



Facility Name & ID Number Center Home Hispanic Elderly

# 0050989 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	<u>98</u>	Skilled (SNF)	<u>98</u>	<u>35,770</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>58</u>	Intermediate (ICF)	<u>58</u>	<u>21,170</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>156</u>	TOTALS	<u>156</u>	<u>56,940</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	<u>25,235</u>	<u>214</u>	<u>4,847</u>	<u>30,296</u>		8
9	SNF/PED						9
10	ICF	<u>19,037</u>	<u>174</u>	<u>1,241</u>	<u>20,452</u>		10
11	ICF/DD						11
12	SC						12
13	DD 16 OR LESS						13
14	TOTALS	<u>44,272</u>	<u>388</u>	<u>6,088</u>	<u>50,748</u>		14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.13%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold 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

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

I. On what date did you start providing long term care at this location?  
Date started 07/01/2010

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 07/01/2010 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 98 and days of care provided 3,330

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name &amp; ID Number

Center Home Hispanic Elderly

# 0050989

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	290,461	52,042	16,744	359,247		359,247		359,247		1
2	Food Purchase		297,013		297,013		297,013	610	297,623		2
3	Housekeeping	253,789	30,988		284,777		284,777	1,045	285,822		3
4	Laundry	114,860	19,481		134,341		134,341		134,341		4
5	Heat and Other Utilities			212,255	212,255		212,255	875	213,130		5
6	Maintenance	78,652	152	175,287	254,091		254,091	(77,083)	177,008		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	737,762	399,676	404,286	1,541,724		1,541,724	(74,553)	1,467,171		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	2,471,942	39,199	154,039	2,665,180		2,665,180	(46,621)	2,618,559		10
10a	Therapy	100,289	14,219		114,508		114,508		114,508		10a
11	Activities	112,702	5,994		118,696		118,696		118,696		11
12	Social Services	176,169		3,481	179,650		179,650		179,650		12
13	CNA Training										13
14	Program Transportation			1,214	1,214		1,214		1,214		14
15	Other (specify):*							10,712	10,712		15
16	<b>TOTAL Health Care and Programs</b>	2,861,102	59,412	170,734	3,091,248		3,091,248	(35,909)	3,055,339		16
	<b>C. General Administration</b>										
17	Administrative	93,280		587,500	680,780		680,780	(553,420)	127,360		17
18	Directors Fees										18
19	Professional Services			85,086	85,086	(10,106)	74,980	2,186	77,167		19
20	Dues, Fees, Subscriptions & Promotions			49,653	49,653		49,653	(10,041)	39,612		20
21	Clerical & General Office Expenses	164,445		112,750	277,195		277,195	(2,315)	274,880		21
22	Employee Benefits & Payroll Taxes			721,224	721,224		721,224		721,224		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,739	1,739		1,739	1,042	2,781		24
25	Other Admin. Staff Transportation			446	446		446	6,179	6,625		25
26	Insurance-Prop.Liab.Malpractice			484,766	484,766		484,766	854	485,620		26
27	Other (specify):*							22,657	22,657		27
28	<b>TOTAL General Administration</b>	257,725		2,043,164	2,300,889	(10,106)	2,290,783	(532,858)	1,757,926		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,856,589	459,088	2,618,184	6,933,861	(10,106)	6,923,755	(643,319)	6,280,436		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 &amp; ID Number

Center Home Hispanic Elderly

#0050989

Report Period Beginning:

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Ending:

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## 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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			15,446	15,446		15,446	67,256	82,702			30
31	Amortization of Pre-Op. & Org.			849	849		849		849			31
32	Interest			13,625	13,625		13,625	1,840	15,465			32
33	Real Estate Taxes			215,000	215,000	10,106	225,106	(32,121)	192,984			33
34	Rent-Facility & Grounds			893,958	893,958		893,958	0	893,958			34
35	Rent-Equipment & Vehicles			3,243	3,243		3,243		3,243			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,142,121	1,142,121	10,106	1,152,227	36,974	1,189,201			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		160,130	597,769	757,899		757,899		757,899			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			373,213	373,213		373,213		373,213			42
43	Other (specify):*			29,977	29,977		29,977	(29,977)				43
44	<b>TOTAL Special Cost Centers</b>		160,130	1,000,959	1,161,089		1,161,089	(29,977)	1,131,112			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,856,589	619,218	4,761,264	9,237,071		9,237,071	(636,322)	8,600,749			45

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

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	63,130	30		9
10	Interest and Other Investment Income	(291)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(23)	02		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	(1,432)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(30,000)	21		24
25	Fund Raising, Advertising and Promotional	(5,863)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(113)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(184,381)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (158,972)		\$	30

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	2	
		Amount	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)	(477,349)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (477,349)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (636,322)		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	2	3	4	
		Yes	No	Amount	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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	52

Center Home Hispanic Elderly

ID# 0050989

Report Period Beginning: 01/01/15

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Medicare Sequestration	\$ (30,152)	21	1
2	Vending Income	(1,300)	02	2
3	Misc. Income	(8,288)	21	3
4	Marketing	(8,006)	43	4
5	Bank Charges	(5,421)	21	5
6	Additional R&M	1,800	06	6
7	PAC Dues	(8,290)	20	7
8	Non-Allowable Legal Fees	(784)	19	8
9	Capitalized R&M	(80,784)	06	9
10	R/E Tax Expense Adjustment for no accrual	(36,520)	33	10
11	Prior Period Expense	(6,636)	21	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	<b>Total</b>	(184,381)		49

Center Home Hispanic Elderly

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	<b>Total</b>		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Center Home Hispanic Elderly# 0050989

Report Period Beginning:

01/01/15

Ending:

12/31/15

## 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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(1,323)		1,780		153							610	2
3	Housekeeping			1,045									1,045	3
4	Laundry													4
5	Heat and Other Utilities			875									875	5
6	Maintenance	(78,984)		1,858		43							(77,083)	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(80,307)</b>		<b>5,558</b>		<b>196</b>							<b>(74,553)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records					(46,621)							(46,621)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					10,712							10,712	15
16	<b>TOTAL Health Care and Programs</b>					<b>(35,909)</b>							<b>(35,909)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(557,829)		4,409							(553,420)	17
18	Directors Fees													18
19	Professional Services	(784)		891	131	1,948							2,186	19
20	Fees, Subscriptions & Promotions	(14,153)		4,058	27	27							(10,041)	20
21	Clerical & General Office Expenses	(82,042)		96,388		(16,662)							(2,315)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			394		648							1,042	24
25	Other Admin. Staff Transportation			860		5,319							6,179	25
26	Insurance-Prop.Liab.Malpractice			854									854	26
27	Other (specify):*			20,616		2,041							22,657	27
28	<b>TOTAL General Administration</b>	<b>(96,979)</b>		<b>(433,768)</b>	<b>159</b>	<b>(2,270)</b>							<b>(532,858)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(177,285)</b>		<b>(428,210)</b>	<b>159</b>	<b>(37,983)</b>							<b>(643,319)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Center Home Hispanic Elderly

# 0050989

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	63,130		1,108	3,017								67,256	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(291)			2,131								1,840	32
33	Real Estate Taxes	(36,520)			4,399								(32,121)	33
34	Rent-Facility & Grounds			10,144	(10,144)								0	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>26,319</b>		<b>11,252</b>	<b>(597)</b>								<b>36,974</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(8,006)				(21,971)							(29,977)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(8,006)</b>				<b>(21,971)</b>							<b>(29,977)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(158,972)		(416,957)	(438)	(59,954)							(636,322)	45

**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 Supplemental Schedule		See Supplemental Schedule		See Supplemental Schedule		

**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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	<b>Total</b>		\$			\$	\$ *	14

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

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	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	2					
			\$	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	\$ 1,780	\$ 1,780
16	V	3					
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,045	1,045
17	V	5					
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	875	875
18	V	6					
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,858	1,858
19	V	17					
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	15,225	15,225
20	V	17					
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	14,446	14,446
21	V	19					
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	891	891
22	V	20					
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	4,058	4,058
23	V	21					
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	10,079	10,079
24	V	21					
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	86,309	86,309
25	V	24					
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	394	394
26	V	25					
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	860	860
27	V	26					
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	854	854
28	V	27					
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	20,616	20,616
29	V	30					
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,108	1,108
30	V	34					
				PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	10,144	10,144
31	V						
32	V	17	587,500				(587,500)
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 587,500			\$ 170,543	\$ * (416,957)

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

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	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	19 PROFESSIONAL FEES		PREMIER HC REAL ESTATE, LLC	100.00%	131	\$	131	15
16	V	20 LICENSES & PERMITS		PREMIER HC REAL ESTATE, LLC	100.00%	27		27	16
17	V	30 DEPRECIATION		PREMIER HC REAL ESTATE, LLC	100.00%	3,017		3,017	17
18	V	32 INTEREST EXPENSE		PREMIER HC REAL ESTATE, LLC	100.00%	2,131		2,131	18
19	V	33 REAL ESTATE TAXES		PREMIER HC REAL ESTATE, LLC	100.00%	4,399		4,399	19
20	V	34 RENT	10,144					(10,144)	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		\$ 10,144			\$ 9,706	\$ *	(438)	39

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

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	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	2 DIETARY	\$	iCare Consulting Services LLC	100.00%	\$ 153	\$ 153
16	V	3 HOUSEKEEPING		iCare Consulting Services LLC	100.00%		
17	V	5 UTILITIES		iCare Consulting Services LLC	100.00%		
18	V	6 REPAIRS AND MAINTENANCE		iCare Consulting Services LLC	100.00%	43	43
19	V	10 NURSING SALARIES	136,262	iCare Consulting Services LLC	100.00%	89,641	(46,621)
20	V	15 EMPLOYEE BEN. HC PROGRAMS		iCare Consulting Services LLC	100.00%	10,712	10,712
21	V	17 ADMIN SALARY NON-RELATED		iCare Consulting Services LLC	100.00%		
22	V	17 M LEVOVITZ-SALARY		iCare Consulting Services LLC	100.00%	4,409	4,409
23	V	19 PROFESSIONAL FEES		iCare Consulting Services LLC	100.00%	1,948	1,948
24	V	20 DUES FEES SUBSCRIPTIONS		iCare Consulting Services LLC	100.00%	27	27
25	V	21 CLERICAL AND GENERAL	34,084	iCare Consulting Services LLC	100.00%	4,752	(29,332)
26	V	21 CLERICAL & GENERAL SALARIES		iCare Consulting Services LLC	100.00%	12,670	12,670
27	V	24 SEMINARS & EDUCATION		iCare Consulting Services LLC	100.00%	648	648
28	V	25 AUTO EXPENSE		iCare Consulting Services LLC	100.00%	5,319	5,319
29	V	26 INSURANCE		iCare Consulting Services LLC	100.00%		
30	V	27 EMPLOYEE BEN. GEN ADMIN.		iCare Consulting Services LLC	100.00%	2,041	2,041
31	V	43 MARKETING	21,971				(21,971)
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 192,317			\$ 132,363	\$ * (59,954)

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

**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	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		\$			\$	\$	15
16	V							16
17	V							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	<b>Total</b>		\$			\$	\$ *	39

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

**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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							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	<b>Total</b>		\$			\$	\$ *	39

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

**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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							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	<b>Total</b>		\$			\$	\$ *	39

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

**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	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		\$			\$	\$	15
16	V							16
17	V							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	<b>Total</b>		\$			\$	\$ *	39

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

**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	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		\$			\$	\$	15
16	V							16
17	V							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	<b>Total</b>		\$			\$	\$ *	39

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

**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	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		\$			\$	\$	15
16	V							16
17	V							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	<b>Total</b>		\$			\$	\$ *	39

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





Facility Name & ID Number Center Home Hispanic Elderly # 0050989 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Shimon Webster	Owner	Administrative	20.00%	See Attached	4.40	11.00%	Alloc. Salary	\$ 15,225	17-7	1	
2	Yeruchom Levovitz	Owner	Administrative	20.00%	See Attached	4.40	11.00%	Alloc. Salary	14,446	17-7	2	
3											3	
4											4	
5											5	
6											6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 29,671		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 Center Home Hispanic Elderly

# 0050989

Report Period Beginning:

01/01/15

Ending: 12/31/15

**VIII. ALLOCATION OF INDIRECT COSTS**

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Center Home Hispanic Elderly

# 0050989

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 PREMIER HEALTHCARE & FINANCIAL SER  
 Street Address 8153 N. LAWNDALE  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 773) 945-1000  
 Fax Number ( 773) 751-2027

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	2	DIETARY	PATIENT DAYS	461,493	11	\$ 16,187	\$ 50,748	\$ 1,780	1	
2	3	HOUSEKEEPING	PATIENT DAYS	461,493	11	9,503	50,748	1,045	2	
3	5	UTILITIES	PATIENT DAYS	461,493	11	7,957	50,748	875	3	
4	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	461,493	11	16,899	50,748	1,858	4	
5	17	S WEBSTER SALARY	PATIENT DAYS	461,493	11	138,451	138,451	50,748	15,225	5
6	17	Y LEVOVITZ-SALARY	PATIENT DAYS	461,493	11	131,370	131,370	50,748	14,446	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	461,493	11	8,102	50,748	891	7	
8	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	461,493	11	36,899	50,748	4,058	8	
9	21	CLERICAL AND GENERAL	PATIENT DAYS	461,493	11	91,659	50,748	10,079	9	
10	21	CLERICAL & GENERAL SALA	PATIENT DAYS	461,493	11	784,868	784,868	50,748	86,309	10
11	24	SEMINARS & EDUCATION	PATIENT DAYS	461,493	11	3,583	50,748	394	11	
12	25	AUTO EXPENSE	PATIENT DAYS	461,493	11	7,819	50,748	860	12	
13	26	INSURANCE	PATIENT DAYS	461,493	11	7,768	50,748	854	13	
14	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	461,493	11	187,476	50,748	20,616	14	
15	30	DEPRECIATION	PATIENT DAYS	461,493	11	10,078	50,748	1,108	15	
16	34	RENT	PATIENT DAYS	461,493	11	92,250	50,748	10,144	16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,550,868	\$ 1,054,689	\$ 170,543	25	

Facility Name & ID Number Center Home Hispanic Elderly

# 0050989

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 PREMIER HC REAL ESTATE, LLC  
 Street Address 8153 N. LAWNSDALE  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number (773) 945-1000  
 Fax Number (773) 751-2027

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	461,493	11	1,195	50,748	131	1
2	20	LICENSES & PERMITS	PATIENT DAYS	461,493	11	250	50,748	27	2
3	30	DEPRECIATION	PATIENT DAYS	461,493	11	27,440	50,748	3,017	3
4	32	INTEREST EXPENSE	PATIENT DAYS	461,493	11	19,378	50,748	2,131	4
5	33	REAL ESTATE TAXES	PATIENT DAYS	461,493	11	40,000	50,748	4,399	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					\$ 88,263	\$	\$ 9,706	25

Facility Name & ID Number Center Home Hispanic Elderly

# 0050989

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 iCare Consulting Services LLC  
 Street Address 8153 N. Lawndale  
 City / State / Zip Code Skokie, IL 60076  
 Phone Number ( 773) 945-1000  
 Fax Number ( 773) 751-2027

1	2	3	4	5	6	7	8	9	
Schedule V	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
Line Reference									
1	2	DIETARY	PATIENT DAYS	461,493	11	\$ 1,393	\$ 50,748	\$ 153	1
2	3	HOUSEKEEPING	PATIENT DAYS	461,493	11		50,748		2
3	5	UTILITIES	PATIENT DAYS	461,493	11		50,748		3
4	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	461,493	11	391	50,748	43	4
5	10	NURSING SALARIES	PATIENT DAYS	461,493	11	815,183	815,183	50,748	89,641
6	15	EMPLOYEE BEN. HC PROGRA	PATIENT DAYS	461,493	11	97,410	50,748	10,712	6
7	17	ADMIN SALARY NON-RELATI	PATIENT DAYS	461,493	11		50,748		7
8	17	M LEVOVITZ-SALARY	PATIENT DAYS	461,493	11	40,090	40,090	50,748	4,409
9	19	PROFESSIONAL FEES	PATIENT DAYS	461,493	11	17,714	50,748	1,948	9
10	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	461,493	11	250	50,748	27	10
11	21	CLERICAL AND GENERAL	PATIENT DAYS	461,493	11	43,215	50,748	4,752	11
12	21	CLERICAL & GENERAL SALA	PATIENT DAYS	461,493	11	115,221	115,221	50,748	12,670
13	24	SEMINARS & EDUCATION	PATIENT DAYS	461,493	11	5,896	50,748	648	13
14	25	AUTO EXPENSE	PATIENT DAYS	461,493	11	48,366	50,748	5,319	14
15	26	INSURANCE	PATIENT DAYS	461,493	11		50,748		15
16	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	461,493	11	18,559	50,748	2,041	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,203,688	\$ 970,494	\$ 132,363	25

Facility Name & ID Number Center Home Hispanic Elderly

# 0050989

Report Period Beginning:

01/01/15

Ending: 12/31/15

**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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Center Home Hispanic Elderly

# 0050989

Report Period Beginning:

01/01/15

Ending: 12/31/15

**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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Center Home Hispanic Elderly

# 0050989

Report Period Beginning:

01/01/15

Ending: 12/31/15

**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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Center Home Hispanic Elderly

# 0050989

Report Period Beginning:

01/01/15

Ending: 12/31/15

**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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Center Home Hispanic Elderly

# 0050989

Report Period Beginning:

01/01/15

Ending: 12/31/15

**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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Center Home Hispanic Elderly

# 0050989

Report Period Beginning:

01/01/15

Ending: 12/31/15

**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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

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**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										
										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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1										1									
2										2									
3										3									
4										4									
5										5									
<b>Working Capital</b>																			
6	MB Financial	X	Capital Expenditure			108,727			8,359	6									
7	MB Financial	X	Note Payable						5,266	7									
8	See Supplemental Schedule								2,131	8									
9	<b>TOTAL Facility Related</b>					\$ 108,727			\$ 15,756	9									
<b>B. Non-Facility Related*</b>																			
10	Interest Income	X							(291)	10									
11										11									
12										12									
13										13									
14	<b>TOTAL Non-Facility Related</b>					\$			\$ (291)	14									
15	<b>TOTALS (line 9+line14)</b>					\$ 108,727			\$ 15,465	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

Center Home Hispanic Elderly

# 0050989

Report Period Beginning:

01/01/15

Ending:

12/31/15

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE**

**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										
										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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1										1									
2										2									
3										3									
4										4									
5										5									
6										6									
7	<b>TOTAL Long-Term</b>									7									
<b>Working Capital</b>																			
8	<b>Allocated from Premier HC Realty</b>									8									
9										9									
10										10									
11										11									
12										12									
13										13									
14	<b>TOTAL Working Capital</b>									14									
<b>B. Non-Facility Related*</b>																			
15										15									
16										16									
17										17									
18										18									
19										19									
20	<b>TOTAL Non-Facility Related</b>									20									

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2014 report.		\$			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.)		\$	<b>182,878</b>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>182,878</b>		3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>10,106</b>		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. <b>TOTAL REFUND \$ <u>20,431</u> For <u>2011</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>192,984</b>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	<u>124,727</u>			8
	2011	<u>124,209</u>			9
	2012	<u>172,619</u>			10
	2013	<u>174,955</u>			11
	2014	<u>178,480</u>			12
<b>Beginning accrual adjusted because the facility does not accrue for real estate taxes as they do not own the building.</b>					
<b>Allocated from Premier HC Realty: \$4,399</b>					
<b>FOR BHF USE ONLY</b>					
	13	FROM R. E. TAX STATEMENT FOR 2014	\$		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.**





Facility Name & ID Number Center Home Hispanic Elderly

# 0050989

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**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 59,149 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

1. Total Amount Incurred: 23,088 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: 849 4. Dates Incurred: 2010

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	<u>Allocated from Premier HC Realty, LLC</u>			\$ <u>2,089</u>	1
2					2
3	<b>TOTALS</b>			\$ <b>2,089</b>	3

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Various		2011		266,944		20	14,394	14,394	45,778
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

\*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 Center Home Hispanic Elderly

# 0050989

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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	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68			122,041		5,113	2,130	20,852	68
69						(15,446)		69
70		\$	\$		\$	\$	\$	70
			388,985		19,507	1,078	66,630	

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

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## XI. OWNERSHIP COSTS (continued)

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

1	2	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	<b>Totals from Page 12A, Carried Forward</b>		\$ 388,985	\$ 18,429		\$ 19,507	\$ 1,078	\$ 66,630	1
2	Cabinetry	2012	2,500		20	125	125	385	2
3	Boiler Tubes	2012	9,075		20	454	454	1,399	3
4	Nurses Station Cabinetry, Storage, Laminate And Granite	2012	15,860		20	793	793	2,445	4
5	Sprinkler Work	2013	15,038		20	752	752	2,130	5
6	Boiler Work	2013	2,600		20	130	130	358	6
7	Outlets For Computers, Mechanical Timers, And Emergency Ligh	2013	3,295		20	659	659	1,702	7
8	Ironwork And Electrical, Overhead Rail, And Conduit	2013	3,590		20	180	180	464	8
9	Pave Lot	2013	23,945		20	1,596	1,596	4,124	9
10	Signage	2013	3,224		20	645	645	1,558	10
11	Boiler Work	2013	4,700		20	235	235	548	11
12	Brickwork, Window Trims, Coping	2013	66,000		20	3,300	3,300	7,150	12
13	Fire Pump	2013	2,750		20	138	138	298	13
14	Boiler Work	2013	3,000		20	150	150	313	14
15	Wiring - Not For Lighting	2013	3,728		20	746	746	1,864	15
16	Masonry	2013	131,750		20	6,588	6,588	19,214	16
17	Lift Floor To Ajaent Floor Level	2013	30,595		20	1,530	1,530	4,462	17
18	Baseboard Heaters	2013	2,743		20	137	137	411	18
19	Replace Wafer Style Check Valve In Therapy Room	2014	3,560		20	178	178	356	19
20	Condensate Pump	2014	12,900		20	645	645	1,236	20
21	Masonry Repair - Admissions Office Exterior	2014	10,400		20	520	520	953	21
22	Masonry Repair - Directly East Of Admissions Office	2014	2,500		20	125	125	229	22
23	Remove/Replace Sprinkler Heads (120)	2014	4,507		20	225	225	432	23
24	Masonry Repair - Northeast Corner	2014	29,820		20	1,491	1,491	2,982	24
25	Elevator Repairs - New Hostway Panel, Door Safety & Circuits, C	2014	23,480		20	1,174	1,174	1,859	25
26	Sprinkler System - Flanged Valve, Bypass Line, Alarm, Gaskets	2014	2,724		20	136	136	159	26
27	Rc Carpentry - Roof Waterproofing	2014	2,800		20	140	140	210	27
28	Xtreme Clean Carpet - Floor Restoration	2014	4,815		20	241	241	361	28
29	Rayes Boiler - Improvements To Boiler	2014	6,400		20	320	320	347	29
30	New Water Heater	2014	5,851		20	293	293	390	30
31	Labor & Materials For Boiler Leak	2015	3,750		20				31
32	Fabrication And Installation Of 2 15' Hoods	2015	7,500		20	281	281	281	32
33	Brick Work	2015	29,060		20				33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 863,445	\$ 18,429		\$ 43,432	\$ 25,003	\$ 125,251	34

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

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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		\$ 863,445	\$ 18,429		\$ 43,432	\$ 25,003	\$ 125,251	1
2	Brick Work	2015	9,180		20				2
3	Conference Room Rehab Flashing Between Roof & Elevator	2015	6,875		20				3
4	Steam Vacuum Pumps Overflow Scuppers	2015	9,350		20	117	117	117	4
5	Lower Level Office Repair Reframe Walls, Drywall, Flooring, Flo	2015	13,640		20				5
6	Boiler	2015	19,833		20	165	165	165	6
7	Security Camera Steps And Railing	2015	18,279		20	609	609	609	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	TOTAL (lines 1 thru 33)		\$ 940,602	\$ 18,429		\$ 44,323	\$ 25,894	\$ 126,142	34

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

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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		\$ 940,602	\$ 18,429		\$ 44,323	\$ 25,894	\$ 126,142	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 940,602	\$ 18,429		\$ 44,323	\$ 25,894	\$ 126,142	34

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

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		\$ 940,602	\$ 18,429		\$ 44,323	\$ 25,894	\$ 126,142
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
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22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 940,602	\$ 18,429		\$ 44,323	\$ 25,894	\$ 126,142

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

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	Building Company		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

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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		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
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22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$	\$		\$	\$	\$

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

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	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Premier HC Realty, LLC	2011	40,952	1,050	35	1,170	120	4,777	3
4	Allocated from Premier HC Realty, LLC	2012	5,214	134	35	149	15	596	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Premier HC Realty, LLC	2011	72,835	1,736	20	3,642	1,906	14,871	9
10	Allocated from Premier HC Realty, LLC	2012	2,111	54	20	106	52	422	10
11	Allocated from Premier HC & Financial Services	2012	929	9	20	46	37	186	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	TOTAL (lines 1 thru 33)		\$ 122,041	\$ 2,983		\$ 5,113	\$ 2,130	\$ 20,852	34

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

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		\$ 122,041	\$ 2,983		\$ 5,113	\$ 2,130	\$ 20,852	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 122,041	\$ 2,983		\$ 5,113	\$ 2,130	\$ 20,852	34

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

Facility Name & ID Number Center Home Hispanic Elderly

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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	\$ 215,898	\$ 44	\$ 37,807	\$ 37,763	10	\$ 142,473	71
72	Current Year Purchases	3,873	1,100	572	(528)	10	572	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 219,771	\$ 1,144	\$ 38,380	\$ 37,236		\$ 143,045	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)	\$ 1,162,462	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 19,573	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 82,703	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 63,130	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 269,187	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.

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**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Center Home Real Estate

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:	156		\$ 893,958			3
4	Additions						4
5							5
6							6
7	TOTAL	156		\$ 893,958			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: \_\_\_\_\_ \*

**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: \$ 3,243

Description: See Attached Schedule

(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

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. /2016 \$ \_\_\_\_\_

13. /2017 \$ \_\_\_\_\_

14. /2018 \$ \_\_\_\_\_

\* 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.

**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.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			592,332			592,332	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				76,175		76,175	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>					5,437	83,955		89,392	13
14	TOTAL			\$		\$ 597,769	\$ 160,130		\$ 757,899	14

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

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XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 42,359	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	2,610,197		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	334,088		6
7	Other Prepaid Expenses	17,536		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,004,180	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	738,500		15
16	Equipment, at Historical Cost	211,308		16
17	Accumulated Depreciation (book methods)	(661,651)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	398,069		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 686,226	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,690,406	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 1,037,180	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,447		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	399,311		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,073		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
<b>Other Current Liabilities(specify):</b>				
36	See Attached Schedule	97,411		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,557,422	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	108,727		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 108,727	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,666,149	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,024,257	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,690,406	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,755,366</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>	<b>Rounding</b>	<b>3</b>	<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,755,369</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>992,888</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(724,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>268,888</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>2,024,257</b>	<b>24</b> *

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

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**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**

1

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,660,891	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 9,660,891	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	303,138	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 303,138	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	291	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 291	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>See Supplemental Schedule</b>	265,639	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 265,639	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 10,229,959	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,541,724	31
32	Health Care	3,091,248	32
33	General Administration	2,300,889	33
<b>B. Capital Expense</b>			
34	Ownership	1,142,121	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	787,876	35
36	Provider Participation Fee	373,213	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 9,237,071	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	992,888	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 992,888	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 7,578,655	44
45	Private Pay - Net Inpatient Revenue	68,745	45
46	Medicare - Net Inpatient Revenue	1,396,766	46
47	Other-(specify) <u>Hospice</u>	474,502	47
48	Other-(specify) <u>Insurance</u>	142,223	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 9,660,891	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.

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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	1,616	1,775	\$ 74,423	\$ 41.93	1
2	Assistant Director of Nursing	2,282	2,516	85,214	33.87	2
3	Registered Nurses	17,248	19,613	549,620	28.02	3
4	Licensed Practical Nurses	34,227	39,260	943,401	24.03	4
5	CNAs & Orderlies	64,636	73,863	756,065	10.24	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,977	8,459	100,289	11.86	8
9	Activity Director	2,086	2,200	31,848	14.48	9
10	Activity Assistants	8,116	8,878	80,854	9.11	10
11	Social Service Workers	10,464	11,118	176,169	15.85	11
12	Dietician					12
13	Food Service Supervisor	1,968	2,392	46,225	19.32	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,609	23,681	244,236	10.31	15
16	Dishwashers					16
17	Maintenance Workers	3,347	3,707	78,652	21.22	17
18	Housekeepers	21,141	23,402	253,789	10.84	18
19	Laundry	9,147	9,899	114,860	11.60	19
20	Administrator	1,659	1,801	89,242	49.55	20
21	Assistant Administrator	110	120	4,038	33.65	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,257	11,371	164,445	14.46	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	3,786	4,204	63,219	15.04	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	220,676	248,259	\$ 3,856,589 *	\$ 15.53	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	356	\$ 16,744	01-03	35
36	Medical Director	Monthly	12,000	09-03	36
37	Medical Records Consultant	Monthly	4,704	10-03	37
38	Nurse Consultant	2,366	141,262	10-03	38
39	Pharmacist Consultant	Monthly	8,073	10-03	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	59	3,481	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,781	\$ 186,264		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses			50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53





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## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. ILCLTC \$25,120
- (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? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 25,245 Line 10-02
- (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. \$ 373,213  
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. \$ No 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% ln14  
d. Have vehicle usage logs been maintained? No  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees.