		20			1,500	51
52	Various	1996	22,253		20			22,253	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)		$ 1,470,847	$ 19,115		$ 40,037	$ 20,922	$ 258,154	70

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

Facility Name & ID Number Little Village Nrsg Rhb Ctr # 0054643 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		$ 1,470,847	$ 19,115		$ 40,037	$ 20,922	$ 258,154	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,470,847	$ 19,115		$ 40,037	$ 20,922	$ 258,154	34

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

Facility Name & ID Number Little Village Nrsg Rhb Ctr # 0054643 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		$ 1,470,847	$ 19,115		$ 40,037	$ 20,922	$ 258,154	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,470,847	$ 19,115		$ 40,037	$ 20,922	$ 258,154	34

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

Facility Name & ID Number Little Village Nrsg Rhb Ctr # 0054643 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		$ 1,470,847	$ 19,115		$ 40,037	$ 20,922	$ 258,154	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,470,847	$ 19,115		$ 40,037	$ 20,922	$ 258,154	34

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

Facility Name & ID Number Little Village Nrsg Rhb Ctr # 0054643 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		$ 1,470,847	$ 19,115		$ 40,037	$ 20,922	$ 258,154	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
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,470,847	$ 19,115		$ 40,037	$ 20,922	$ 258,154	34

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

Facility Name & ID Number Little Village Nrsg Rhb Ctr # 0054643 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 12E, Carried Forward		$ 1,470,847	$ 19,115		$ 40,037	$ 20,922	$ 258,154	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,470,847	$ 19,115		$ 40,037	$ 20,922	$ 258,154	34

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

Facility Name & ID Number Little Village Nrsg Rhb Ctr # 0054643 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	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 1,470,847	$ 19,115		$ 40,037	$ 20,922	$ 258,154	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,470,847	$ 19,115		$ 40,037	$ 20,922	$ 258,154	34

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

Facility Name & ID Number Little Village Nrsg Rhb Ctr # 0054643 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 12G, Carried Forward		$ 1,470,847	$ 19,115		$ 40,037	$ 20,922	$ 258,154	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,470,847	$ 19,115		$ 40,037	$ 20,922	$ 258,154	34

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

Facility Name & ID Number Little Village Nrsg Rhb Ctr # 0054643 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 12H, Carried Forward		$ 1,470,847	$ 19,115		$ 40,037	$ 20,922	$ 258,154	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,470,847	$ 19,115		$ 40,037	$ 20,922	$ 258,154	34

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

Facility Name & ID Number Little Village Nrsg Rhb Ctr # 0054643 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	$ 8,533	$	$ 853	$ 853	10	$ 2,560	71
72	Current Year Purchases	2,900		290	290	10	290	72
73	Fully Depreciated Assets					10		73
74	See Attached	200,000				10	200,000	74
75	TOTALS	$ 211,433	$	$ 1,143	$ 1,143		$ 202,850	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	Facility	Truck	2020	$ 17,706	$	$ 3,541	$ 3,541	5	$ 3,541	76
77										77
78										78
79										79
80	TOTALS			$ 17,706	$	$ 3,541	$ 3,541		$ 3,541	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)	$ 1,740,636	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 19,115	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 44,721	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 25,606	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 464,545	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: Little Village Nrsg Rhb Ctr # 0054643 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	Allocated From Jade Financial				5,136			5
6								6
7	TOTAL				$ 5,136 **			7

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	$

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: *

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: $ 5,831 Description: $5,831 Toshiba Copier/Printer
    (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	Facility	Lexus	$ 1,380	$ 16,557	17
18					18
19					19
20					20
21	TOTAL		$ 1,380.00	$ 16,557	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: Little Village Nrsg Rhb Ctr # 0054643 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	V10A	hrs	$	2,697	$ 202,307	$	2,697	$ 202,307	1
2	Licensed Speech and Language Development Therapist	V10A	hrs		1,500	112,524		1,500	112,524	2
3	Licensed Recreational Therapist	V10A	hrs							3
4	Licensed Physical Therapist	V10A	hrs		2,843	213,204		2,843	213,204	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	V39	hrs	121,216					121,216	8
9	Pharmacy	V39	# of prescrpts				52,976		52,976	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB/RADIOLOGY	V39					9,214		9,214	12
13	Other (specify): BILLABLE SUPPLIES	V39					211		211	13
14	TOTAL			$ 121,216	7,040	$ 528,035	$ 62,401	7,040	$ 711,652	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 Little Village Nrsg Rhb Ctr # 0054643 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	$ 1,790,636	$ 2,226,643	1
2	Cash-Patient Deposits	61,401	61,401	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 618,008)	1,382,959	1,382,959	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	76,544	76,544	6
7	Other Prepaid Expenses	6,837	6,837	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	255,542	357,744	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,573,919	$ 4,112,128	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		40,650	13
14	Buildings, at Historical Cost		1,020,720	14
15	Leasehold Improvements, at Historical Cost	205,903	358,720	15
16	Equipment, at Historical Cost	71,096	271,096	16
17	Accumulated Depreciation (book methods)	(28,402)	(1,401,939)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		36,519	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(15,217)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe See Attached			22
23	Other(specify): See Attached	206,284	3,882,233	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 454,881	$ 4,192,782	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,028,800	$ 8,304,911	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 657,001	$ 656,999	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	61,343	61,343	28
29	Short-Term Notes Payable	180,000	180,000	29
30	Accrued Salaries Payable	281,818	281,818	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,732	13,732	31
32	Accrued Real Estate Taxes(Sch.IX-B)	178,955	178,955	32
33	Accrued Interest Payable	17,214	19,521	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached			36
37	See Attached	824,288	1,155,962	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,214,351	$ 2,548,330	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,770,079	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	220,119	220,119	43
44	See Attached			44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 220,119	$ 3,990,198	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,434,470	$ 6,538,528	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,594,330	$ 1,766,383	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,028,800	$ 8,304,911	48

*(See instructions.)

Facility Name & ID Number Little Village Nrsg Rhb Ctr # 0054643 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**	$ 475,233	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 475,233	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,219,959	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	(100,862)	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)**	$ 1,119,097	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,594,330	24 *

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

Facility Name & ID Number Little Village Nrsg Rhb Ctr # 0054643 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	$ 7,895,991	1
2	Discounts and Allowances for all Levels	(1,565,897)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,330,094	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,411,459	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,411,459	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	47,741	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,705	19
20	Radiology and X-Ray	1,155	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 56,601	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,154	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,154	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a		895,972	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 895,972	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,695,280	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,380,392	31
32	Health Care	3,083,723	32
33	General Administration	1,896,441	33
	B. Capital Expense		
34	Ownership	808,789	34
	C. Ancillary Expense		
35	Special Cost Centers	66,834	35
36	Provider Participation Fee	239,142	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,475,321	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,219,959	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,219,959	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,740,875	44
45	Private Pay - Net Inpatient Revenue	12,350	45
46	Medicare - Net Inpatient Revenue	1,027,297	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	37,394	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS/WO/PART B	(487,822)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,330,094	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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 Little Village Nrsg Rhb Ctr # 0054643 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	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,942	2,525	$ 121,862	$ 48.26	1
2	Assistant Director of Nursing	454	579	20,644	35.65	2
3	Registered Nurses	6,646	7,248	285,312	39.36	3
4	Licensed Practical Nurses	13,300	15,668	490,057	31.28	4
5	CNAs & Orderlies	39,393	46,660	818,442	17.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,939	5,700	121,216	21.27	8
9	Activity Director	2,093	2,288	43,717	19.11	9
10	Activity Assistants	6,172	7,032	117,419	16.70	10
11	Social Service Workers	7,737	8,039	222,085	27.63	11
12	Dietician					12
13	Food Service Supervisor	1,864	2,118	38,599	18.22	13
14	Head Cook	15,781	17,508	280,732	16.03	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,379	4,865	89,174	18.33	17
18	Housekeepers	13,723	15,609	252,639	16.19	18
19	Laundry	3,858	4,305	69,821	16.22	19
20	Administrator	2,234	2,357	118,427	50.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,323	8,619	228,604	26.52	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,873	2,127	42,073	19.78	31
32	Other Health Care(specify)	6,914	7,644	123,363	16.14	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	140,625	160,891	$ 3,484,186 *	$ 21.66	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	175	$ 8,488	V01-03	35
36	Medical Director	Monthly Fees	12,000	V09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly Fees	6,822	V10-03	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 Fees	3,923	V12-03	45
46	Other(specify)				46
47	Psychiatrist	Monthly Fees	12,000	V12-03	47
48					48
49	TOTAL (lines 35 - 48)	175	$ 43,233		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	1,377	61,466	V10-03	51
52	Certified Nurse Assistants/Aides	378	9,392	V10-03	52
53	TOTAL (lines 50 - 52)	1,755	$ 70,858		53

Facility Name & ID Number: Little Village Nrsg Rhb Ctr   # 0054643   Report Period Beginning: 1/1/20   Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jennifer Davey	Administrator	0.00%	$ 107,534
Yechiel Mashiach	Administrative	40.00%	4,393
Yaacov Mashiach	Administrative	40.00%	6,500
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 118,427

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
Paycor Payroll Service	Payroll Processing	$ 17,328
National Data Care Corp	Data Processing	1,754
Matrix Care	Data Processing & Software	3,971
Ability Network	Data Processing & Billing	6,072
Achieve Accreditation	Accreditation Services	14,740
See Attached	Legal Services	43,363
Plante Moran	Accounting Services	5,900
Personnel Planners	Unemployment Consulting	900
Legat Architects	Architecture Services	4,104
Ronald Cournaya	Cost Reporting	2,860
Terrill Consulting	AR Consulting	56,361
See Supplemental Page 21		449,382
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 606,734

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 57,895
Unemployment Compensation Insurance	25,407
FICA Taxes	260,308
Employee Health Insurance	147,615
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	32,154
Other Employee Benefits	6,720
Holiday Expense	3,000
TOTAL (agree to Schedule V, line 22, col.8)	$ 533,099

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,228
Advertising: Employee Recruitment	19,089
Health Care Worker Background Check	1,224
(Indicate # of checks performed 122)	
Patient Background Checks	
Dues & Subscriptions	14,971
Licenses & Fees	2,388
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 39,900

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,908
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,908

**See instructions.

Facility Name & ID Number Little Village Nrsg Rhb Ctr # 0054643 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

C. Professional Services

Vendor/Payee	Type	Amount
GCHMO	Managed Care Consulting	$ 34,348
Extended Care Consulting	Bookkeeping	129,568
Jade Financial	Consulting Fees	227,821
Rita Lipshitz	Consulting Fees	52,000
Finkel Martwick Colson	RE Tax Appeal	5,645
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 449,382

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$

G. Schedule of Travel and Seminar**

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

**See instructions.

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Healthcare Council of Illinois $16,515**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,514** Line **10-2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **239,142**
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? **No** 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? **100% Ln1**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
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.