

Facility Name & ID Number Little Village Nursing & Rehab Center

0054643 Report Period Beginning: 01/01/18 Ending: 12/31/18

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	14	Skilled (SNF)	14	5,110	1
2		Skilled Pediatric (SNF/PED)			2
3	92	Intermediate (ICF)	92	33,580	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,690	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	1,771		2,826	4,597	8
9	SNF/PED					9
10	ICF	30,211			30,211	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,982		2,826	34,808	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.97%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
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 08/01/17

J. Was the facility purchased or leased after January 1, 1978?
YES Date 08/01/17 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 14 and days of care provided 2,804

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/18 Fiscal Year: 12/31/18

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Little Village Nursing & Rehab Center # 0054643 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	260,871	21,575	7,283	289,729		289,729		289,729		1
2	Food Purchase		170,874		170,874		170,874		170,874		2
3	Housekeeping	219,357	23,171	147	242,675		242,675		242,675		3
4	Laundry	27,448	9,312		36,760		36,760		36,760		4
5	Heat and Other Utilities			117,316	117,316		117,316		117,316		5
6	Maintenance	42,274		94,654	136,928		136,928		136,928		6
7	Other (specify):* See Supplemental	71,165			71,165		71,165		71,165		7
8	TOTAL General Services	621,115	224,932	219,400	1,065,447		1,065,447		1,065,447		8
	B. Health Care and Programs										
9	Medical Director			11,118	11,118		11,118		11,118		9
10	Nursing and Medical Records	1,410,482	58,097	48,844	1,517,423		1,517,423		1,517,423		10
10a	Therapy	124,313			124,313		124,313		124,313		10a
11	Activities	131,568	14,482		146,050		146,050		146,050		11
12	Social Services	137,279	11,107	13,764	162,150		162,150		162,150		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* See Supplemental										15
16	TOTAL Health Care and Programs	1,803,642	83,686	73,726	1,961,054		1,961,054		1,961,054		16
	C. General Administration										
17	Administrative	107,124		181,570	288,694		288,694		288,694		17
18	Directors Fees										18
19	Professional Services			200,039	200,039		200,039	(960)	199,079		19
20	Dues, Fees, Subscriptions & Promotions			54,096	54,096		54,096	(7,789)	46,307		20
21	Clerical & General Office Expenses	282,274	3,225	418,346	703,845		703,845	(382,661)	321,184		21
22	Employee Benefits & Payroll Taxes			456,786	456,786		456,786		456,786		22
23	Inservice Training & Education			859	859		859		859		23
24	Travel and Seminar			2,654	2,654		2,654		2,654		24
25	Other Admin. Staff Transportation			11,625	11,625		11,625		11,625		25
26	Insurance-Prop.Liab.Malpractice			118,270	118,270		118,270		118,270		26
27	Other (specify):* See Supplemental										27
28	TOTAL General Administration	389,398	3,225	1,444,245	1,836,868		1,836,868	(391,410)	1,445,458		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,814,155	311,843	1,737,371	4,863,369		4,863,369	(391,410)	4,471,959		29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Little Village Nursing & Rehab Center
 Medicaid Cost Report
 01/01/18 - 12/31/18

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 7 - Other General Services				
Security	71,165			71,165
				-
				-
				-
				-
				-
Sub-Total	<u>71,165</u>	<u>-</u>	<u>-</u>	<u>71,165</u>
Line 15 - Other Health Care Services				
				-
				-
				-
				-
				-
				-
Sub-Total	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
Line 27 - Other General Administration				
				-
				-
				-
				-
				-
				-
Sub-Total	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>

Facility Name & ID Number Little Village Nursing & Rehab Center

#0054643

Report Period Beginning:

01/01/18

Ending:

12/31/18

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			2,489	2,489	2,489		2,489			30
31	Amortization of Pre-Op. & Org.			2,423	2,423	2,423	(2,423)				31
32	Interest			49,802	49,802	49,802	(7,421)	42,381			32
33	Real Estate Taxes			179,592	179,592	179,592		179,592			33
34	Rent-Facility & Grounds			525,896	525,896	525,896		525,896			34
35	Rent-Equipment & Vehicles			14,863	14,863	14,863		14,863			35
36	Other (specify):* See Supplemental										36
37	TOTAL Ownership			775,065	775,065	775,065	(9,844)	765,221			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		85,368	403,939	489,307	489,307		489,307			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			258,085	258,085	258,085		258,085			42
43	Other (specify):* See Supplemental										43
44	TOTAL Special Cost Centers		85,368	662,024	747,392	747,392		747,392			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,814,155	397,211	3,174,460	6,385,826	6,385,826	(401,254)	5,984,572			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Little Village Nursing & Rehab Center
 Medicaid Cost Report
 01/01/18 - 12/31/18

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 36 - Other Capital Costs				
				-
				-
				-
				-
				-
				-
				-
Sub-Total	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
Line 43 - Other Special Cost Centers				
				-
				-
				-
				-
				-
				-
				-
Sub-Total	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>

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				9
10	Interest and Other Investment Income	(7,421)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,340)	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	(375,521)	21		24
25	Fund Raising, Advertising and Promotional	(7,789)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Supplemental	(8,183)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (401,254)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (401,254)		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' PREPARATION REPORT

Little Village Nursing & Rehab Center

ID# 0054643

Report Period Beginning: 01/01/18

Ending: 12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Other Income	\$ (150)	21	1
2	Other Professional	(960)	19	2
3	Bank Charges	(4,650)	21	3
4	Amortization	(2,423)	31	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	(8,183)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Little Village Nursing & Rehab Center

0054643

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

	Operating Expenses	PAGES	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	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(960)	0	0	0	0	0	0	0	0	0	0	(960)	19
20	Fees, Subscriptions & Promotions	(7,789)	0	0	0	0	0	0	0	0	0	0	(7,789)	20
21	Clerical & General Office Expenses	(382,661)	0	0	0	0	0	0	0	0	0	0	(382,661)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(391,410)	0	0	0	0	0	0	0	0	0	0	(391,410)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(391,410)	0	0	0	0	0	0	0	0	0	0	(391,410)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Little Village Nursing & Rehab Center # 0054643 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	(2,423)	0	0	0	0	0	0	0	0	0	0	(2,423)	31
32	Interest	(7,421)	0	0	0	0	0	0	0	0	0	0	(7,421)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(9,844)	0	0	0	0	0	0	0	0	0	0	(9,844)	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)	(401,254)	0	0	0	0	0	0	0	0	0	0	(401,254)	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 Page 6 - Supp		See Page 6 - Supp		See Page 6 - Supp		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	Total		\$			\$	\$ *		14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Little Village Nursing & Rehab Center

0054643

Report Period Beginning:

01/01/18

Ending:

12/31/18

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Rita Lipshitz	20.00%	Aperion Care Wilmington	Wilmington, IL	Jade Financial		Mgmt. Company	1
2	David Mashiach	40.00%	Tri-State Village Nursing & Rehab	Lansing, IL				2
3	Jake Mashiach	40.00%	Wheaton Village Nursing & Rehab	Wheaton, IL				3
4			Kensington Place Nursing & Rehab	Chicago, IL				4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

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	17 Management Fees	\$ 181,570	Jade Financial Services, LLC	100.00%	\$ 181,570	\$	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	Total		\$ 181,570			\$ 181,570	\$ *	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Little Village Nursing & Rehab Center # 0054643 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Little Village Nursing & Rehab Center

0054643

Report Period Beginning:

01/01/18

Ending: 12/31/18

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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Little Village Nursing & Rehab Center

0054643

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Jade Financial Services, LLC

Street Address

2320 South Lawndale Avenue

City / State / Zip Code

Chicago, Illinois 60623

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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Little Village Nursing & Rehab Center # 0054643 Report Period Beginning: 01/01/18 Ending: 12/31/18

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						\$	\$			\$	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6	HFG	X	Line of Credit				450,000			49,802	6									
7											7									
8											8									
9	TOTAL Facility Related					\$	\$ 450,000			\$ 49,802	9									
B. Non-Facility Related*																				
10											10									
11											11									
12	Interest Income	X								(7,421)	12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$ (7,421)	14									
15	TOTALS (line 9+line14)					\$	\$ 450,000			\$ 42,381	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # 36 - 03

* 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' PREPARATION 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

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 2017 report.	\$	<u>167,859</u>	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.)	\$	<u>169,488</u>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<u>1,629</u>	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<u>177,963</u>	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.	\$	<u>179,592</u>	7

Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2013	_____	8
	2014	_____	9
	2015	_____	10
	2016	_____	11
	2017	<u>169,488</u>	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2017	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

Accrued Real Estate Taxes = \$169,488 * 1.05 = \$177,963

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.

SEE ACCOUNTANTS' PREPARATION REPORT

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Little Village Nursing & Rehab Center COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0054643
 CONTACT PERSON REGARDING THIS REPORT Edward N. Slack, CPA
 TELEPHONE (847) 628 - 8796 FAX #: (248) 327 - 8417

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 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 2017.

(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>16 - 26 - 105 - 075 - 0000</u>	<u>Long Term Care Facility</u>	\$ <u>40,525.61</u>	\$ <u>40,525.61</u>
2. <u>16 - 26 - 105 - 079 - 0000</u>	<u>Long Term Care Facility</u>	\$ <u>64,425.73</u>	\$ <u>64,425.73</u>
3. <u>16 - 26 - 105 - 080 - 0000</u>	<u>Long Term Care Facility</u>	\$ <u>64,536.83</u>	\$ <u>64,536.83</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>169,488.17</u></u>	\$ <u><u>169,488.17</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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (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).

Blank lines for listing other business entities.

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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for row numbers 1, 2, 3. Row 3 is shaded and labeled 'TOTALS'.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Little Village Nursing & Rehab Center

0054643

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Doors (Rear Exit to Parking Lot / South Stairwell)		2018	11,610	699		699		699	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

*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

SEE ACCOUNTANTS' PREPARATION REPORT

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)	\$	\$ 11,610		\$ 699	\$ 699	\$ 699	70

SEE ACCOUNTANTS' PREPARATION REPORT

**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	\$ 5,371	\$ 1,790	\$ 1,790	\$		\$ 2,536	71
72	Current Year Purchases	3,162						72
73	Fully Depreciated Assets							73
74	See Supplemental							74
75	TOTALS	\$ 8,533	\$ 1,790	\$ 1,790	\$		\$ 2,536	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	2	
	Reference	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)	\$ 20,143	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 2,489	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 2,489	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)	\$ 3,235	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Little Village Nursing & Rehab Center

0054643

Report Period Beginning: 01/01/18

Ending: 12/31/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. [X] YES [] NO

Table with 8 columns: Line, Description, 1 Year Constructed, 2 Number of Beds, 3 Original Lease Date, 4 Rental Amount, 5 Total Years of Lease, 6 Total Years Renewal Option*, 7. Rows include Original Building, Additions, See Suppl., and TOTAL.

10. Effective dates of current rental agreement: Beginning Ending

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

Table with 2 columns: Fiscal Year Ending, Annual Rent. Rows for years 2019, 2020, and 2021.

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? [X] YES [] NO

16. Rental Amount for movable equipment: \$ 6,063 Description: See Supplemental Schedule (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

Table with 5 columns: Line, 1 Use, 2 Model Year and Make, 3 Monthly Lease Payment, 4 Rental Expense for this Period, 5. Rows include Facility, Lexus, and TOTAL.

* 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.

SEE ACCOUNTANTS' PREPARATION REPORT

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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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.
- SEE ACCOUNTANTS' PREPARATION REPORT

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	39 - 03	hrs	\$		\$ 196,570	\$		\$ 196,570	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			11,641			11,641	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			191,153			191,153	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				67,326		67,326	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					18,042		18,042	12
13	Other (specify): See Supplemental	39 - 03				4,575			4,575	13
14	TOTAL			\$		\$ 403,939	\$ 85,368		\$ 489,307	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number **Little Village Nursing & Rehab Center**

0054643

Report Period Beginning: **01/01/18**

Ending:

12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/18**

(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	\$ 124,864	\$	1
2	Cash-Patient Deposits	7,718		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>337,628</u>)	1,382,442		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	97,375		6
7	Other Prepaid Expenses	6,190		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Supplemental Schedule</u>	638		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,619,227	\$	10
B. Long-Term Assets				
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	11,610		15
16	Equipment, at Historical Cost	8,533		16
17	Accumulated Depreciation (book methods)	(3,235)		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): <u>See Supplemental Schedule</u>	9,694		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 26,602	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,645,829	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 769,127	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,718		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	206,180		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,236		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	30,021		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Supplemental Schedule</u>			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,022,282	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	450,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Supplemental Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 450,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,472,282	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 173,547	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,645,829	\$	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Little Village Nursing & Rehab Center
 Medicaid Cost Report
 01/01/18 - 12/31/18

Page 17 Supplemental Schedule

Description	Operating	Building	Total
Line 9 - Other Current Assets			
Employee Loans	638		638
			-
			-
			-
Sub-Total	<u>638</u>	<u>-</u>	<u>638</u>
Line 23 - Long Term Assets			
Financing Fees (Net of Amortization)	9,694		9,694
			-
			-
			-
Sub-Total	<u>9,694</u>	<u>-</u>	<u>9,694</u>
Line 36 - Other Current Liability			
			-
			-
			-
			-
Sub-Total	<u>-</u>	<u>-</u>	<u>-</u>
Line 43 - Long term Liabilities			
			-
			-
			-
			-
Sub-Total	<u>-</u>	<u>-</u>	<u>-</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 57,868	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 57,868	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	115,679	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)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 115,679	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)	\$ 173,547	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

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	\$ 6,348,602	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,348,602	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	145,332	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 145,332	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***	7,421	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,421	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	150	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 150	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,501,505	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,065,447	31
32	Health Care	1,961,054	32
33	General Administration	1,836,868	33
B. Capital Expense			
34	Ownership	775,065	34
C. Ancillary Expense			
35	Special Cost Centers	489,307	35
36	Provider Participation Fee	258,085	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,385,826	40
41	Income before Income Taxes (line 30 minus line 40)**	115,679	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 115,679	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 4,770,655	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue	1,507,963	46
47	Other-(specify) <u>Insurance - Net Inpatient Revenue</u>	13,051	47
48	Other-(specify) <u>Hospice - Net Inpatient Revenue</u>	56,933	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,348,602	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Final 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.

SEE ACCOUNTANTS' PREPARATION REPORT

Little Village Nursing & Rehab Center
 Medicaid Cost Report
 01/01/18 - 12/31/18

Page 19 Supplemental Schedule

Description		Amount		Total		
Other Income		150		150		
Total				<u>150</u>		<u>150</u>

Facility Name & ID Number Little Village Nursing & Rehab Center

0054643

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	1,781	1,982	\$ 84,647	\$ 42.71	1
2	Assistant Director of Nursing	1,861	2,394	87,923	36.73	2
3	Registered Nurses	3,275	3,584	96,043	26.80	3
4	Licensed Practical Nurses	13,766	15,041	400,612	26.63	4
5	CNAs & Orderlies	39,113	43,764	607,759	13.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,767	6,360	124,313	19.55	8
9	Activity Director	2,045	2,294	40,181	17.52	9
10	Activity Assistants	6,466	7,229	91,387	12.64	10
11	Social Service Workers	6,994	7,443	137,279	18.44	11
12	Dietician					12
13	Food Service Supervisor	1,935	2,109	38,736	18.37	13
14	Head Cook	6,252	7,041	89,121	12.66	14
15	Cook Helpers/Assistants	9,309	10,465	133,014	12.71	15
16	Dishwashers					16
17	Maintenance Workers	2,078	2,303	42,274	18.36	17
18	Housekeepers	14,800	16,692	219,357	13.14	18
19	Laundry	1,891	2,131	27,448	12.88	19
20	Administrator	2,037	2,152	107,124	49.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,580	11,768	282,274	23.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	9,657	10,654	204,663	19.21	33
34	TOTAL (lines 1 - 33)	139,607	155,406	\$ 2,814,155 *	\$ 18.11	34

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	\$ 7,283	01 - 03	35
36	Medical Director	11,118	09 - 03	36
37	Medical Records Consultant			37
38	Nurse Consultant	28,781	10 - 03	38
39	Pharmacist Consultant	7,168	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	1,764	12 - 03	45
46	Other(specify) <u>See Supplemental</u>	24,895		46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 81,009		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

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount	Description	Amount		
<u>Amy Skrypkun - Castro / Jennifer Davey</u>	<u>Administrator</u>	<u>0</u>	\$ <u>107,124</u>	<u>Workers' Compensation Insurance</u>	\$ <u>58,561</u>	<u>IDPH License Fee</u>	\$ <u>1,990</u>		
				<u>Unemployment Compensation Insurance</u>	<u>26,888</u>	<u>Advertising: Employee Recruitment</u>	<u>36,537</u>		
				<u>FICA Taxes</u>	<u>218,079</u>	<u>Health Care Worker Background Check</u>	<u>6,852</u>		
				<u>Employee Health Insurance</u>	<u>120,522</u>	(Indicate # of checks performed)			
				<u>Employee Meals</u>		<u>Patient Background Checks</u>			
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Licenses</u>	<u>928</u>		
				<u>Pension</u>	<u>25,115</u>	<u>Advertising and Promotion</u>	<u>7,789</u>		
				<u>Other Employee Benefits</u>	<u>7,621</u>				
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>107,124</u>						
(List each licensed administrator separately.)									
B. Administrative - Other			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
<u>Jade Financial Services, LLC - Management Company</u>			\$ <u>181,570</u>				<u>Out-of-State Travel</u>	\$	
							<u>In-State Travel</u>		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>181,570</u>	TOTAL (agree to Schedule V, line 22, col.8)			\$ <u>456,786</u>	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)									\$ <u>46,307</u>
C. Professional Services			Amount	G. Schedule of Travel and Seminar**			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type			Description	Line #	Amount	Description	Amount	
<u>Extended Care Consulting, LLC</u>	<u>Home Office</u>	\$ <u>114,000</u>					<u>Out-of-State Travel</u>	\$	
<u>Plante & Moran, PLLC</u>	<u>Accounting</u>	<u>24,000</u>							
<u>Personnel Planners, Inc.</u>	<u>Unemployment Consultant</u>	<u>852</u>					<u>In-State Travel</u>		
<u>Ability Network</u>	<u>Data Processing / IT Cons.</u>	<u>9,500</u>							
<u>National Datacare Corporation</u>	<u>Data Processing / IT Cons.</u>	<u>5,531</u>							
<u>Paycor</u>	<u>Data Processing / IT Cons.</u>	<u>19,383</u>							
<u>Matrixcare</u>	<u>Data Processing / IT Cons.</u>	<u>14,707</u>					<u>Seminar Expense</u>	<u>2,654</u>	
<u>Other</u>	<u>Data Processing / IT Cons.</u>	<u>3,380</u>							
<u>Other</u>	<u>Other Professional</u>	<u>7,726</u>							
<u>Other</u>	<u>Non-Allowable</u>	<u>960</u>					<u>Entertainment Expense</u>	()	
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>200,039</u>	TOTAL			\$	(agree to Sch. V, line 24, col. 8)	
(For legal fee disclosure, see page 39 of instructions)							TOTAL	\$ <u>2,654</u>	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**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 - 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 81 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. \$ 258,085
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.

SEE ACCOUNTANTS' PREPARATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 0
- (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? Ln 14
 - d. Have vehicle usage logs been maintained? Yes
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees