

		FOR BHF USE					

LL1

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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.

<p>I. IDPH License ID Number: <u>0053553</u></p> <p>Facility Name: <u>Central Nursing Home</u></p> <p>Address: <u>2450 N Central Ave</u> <u>Chicago</u> <u>60639</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(773) 889-1333</u> Fax # <u>(773) 889-1516</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>05/01/15</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input checked="" type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Sanford B. Alper</u> Telephone Number: <u>(847) 580-4100</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>05/01/2015</u> to <u>12/31/2015</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) _____ (Date) _____</td> </tr> <tr> <td rowspan="4" style="width: 20%; vertical-align: top;">Paid Preparer</td> <td>(Title) _____</td> </tr> <tr> <td>(Signed) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Sanford B. Alper</u> <u>Director</u></td> </tr> <tr> <td>(Firm Name & Address) <u>Kessler, Orlean, Silver & Company, P.C.</u> <u>1101 Lake Cook Road, Suite C, Deerfield IL 60015</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 580-4100</u> Fax # <u>(847) 580-4199</u></td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____ (Date) _____	Paid Preparer	(Title) _____	(Signed) _____	(Print Name and Title) <u>Sanford B. Alper</u> <u>Director</u>	(Firm Name & Address) <u>Kessler, Orlean, Silver & Company, P.C.</u> <u>1101 Lake Cook Road, Suite C, Deerfield IL 60015</u>		(Telephone) <u>(847) 580-4100</u> Fax # <u>(847) 580-4199</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																	
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																	
<input type="checkbox"/> Trust	<input checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County																																	
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																																	
	<input type="checkbox"/> "Sub-S" Corp.																																		
	<input type="checkbox"/> Limited Liability Co.																																		
	<input type="checkbox"/> Trust																																		
	<input type="checkbox"/> Other _____																																		
Officer or Administrator of Provider	(Signed) _____																																		
	(Type or Print Name) _____ (Date) _____																																		
Paid Preparer	(Title) _____																																		
	(Signed) _____																																		
	(Print Name and Title) <u>Sanford B. Alper</u> <u>Director</u>																																		
	(Firm Name & Address) <u>Kessler, Orlean, Silver & Company, P.C.</u> <u>1101 Lake Cook Road, Suite C, Deerfield IL 60015</u>																																		
	(Telephone) <u>(847) 580-4100</u> Fax # <u>(847) 580-4199</u>																																		

Facility Name & ID Number Central Nursing Home

0053553 Report Period Beginning: 05/01/2015 Ending: 12/31/2015

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 245

	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	245	Skilled (SNF)	245	60,025	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	245	TOTALS	245	60,025	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	51,260	121	4,185	55,566	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	51,260	121	4,185	55,566	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.57%

D. How many bed-hold days during this year were paid by the Department?

0 (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)

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

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 05/01/2015

J. Was the facility purchased or leased after January 1, 1978?

YES Date 01/01/2015 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 245 and days of care provided 3,295

Medicare Intermediary Wisconsin Physicans Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number Central Nursing Home # 0053553 Report Period Beginning: 05/01/2015 Ending: 12/31/2015

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
	A. General Services										
1	Dietary	167,050	14,073	10,421	191,544		191,544	18,950	210,494		1
2	Food Purchase		203,676		203,676	(27,481)	176,195	22	176,217		2
3	Housekeeping	143,255	21,732		164,987		164,987		164,987		3
4	Laundry		7,539		7,539		7,539		7,539		4
5	Heat and Other Utilities			127,728	127,728		127,728	6,554	134,282		5
6	Maintenance	22,739	33,267		56,006		56,006	372,654	428,660		6
7	Other (specify):* Attached Schedule			52,455	52,455		52,455	187	52,642		7
8	TOTAL General Services	333,044	280,287	190,604	803,935	(27,481)	776,454	398,367	1,174,821		8
	B. Health Care and Programs										
9	Medical Director			1,000	1,000		1,000		1,000		9
10	Nursing and Medical Records	1,520,611	69,461	73,431	1,663,503		1,663,503		1,663,503		10
10a	Therapy	7,800		457,148	464,948		464,948		464,948		10a
11	Activities	51,829	48,651	17,700	118,180		118,180		118,180		11
12	Social Services	77,436		86,501	163,937		163,937		163,937		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,657,676	118,112	635,780	2,411,568		2,411,568		2,411,568		16
	C. General Administration										
17	Administrative	55,269		844,710	899,979		899,979	(203,431)	696,548		17
18	Directors Fees										18
19	Professional Services			79,147	79,147		79,147	10,613	89,760		19
20	Dues, Fees, Subscriptions & Promotions			2,890	2,890		2,890	3,872	6,762		20
21	Clerical & General Office Expenses	67,752		289,762	357,514		357,514	(132,060)	225,454		21
22	Employee Benefits & Payroll Taxes			531,217	531,217	27,481	558,698	71,254	629,952		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,320	1,320		1,320	95	1,415		24
25	Other Admin. Staff Transportation			870	870		870	262	1,132		25
26	Insurance-Prop.Liab.Malpractice			127,388	127,388		127,388	27,316	154,704		26
27	Other (specify):*										27
28	TOTAL General Administration	123,021		1,877,304	2,000,325	27,481	2,027,806	(222,079)	1,805,727		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,113,741	398,399	2,703,688	5,215,828		5,215,828	176,288	5,392,116		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Central Nursing Home

#0053553

Report Period Beginning:

05/01/2015

Ending:

12/31/2015

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			147,034	147,034		147,034	154,032	301,066			30
31	Amortization of Pre-Op. & Org.							975,216	975,216			31
32	Interest			58,360	58,360		58,360	621,237	679,597			32
33	Real Estate Taxes							228,369	228,369			33
34	Rent-Facility & Grounds			1,184,957	1,184,957		1,184,957	(1,184,696)	261			34
35	Rent-Equipment & Vehicles			1,768	1,768		1,768	186	1,954			35
36	Other (specify):*											36
37	TOTAL Ownership			1,392,119	1,392,119		1,392,119	794,344	2,186,463			37
	Ancillary Expense											
	E. Special Cost Centers											
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			406,496	406,496		406,496		406,496			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			406,496	406,496		406,496		406,496			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,113,741	398,399	4,502,303	7,014,443		7,014,443	970,632	7,985,075			45

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

Central Nursing Home

ID# 0053553

Report Period Beginning: 05/01/2015

Ending: 12/31/2015

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Sales Taxes (Management Company)	\$ (162)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(162)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Central Nursing Home# 0053553

Report Period Beginning:

05/01/2015

Ending:

12/31/2015

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	0	0	18,950	0	0	0	0	0	0	0	0	18,950	1
2	Food Purchase	(140)	0	162	0	0	0	0	0	0	0	0	22	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	6,554	0	0	0	0	0	0	0	0	0	6,554	5
6	Maintenance	0	898	371,756	0	0	0	0	0	0	0	0	372,654	6
7	Other (specify):*	0	35	152	0	0	0	0	0	0	0	0	187	7
8	TOTAL General Services	(140)	7,487	391,020	0	0	0	0	0	0	0	0	398,367	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(203,431)	0	0	0	0	0	0	0	0	(203,431)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	8,586	2,027	0	0	0	0	0	0	0	10,613	19
20	Fees, Subscriptions & Promotions	0	3,625	247	0	0	0	0	0	0	0	0	3,872	20
21	Clerical & General Office Expenses	(256,317)	6,667	117,590	0	0	0	0	0	0	0	0	(132,060)	21
22	Employee Benefits & Payroll Taxes	0	56,856	14,398	0	0	0	0	0	0	0	0	71,254	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	95	0	0	0	0	0	0	0	0	95	24
25	Other Admin. Staff Transportation	0	29	233	0	0	0	0	0	0	0	0	262	25
26	Insurance-Prop.Liab.Malpractice	0	1,652	0	25,664	0	0	0	0	0	0	0	27,316	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(256,317)	68,829	(62,282)	27,691	0	(222,079)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(256,457)	76,316	328,738	27,691	0	176,288	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Central Nursing Home# 0053553

Report Period Beginning:

05/01/2015

Ending:

12/31/2015

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	6,581	147,451	0	0	0	0	0	0	0	154,032	30
31	Amortization of Pre-Op. & Org.	0	0	0	975,216	0	0	0	0	0	0	0	975,216	31
32	Interest	0	0	(3)	621,240	0	0	0	0	0	0	0	621,237	32
33	Real Estate Taxes	0	0	0	228,369	0	0	0	0	0	0	0	228,369	33
34	Rent-Facility & Grounds	0	16,916	(16,916)	(1,184,696)	0	0	0	0	0	0	0	(1,184,696)	34
35	Rent-Equipment & Vehicles	0	0	186	0	0	0	0	0	0	0	0	186	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	16,916	(10,152)	787,580	0	0	0	0	0	0	0	794,344	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(256,457)	93,232	318,586	815,271	0	0	0	0	0	0	0	970,632	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
Marvin Mermelstein	45.00	Winston Manor Nursing Home	Chicago	Nivram Mng, Inc.	Lincolnwood	Management
Joseph Mermelstein	45.00	Balmoral Home, Inc.	Chicago			
Marvin Mermelstein Family Trust	5.00	Chicago Ridge Nursing Center	Chicago Ridge			
Joseph Mermelstein Family Trust	5.00					

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)		
1	V	25 Auto Expense	\$	Nivram Management, Inc.	100.00%	\$ 29	\$	29	1
2	V	20 Advertising		Nivram Management, Inc.	100.00%	565		565	2
3	V	21 Bank Charges		Nivram Management, Inc.	100.00%	32		32	3
4	V	6 Repair & Maintenance		Nivram Management, Inc.	100.00%	898		898	4
5	V	5 Utilities		Nivram Management, Inc.	100.00%	6,554		6,554	5
6	V	21 Donations		Nivram Management, Inc.	100.00%	1,339		1,339	6
7	V	21 Office Expense		Nivram Management, Inc.	100.00%	5,248		5,248	7
8	V	20 Dues & Subscriptions		Nivram Management, Inc.	100.00%	3,060		3,060	8
9	V	7 Exterminating		Nivram Management, Inc.	100.00%	35		35	9
10	V	21 Taxes - Other		Nivram Management, Inc.	100.00%	48		48	10
11	V	22 Payroll Taxes		Nivram Management, Inc.	100.00%	56,856		56,856	11
12	V	34 Rent		Nivram Management, Inc.	100.00%	16,916		16,916	12
13	V	26 Insurance		Nivram Management, Inc.	100.00%	1,652		1,652	13
14	Total		\$			\$ 93,232	\$ *	93,232	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	22 Health Insurance	\$	Nivram Management, Inc.	100.00%	\$ 14,398	\$	14,398	15
16	V	7 Scavenger		Nivram Management, Inc.	100.00%	152		152	16
17	V	35 Rental Equipment		Nivram Management, Inc.	100.00%	186		186	17
18	V	21 Miscellaneous		Nivram Management, Inc.	100.00%	479		479	18
19	V	21 Postage		Nivram Management, Inc.	100.00%	964		964	19
20	V	2 Sales Expense		Nivram Management, Inc.	100.00%	162		162	20
21	V	20 Licenses & Permits		Nivram Management, Inc.	100.00%	247		247	21
22	V	25 Travel		Nivram Management, Inc.	100.00%	233		233	22
23	V	30 Depreciation		Nivram Management, Inc.	100.00%	569		569	23
24	V	21 Data Processing		Nivram Management, Inc.	100.00%	1,430		1,430	24
25	V	19 Outside Services		Nivram Management, Inc.	100.00%	8,586		8,586	25
26	V	24 Seminars		Nivram Management, Inc.	100.00%	95		95	26
27	V	6 Plant Supervisor Salary		Nivram Management, Inc.	100.00%	371,756		371,756	27
28	V	17 Asst. Administrator Salary		Nivram Management, Inc.	100.00%	557,634		557,634	28
29	V	21 Office Manager Salary		Nivram Management, Inc.	100.00%	30,643		30,643	29
30	V	1 Food Service Supervisor		Nivram Management, Inc.	100.00%	18,950		18,950	30
31	V	17 Administrative Salaries		Nivram Management, Inc.	100.00%	83,645		83,645	31
32	V	21 Clerical Salaries		Nivram Management, Inc.	100.00%	83,993		83,993	32
33	V	17 Management Fees	844,710	Nivram Management, Inc.	100.00%			(844,710)	33
34	V	34 Rental Income	16,916	Hamlin Arthur Building Partnership	100.00%			(16,916)	34
35	V	32 Interest Income	3	Hamlin Arthur Building Partnership	100.00%			(3)	35
36	V	21 Bank Fees		Hamlin Arthur Building Partnership	100.00%	81		81	36
37	V	30 Depreciation		Hamlin Arthur Building Partnership	100.00%	6,012		6,012	37
38	V								38
39	Total		\$ 861,629			\$ 1,180,215	\$ *	318,586	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	19 Legal Fees	\$	Hamlin Arthur Building Partnership	100.00%	\$ 2,027	\$	2,027	15
16	V	33 Real Estate Taxes		Hamlin Arthur Building Partnership	100.00%	10,982		10,982	16
17	V	34 Rental Income	1,184,696	Novo Investors, LLC	100.00%			(1,184,696)	17
18	V	32 Interest Income	385	Novo Investors, LLC	100.00%			(385)	18
19	V	33 Real Estate Taxes		Novo Investors, LLC	100.00%	217,387		217,387	19
20	V	26 Insurance Expense		Novo Investors, LLC	100.00%	25,664		25,664	20
21	V	32 Interest Expense		Novo Investors, LLC	100.00%	621,625		621,625	21
22	V	30 Depreciation Expense		Novo Investors, LLC	100.00%	147,451		147,451	22
23	V	31 Amortization Expense		Novo Investors, LLC	100.00%	975,216		975,216	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 1,185,081			\$ 2,000,352	\$ *	815,271	39

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

Facility Name & ID Number

Central Nursing Home

#

0053553

Report Period Beginning:

05/01/2015

Ending:

12/31/2015

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	Henry Mermelstein	Administrative Asst.	Administrative	0.00	187,500	13	33.33	Salary	\$ 62,500	17-7	1
2	Louise Mermelstein	Food Serv Superv	Support	0.00	56,849	6	33.33	Salary	18,950	1-7	2
3	Marvin Mermelstein	Plant Supervisor	Support	50.00	946,840	6	34.13	Salary	371,756	6-7	3
4	Doreen Mermelstein	Office Manager	Administrative	0.00	91,927	13	33.33	Salary	30,643	21-7	4
5											5
6	Marvin Mermelstein	Administrative Asst.	Administrative	See Above	1,420,261	9	34.13	Salary	557,634	17-7	6
7	Joseph Mermelstein	Owner	Administrative	50.00	56,617	4	34.13	Salary	21,145	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,062,628		13

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

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

Facility Name & ID Number Central Nursing Home# 0053553

Report Period Beginning:

05/01/2015Ending: 2/31/2015

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

Name of Related Organization

Nivram Management, Inc.

Street Address

6500 N. Hamlin Avenue

City / State / Zip Code

Lincolnwood, IL 60712

Phone Number

(847) 679-7484

Fax Number

(847) 679-7494

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	25	Auto Expense	Resident Beds	869	4	\$ 103	\$ 245	\$ 29	1
2	20	Advertising	Resident Beds	869	4	2,005	245	565	2
3	21	Bank Charges	Resident Beds	869	4	115	245	32	3
4	6	Repairs & Maintenance	Resident Beds	869	4	3,185	245	898	4
5	5	Utilities	Resident Beds	869	4	23,242	245	6,553	5
6	21	Donations	Resident Beds	869	4	4,750	245	1,339	6
7	21	Office Expense	Resident Beds	869	4	18,613	245	5,248	7
8	20	Dues & Subscriptions	Resident Beds	869	4	10,853	245	3,060	8
9	7	Exterminating	Resident Beds	869	4	125	245	35	9
10	21	Taxes - Other	Resident Beds	869	4	172	245	48	10
11	22	Payroll Taxes	Resident Beds	869	4	201,663	245	56,856	11
12	34	Rent	Resident Beds	869	4	60,000	245	16,916	12
13	26	Insurance	Resident Beds	869	4	5,861	245	1,652	13
14	22	Health Insurance	Resident Beds	869	4	51,068	245	14,398	14
15	7	Scavenger	Resident Beds	869	4	540	245	152	15
16	35	Rental Equipment	Resident Beds	869	4	660	245	186	16
17	21	Miscellaneous	Resident Beds	869	4	1,690	245	476	17
18	21	Postgage	Resident Beds	869	4	3,418	245	964	18
19	2	Sales Expense	Resident Beds	869	4	576	245	162	19
20	20	Licenses & Permits	Resident Beds	869	4	877	245	247	20
21	25	Travel	Resident Beds	869	4	827	245	233	21
22	30	Depreciation	Resident Beds	869	4	2,019	245	569	22
23	21	Data Processing	Resident Beds	869	4	5,073	245	1,430	23
24	19	Outside Services	Resident Beds	869	4	30,453	245	8,586	24
25	TOTALS					\$ 427,888	\$	\$ 120,634	25

Facility Name & ID Number Central Nursing Home

0053553

Report Period Beginning:

05/01/2015

Ending: 2/31/2015

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 Nivram Management, Inc.
 Street Address 6500 N. Hamlin Avenue
 City / State / Zip Code Lincolnwood, IL 60712
 Phone Number (847) 679-7484
 Fax Number (847) 679-7494

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	24	Seminars	Resident Beds	869	4	\$ 338	\$ 245	\$ 95	1
2	6	Plant Supervisor Salary	Direct Cost	1	1	371,756	371,756	1	371,756
3	17	Asst. Administrator Salary	Direct Cost	1	1	557,634	557,634	1	557,634
4	21	Office Manager Salary	Direct Cost	1	1	30,643	30,643	1	30,643
5	1	Food Service Supervisor	Direct Cost	1	1	18,950	18,950	1	18,950
6	17	Administrative Salaries	Direct Cost	1	1	83,645	83,645	1	83,645
7	21	Clerical Salaries	Direct Cost	1	1	83,993		1	83,993
8	21	Bank Fees	Direct Cost	869	4	288	245	81	8
9	30	Depreciation	Direct Cost	869	4	21,325	245	6,012	9
10	19	Legal Fees	Direct Cost	869	4	7,190	245	2,027	10
11	33	Real Estate Taxes	Direct Cost	869	4	38,951	245	10,982	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					\$ 1,214,713	\$ 1,062,628	\$ 1,165,818	25

Facility Name & ID Number

Central Nursing Home

0053553

Report Period Beginning:

05/01/2015

Ending:

12/31/2015

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	Capital One Commercial		X	Mortgage	\$100,282.00	05/01/15	\$ 20,711,110	\$ 20,492,623	09/01/2044	4.0200	\$ 621,625	1								
2	Central Nursing and Rehab		X	Purchase - Finance	N/A	05/01/15	861,758	251,706	04/30/2017	6.0000	51,706	2								
3												3								
4												4								
5												5								
Working Capital																				
6	Marvin Mermelstein	X		Working Capital	N/A	05/31/15	450,000		N/A	3.2500	6,654	6								
7												7								
8												8								
9	TOTAL Facility Related				\$100,282.00		\$ 22,022,868	\$ 20,744,329			\$ 679,985	9								
B. Non-Facility Related*																				
10	Offset Against Int Inc										(385)	10								
11	Offset Against Int Inc										(3)	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (388)	14								
15	TOTALS (line 9+line14)						\$ 22,022,868	\$ 20,744,329			\$ 679,597	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 9,312 Line # 26

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

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

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.

1. Real Estate Tax accrual used on 2014 report.		\$	157,613	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.)		\$	10,982	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(146,631)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	375,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	228,369	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2010	<u>334,779</u>	<u>8</u>	
	2011	<u>333,386</u>	<u>9</u>	
	2012	<u>369,186</u>	<u>10</u>	
	2013	<u>345,745</u>	<u>11</u>	
	2014	<u>352,710</u>	<u>12</u>	
\$157,613 - Real Estate Tax Accrual, represent credit received at the time of the purchase of the Central Nursing Home				
				FOR BHF USE ONLY
	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Central Nursing Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053553

CONTACT PERSON REGARDING THIS REPORT Sanford B. Alper

TELEPHONE (847) 580-4100 FAX #: (847) 580-4199

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2014 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 2014.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>Attached Schedule</u>	<u>Nursing Home</u>	\$ <u>352,709.94</u>	\$ <u>352,709.94</u>
2. <u>10-35-325-029-0000</u>	<u>Management Company</u>	\$ <u>4,246.74</u>	\$ <u>1,029.68</u>
3. <u>10-35-325-015-0000</u>	<u>Management Company</u>	\$ <u>41,045.43</u>	\$ <u>9,951.98</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>398,002.11</u></u>	\$ <u><u>363,691.60</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

Facility Name & ID Number Central Nursing Home

0053553 Report Period Beginning:

05/01/2015 Ending:

12/31/2015

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (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).

N/A

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: _____ 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	<u>Nursing Home</u>	<u>30,000</u>	<u>2015</u>	<u>\$ 500,000</u>	1
2					2
3	TOTALS	30,000		\$ 500,000	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	245	2015	1973	\$ 6,168,927	\$ 103,879	39	\$ 103,879	\$	\$ 103,879
5									
6									
7									
8									
Improvement Type**									
9	Cooled Chiller Unit		2015	92,000	5,476	7	5,476		5,476
10	Time Clock Reader		2015	2,574	47	27.5	47		47
11	HVAC Unit		2015	4,227	201	7	201		201
12	Compressor		2015	8,500	103	27.5	103		103
13	New Doors		2015	5,201	16	27.5	16		16
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

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								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 6,281,429	\$ 109,722		\$ 109,722	\$	\$ 109,722	70

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

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	\$	\$	\$	\$		\$	71
72	Current Year Purchases	<u>1,106,000</u>	<u>146,667</u>	<u>146,667</u>		<u>5-7</u>	<u>146,667</u>	72
73	Fully Depreciated Assets							73
74	<u>Novo Investments</u>		<u>38,096</u>	<u>38,096</u>		<u>5</u>		74
75	TOTALS	\$ <u>1,106,000</u>	\$ <u>184,763</u>	\$ <u>184,763</u>	\$		\$ <u>146,667</u>	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)	\$ 7,887,429	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 294,485	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 294,485	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 256,389	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Central Nursing Home

0053553

Report Period Beginning: 05/01/2015

Ending: 12/31/2015

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Novo Investors, LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning 05/01/2015

Ending 05/01/2035

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	<u>12/31/2016</u>	\$ <u>1,777,044</u>
13.	<u>12/31/2017</u>	\$ <u>1,777,044</u>
14.	<u>12/31/2018</u>	\$ <u>1,777,044</u>

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: \$ 1,954 Description: Ice Maker - \$741; Postal Machine - \$485; Copier - \$542; Copier - \$186

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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			
		1	2	3	4
		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.)

	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		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$		\$	\$		\$	14

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

Facility Name & ID Number Central Nursing Home

0053553

Report Period Beginning: 05/01/2015

Ending:

12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,212,822	\$ 1,245,228	1
2	Cash-Patient Deposits	118,168	118,168	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,743,068	1,743,068	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	124,400	235,006	6
7	Other Prepaid Expenses	60	60	7
8	Accounts Receivable (owners or related parties)	8,492		8
9	Other(specify): <u>Attached Schedule</u>		637,468	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,207,010	\$ 3,978,998	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		500,000	13
14	Buildings, at Historical Cost		6,168,927	14
15	Leasehold Improvements, at Historical Cost	20,502	20,502	15
16	Equipment, at Historical Cost	1,106,000	1,391,718	16
17	Accumulated Depreciation (book methods)	(147,034)	(294,485)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Goodwill</u>)		13,653,027	22
23	Other(specify): <u>Deposits</u>	2,300	2,300	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 981,768	\$ 21,441,989	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,188,778	\$ 25,420,987	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 314,020	\$ 314,020	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	44,305	44,305	28
29	Short-Term Notes Payable	303,923	303,923	29
30	Accrued Salaries Payable	114,430	114,430	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		375,000	32
33	Accrued Interest Payable		68,650	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	2,635	2,635	35
	Other Current Liabilities(specify):			
36	<u>Attached Schedule</u>	1,123,158	1,123,158	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,902,471	\$ 2,346,121	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		20,492,623	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 20,492,623	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,902,471	\$ 22,838,744	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,286,307	\$ 2,582,243	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,188,778	\$ 25,420,987	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,197,481	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Contributions	88,826	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 2,286,307	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,286,307	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Central Nursing Home

0053553

Report Period Beginning: 05/01/2015

Ending: 12/31/2015

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,938,111	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,938,111	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	262,573	6
7	Oxygen	364	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 262,937	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,531	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,531	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	11,980	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,980	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,214,559	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	833,755	31
32	Health Care	2,365,335	32
33	General Administration	2,016,738	33
B. Capital Expense			
34	Ownership	1,392,119	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	406,496	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,014,443	40
41	Income before Income Taxes (line 30 minus line 40)**	2,200,116	41
42	Income Taxes	(2,635)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,197,481	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

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

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

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

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

Facility Name & ID Number Central Nursing Home

0053553

Report Period Beginning:

05/01/2015

Ending:

12/31/2015

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	1,400	1,592	\$ 78,009	\$ 49.00	1
2	Assistant Director of Nursing	1,351	1,461	48,599	33.26	2
3	Registered Nurses	27,174	29,002	820,394	28.29	3
4	Licensed Practical Nurses	3,672	4,076	88,984	21.83	4
5	CNAs & Orderlies	35,060	39,755	419,588	10.55	5
6	CNA Trainees					6
7	Licensed Therapist	304	312	7,800	25.00	7
8	Rehab/Therapy Aides	3,580	3,929	45,734	11.64	8
9	Activity Director	931	938	13,373	14.26	9
10	Activity Assistants	3,541	3,875	38,456	9.92	10
11	Social Service Workers	4,377	4,600	77,436	16.83	11
12	Dietician					12
13	Food Service Supervisor	2,108	2,166	46,207	21.33	13
14	Head Cook	1,448	1,614	28,380	17.58	14
15	Cook Helpers/Assistants	7,693	8,608	92,463	10.74	15
16	Dishwashers					16
17	Maintenance Workers	1,249	1,435	22,739	15.85	17
18	Housekeepers	11,879	12,758	143,255	11.23	18
19	Laundry					19
20	Administrator	1,347	1,347	55,269	41.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	488	488	8,212	16.83	23
24	Clerical	4,814	5,205	59,540	11.44	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	1,479	1,556	19,303	12.41	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	113,895	124,717	\$ 2,113,741 *	\$ 16.95	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	M	\$ 10,421	1-3	35
36	Medical Director	O	1,000	9-3	36
37	Medical Records Consultant	N			37
38	Nurse Consultant	T			38
39	Pharmacist Consultant	H	73,431	10-3	39
40	Physical Therapy Consultant	L	457,148	10a-3	40
41	Occupational Therapy Consultant	Y			41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	F			43
44	Activity Consultant	E	17,700	11-3	44
45	Social Service Consultant	E	86,501	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 646,201		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Philip Morganstein	Administrator	0.00	\$ 55,269	Workers' Compensation Insurance	\$ 122,011	IDPH License Fee	\$	
				Unemployment Compensation Insurance	39,914	Advertising: Employee Recruitment	1,110	
				FICA Taxes	170,901	Health Care Worker Background Check (Indicate # of checks performed)		
				Employee Health Insurance	181,071	Patient Background Checks	135 1,350	
				Employee Meals	27,481	Licenses & Permits	430	
				Illinois Municipal Retirement Fund (IMRF)*		Allocation from Management Company	3,872	
				Employee Dental Insurance	603			
				Other Employee Benefits	831			
				Employee Union Pension	15,886			
				Allocation from Management Company	71,254			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 55,269					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount		\$ 629,952	Less: Public Relations Expense	()	
Management Fees			\$ 844,710			Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 844,710					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Attached Schedule			\$ 79,147				Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	1,320
							Allocation from Management Company	95
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 79,147	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,415

* Attach copy of IMRF notifications

**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? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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? 5-7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line N/A
- (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. \$ 406,496
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? Yes 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? N/A
- (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. \$ 27,481 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? N/A 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? No
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? 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