

		FOR BHF USE					

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0054643 Facility Name: Little Village Nursing & Rehab Center Address: 2320 South Lawndale Avenue Chicago 60623 County: Cook Telephone Number: (773) 522 - 0400 Fax # (773) 522 - 1692 HFS ID Number: Date of Initial License for Current Owners: 08/01/17 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. X Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Edward N. Slack, CPA Telephone Number: (847) 628 - 8796 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/18 to 12/31/18 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. Officer or Administrator of Provider (Signed) (Type or Print Name) (Title) Paid Preparer (Signed) (Print Name and Title) Edward N. Slack, CPA Partner, Health and Human Services (Firm Name & Address) Plante & Moran, PLLC 200 N. Martingale Road, Suite 900 Schaumburg, IL 60173 (Telephone) (847) 628 - 8796 Fax # (248) 327 - 8417 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
--	---

SEE ACCOUNTANTS' PREPARATION REPORT

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 <u>N/A</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>14</u>	Skilled (SNF)	<u>14</u>	<u>5,110</u>	<u>1</u>
2		Skilled Pediatric (SNF/PED)			<u>2</u>
3	<u>92</u>	Intermediate (ICF)	<u>92</u>	<u>33,580</u>	<u>3</u>
4		Intermediate/DD			<u>4</u>
5		Sheltered Care (SC)			<u>5</u>
6		ICF/DD 16 or Less			<u>6</u>
7	<u>106</u>	TOTALS	<u>106</u>	<u>38,690</u>	<u>7</u>

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,771</u>		<u>2,826</u>	<u>4,597</u>	<u>8</u>
9	SNF/PED					<u>9</u>
10	ICF	<u>30,211</u>			<u>30,211</u>	<u>10</u>
11	ICF/DD					<u>11</u>
12	SC					<u>12</u>
13	DD 16 OR LESS					<u>13</u>
14	TOTALS	<u>31,982</u>		<u>2,826</u>	<u>34,808</u>	<u>14</u>

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

ACCRAUAL ☒ 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.

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	71,165	-	-	71,165

Line 15 - Other Health Care Services								
								-
								-
								-
								-
								-
								-
								-
								-
Sub-Total		-		-		-		-

Line 27 - Other General Administration							
							-
							-
							-
							-
							-
							-
							-
							-
Sub-Total		-		-		-	-

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

Page 3 Supplemental Schedule - Other Staff Administration Travel Expense

Employee	Travel Purpose	Travel Destination	Travel Date	Expenses			Total
				Travel	Accomodations	Meals	
Care Management	Various	Various	Various	6,731	-	-	6,731
Jennifer Davey	Various	Various	Various	1,773	-	-	1,773
Lacrista Myles	Various	Various	Various	972	-	-	972
Maritza	Various	Various	Various	655	-	-	655
Amy Skrypkun-Castro	Various	Various	Various	550	-	-	550
Jake Mashlach	Various	Various	Various	519	-	-	519
Business Green Card	Various	Various	Various	425	-	-	425
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
Total				11,625	-	-	11,625

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			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
	GRAND TOTAL COST											
45	(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		== - ==		== - ==		== - ==		== - ==
Line 43 - Other Special Cost Centers								
								-
								-
								-
								-
								-
								-
Sub-Total		== - ==		== - ==		== - ==		== - ==

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				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

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS 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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

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	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	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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	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:	
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			\$			\$	\$	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

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

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

- 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 Jade Financial Services, LLC
Street Address 2320 South Lawndale Avenue
City / State / Zip Code Chicago, Illinois 60623
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

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.)

B. Real Estate Taxes

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.

HFS 3745 (N-4-99)

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 Index Number</u>		<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</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.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
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 providecopies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,849

B. General Construction Type: Exterior BrickFrame 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).

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				\$	1
2					2
3	TOTALS			\$	3

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	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Doors (Rear Exit to Parking Lot / South Stairwell)		2018		11,610	699		699		699
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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									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 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)	\$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

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

Page 13 - Related Party Furniture and Equipment Allocations

[illegible]

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? ☒ YES ☐ NO
- If NO, see instructions.

		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:		106	08/01/17	\$ 525,000			3
4	Additions							4
5	See Suppl.				896			5
6								6
7	TOTAL		106		\$ 525,896			7

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2019	\$
13.	/2020	\$
14.	/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? ☒ 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.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Lexus	\$ 800.00	\$ 8,800	17
18					18
19					19
20					20
21	TOTAL		\$ 800.00	\$ 8,800	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Description		Amount		Total
Building Rental				
Offsite Storage		896		896
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total		896		896
Equipment Rental				
Toshiba Financial Services		5,383		5,383
Neopost		215		215
Other		465		465
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total		6,063		6,063

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' PREPARATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8		
	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 prescrpts					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

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 337,628)	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): See Supplemental Schedule	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): See Supplemental Schedule	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	See Supplemental Schedule			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	See Supplemental Schedule			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		638		-		638
Line 23 - Long Term Assets						
Financing Fees (Net of Amortization)		9,694				9,694
						-
						-
						-
						-
Sub-Total		9,694		-		9,694
Line 36 - Other Current Liability						
						-
						-
						-
						-
						-
Sub-Total		-		-		-
Line 43 - Long term Liabilities						
						-
						-
						-
						-
						-
Sub-Total		-		-		-

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

Facility Name & ID Number Little Village Nursing & Rehab Center

0054643

Report Period Beginning:

01/01/18

Ending:

12/31/18

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		
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

[illegible]

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.

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

Page 20 Supplemental Schedule

Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
Nursing Home Employees							
Security	07	5,044	5,671	71,165	12.55		
Resident Escort	10	1,351	1,475	18,011	12.21		
Ward Clerk	10	496	573	7,103	12.40		
Care Plan Coordinator	10	2,766	2,935	108,384	36.93		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
Total		9,657	10,654	204,663	19.21		

Contracted Services							
MDS Consultant	10						12,895
Phsychiatrist	12						12,000
Total						-	24,895

XIX. SUPPORT SCHEDULES

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

*** 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?
If YES, give association name and amount.

No

N/A

(3)

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

No

N/A

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No

N/A

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes

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

Line10 - 02

(7)

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

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No

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
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

X

N/A

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$258,085

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

(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?
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.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?
Indicate the amount.

\$0

Yes

\$0

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No

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?
Indicate the amount of income earned from providing such transportation during this reporting period.

No

N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

No

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.
Attach invoices and a summary of services for all architect and appraisal fees

N/A

SEE ACCOUNTANTS' PREPARATION REPORT