

		FOR BHF USE					

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

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: <u>0050989</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Center Home Hispanic Elderly</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/20</u> to <u>12/31/20</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																															
Address: <u>1401 N California</u> <u>Chicago</u> <u>60622</u>																																																	
Number City Zip Code																																																	
County: <u>Cook</u>																																																	
Telephone Number: <u>(773)782-8700</u> Fax # <u>(773)276-0465</u>																																																	
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____ <u>05/24/2021</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>* Subject to the attached Accountants' Consulting Report (Date)</td></tr><tr><td>(Print Name <u>Steven N. Lavenda, CPA</u></td></tr><tr><td>and Title) <u>Partner</u></td></tr><tr><td>(Firm Name <u>Marcum, LLP</u></td></tr><tr><td colspan="2" rowspan="4"></td><td>(Address) <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td></tr><tr><td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE</td></tr><tr><td colspan="2">ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</td></tr><tr><td colspan="2" rowspan="3"></td><td colspan="2">201 S. Grand Avenue East</td></tr><tr><td colspan="2">Springfield, IL 62763-0001</td></tr><tr><td colspan="2">Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____ <u>05/24/2021</u>	Paid Preparer	* Subject to the attached Accountants' Consulting Report (Date)	(Print Name <u>Steven N. Lavenda, CPA</u>	and Title) <u>Partner</u>	(Firm Name <u>Marcum, LLP</u>			(Address) <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>	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																					
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		Phone # (217) 782-1630																																															
Date of Initial License for Current Owners: <u>7/1/2010</u>																																																	
Type of Ownership:																																																	
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☒</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table>		☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☒	"Sub-S" Corp.					☐	Limited Liability Co.					☐	Trust					☐	Other _____		
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In the event there are further questions about this report, please contact:																																																	
Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u>																																																	
Email Address: _____																																																	

Facility Name & ID Number Center Home Hispanic Elderly

0050989 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>98</u>	Skilled (SNF)	<u>98</u>	<u>35,868</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>58</u>	Intermediate (ICF)	<u>58</u>	<u>21,228</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>156</u>	TOTALS	<u>156</u>	<u>57,096</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>3,785</u>	<u>3,785</u>	8
9	SNF/PED					9
10	ICF	<u>34,049</u>	<u>198</u>	<u>1,197</u>	<u>35,444</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>34,049</u>	<u>198</u>	<u>4,982</u>	<u>39,229</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.71%

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

None (Do not include bed reserve days in Section B.)

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

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

☐

NO

☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

☐

NO

☒

I. On what date did you start providing long term care at this location?

Date started 07/01/2010

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

YES

☒

Date 07/01/2010

NO

☐

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

YES

☒

NO

☐

If YES, enter number

of beds certified

98

and days of care provided

3,785

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒

NO

☐

Tax Year: 12/31/20

Fiscal Year: 12/31/20

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

Facility Name & ID Number Center Home Hispanic Elderly # 0050989 Report Period Beginning: 01/01/20 Ending: 12/31/20
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 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	423,204	60,252	13,818	497,274		497,274		497,274			1
2	Food Purchase		220,550		220,550		220,550	(11)	220,539			2
3	Housekeeping	394,674	95,096		489,770		489,770	3,016	492,786			3
4	Laundry	146,052	10,387	8,435	164,874		164,874		164,874			4
5	Heat and Other Utilities			171,238	171,238		171,238	1,947	173,185			5
6	Maintenance	101,017		99,297	200,314		200,314	(17,572)	182,742			6
7	Other (specify):*							2,036	2,036			7
8	TOTAL General Services	1,064,947	386,285	292,788	1,744,020		1,744,020	(10,584)	1,733,436			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,804,594	227,049	144,680	3,176,323		3,176,323	(88,175)	3,088,148			10
10a	Therapy	17,787			17,787		17,787		17,787			10a
11	Activities	149,514	4,747		154,261		154,261		154,261			11
12	Social Services	133,004		2,717	135,721		135,721		135,721			12
13	CNA Training											13
14	Program Transportation			2,592	2,592		2,592		2,592			14
15	Other (specify):*							5,064	5,064			15
16	TOTAL Health Care and Programs	3,104,899	231,796	161,989	3,498,684		3,498,684	(83,111)	3,415,573			16
	C. General Administration											
17	Administrative	138,844		54,000	192,844		192,844	30,324	223,168			17
18	Directors Fees											18
19	Professional Services			416,620	416,620	(1,286)	415,334	(289,252)	126,082			19
20	Dues, Fees, Subscriptions & Promotions			68,711	68,711		68,711	(15,976)	52,735			20
21	Clerical & General Office Expenses	196,589		405,785	602,374		602,374	(205,525)	396,849			21
22	Employee Benefits & Payroll Taxes			742,187	742,187		742,187		742,187			22
23	Inservice Training & Education											23
24	Travel and Seminar							704	704			24
25	Other Admin. Staff Transportation			998	998		998	4,244	5,242			25
26	Insurance-Prop.Liab.Malpractice			630,129	630,129		630,129	3,600	633,729			26
27	Other (specify):*							41,986	41,986			27
28	TOTAL General Administration	335,433		2,318,430	2,653,863	(1,286)	2,652,577	(429,895)	2,222,682			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,505,279	618,081	2,773,207	7,896,567	(1,286)	7,895,281	(523,590)	7,371,691			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			71,525	71,525		71,525	465,354	536,879			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,599	8,599		8,599	592,998	601,597			32
33	Real Estate Taxes			324,707	324,707	1,286	325,993	12,730	338,723			33
34	Rent-Facility & Grounds			929,000	929,000		929,000	(929,000)				34
35	Rent-Equipment & Vehicles			3,312	3,312		3,312		3,312			35
36	Other (specify):*			849	849		849	(849)				36
37	TOTAL Ownership			1,337,992	1,337,992	1,286	1,339,278	141,233	1,480,511			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	10,847	71,895	680,140	762,882		762,882		762,882			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			332,974	332,974		332,974		332,974			42
43	Other (specify):*			18,198	18,198		18,198	(18,198)	(0)			43
44	TOTAL Special Cost Centers	10,847	71,895	1,031,312	1,114,054		1,114,054	(18,198)	1,095,856			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,516,126	689,976	5,142,511	10,348,613		10,348,613	(400,555)	9,948,058			45

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

VI. ADJUSTMENT DETAIL

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

	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	465,354	30		9
10	Interest and Other Investment Income	(20,771)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(11)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,076)	21		18
19	Entertainment				19
20	Contributions	(123)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(268,734)	21		24
25	Fund Raising, Advertising and Promotional	(1,615)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,748)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(209,115)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (40,839)		\$	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)	(359,717)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (359,717)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (400,556)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Charges	\$ (13,999)	21	1
2	Sequestration Expense	(67,755)	21	2
3	Miscellaneous Income	(17,022)	21	3
4	Marketing Expense	(1,398)	43	4
5	Bldg Co - Professional Fees	(7,100)	19	5
6	RE Taxes	5,178	33	6
7	PAC Dues	(14,383)	20	7
8	Non-Allowable Legal	(30,930)	19	8
9	Prior Period Misc. Expenses	(2,104)	21	9
10	Amortization Expense	(849)	36	10
11	Prior Period Professional Fees	(46,969)	19	11
12	Capitalized R&M	(11,784)	06	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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36				36
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(209,115)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Center Home Hispanic Elderly # 0050989 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(11)											(11)	2
3	Housekeeping			3,016									3,016	3
4	Laundry													4
5	Heat and Other Utilities			1,947									1,947	5
6	Maintenance	(11,784)		2,208		(7,996)							(17,572)	6
7	Other (specify):*					2,036							2,036	7
8	TOTAL General Services	(11,795)		7,171		(5,960)							(10,584)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records					(88,175)							(88,175)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					5,064							5,064	15
16	TOTAL Health Care and Programs					(83,111)							(83,111)	16
	C. General Administration													
17	Administrative			2,810		27,514							30,324	17
18	Directors Fees													18
19	Professional Services	(84,998)	7,100	(214,568)	1,170	2,044							(289,252)	19
20	Fees, Subscriptions & Promotions	(16,121)		81		64							(15,976)	20
21	Clerical & General Office Expenses	(375,438)		127,795		42,118							(205,525)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			574		130							704	24
25	Other Admin. Staff Transportation					4,244							4,244	25
26	Insurance-Prop.Liab.Malpractice			1,241		2,359							3,600	26
27	Other (specify):*			29,950		12,036							41,986	27
28	TOTAL General Administration	(476,557)	7,100	(52,117)	1,170	90,509							(429,895)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(488,352)	7,100	(44,946)	1,170	1,438							(523,590)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Center Home Hispanic Elderly # 0050989 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	465,354											465,354	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(20,771)	607,970	4	1,670		4,125						592,998	32
33	Real Estate Taxes	5,178			1,922		5,630						12,730	33
34	Rent-Facility & Grounds		(929,000)	21,971	(9,517)		(12,454)						(929,000)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(849)											(849)	36
37	TOTAL Ownership	448,912	(321,030)	21,975	(5,924)		(2,699)						141,233	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(1,398)				(16,800)							(18,198)	43
44	TOTAL Special Cost Centers	(1,398)				(16,800)							(18,198)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(40,839)	(313,930)	(22,972)	(4,754)	(15,362)	(2,699)						(400,555)	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-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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	34	Rent	\$ 929,000	Center Home Realty, LLC		\$	(929,000)	1
2	V	32	Interest		Center Home Realty, LLC		607,970	607,970	2
3	V	19	Professional Fees		Center Home Realty, LLC		7,100	7,100	3
4	V	33	Real Estate Taxes	511,322	Center Home Realty, LLC		511,322		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			\$ 1,440,322			\$ 1,126,392	\$ * (313,930)	14

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

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			1
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Atied Associates, LLC	40.00 %	Pine Crest Healthcare	Hezel Crest	Center Home Realty	Chicago	Building Co.	1
2	EZ & A, LLC	3.21 %	Park View Rehab Center	Chicago	Premier HC & Financial	Skokie	Consulting Co.	2
3	Howard Wengrow	10.00 %	River View Rehab Center	Elgin	Premier HC Real Estate	Skokie	Building Co.	3
4	Jeffrey Webster	3.59 %	Rock River Health Care	Rockford	iCare Consulting Services	Skokie	Consulting Co.	4
5	Shimon Webster	20.00 %	Prairie Oasis	South Holland	8131 Monticello Realty, LLC	Skokie	Building Co.	5
6	Yeruchom Levovitz	20.00 %	Oak Park Oasis	Oak Park	iCare Health Services Incorporated	Burlington, VT	Insurance	6
7	Eli Webster	3.21 %	Austin Oasis	Chicago				7
8			Forest City Rehab& Nursing Center	Rockford				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

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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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	3	HOUSEKEEPING	\$	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		\$ 3,016	\$ 3,016	15
16	V	5	UTILITIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		1,947	1,947	16
17	V	6	REPAIRS AND MAINTENANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		2,208	2,208	17
18	V	17	ADMINISTRATIVE SALARIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		56,810	56,810	18
19	V	19	PROFESSIONAL FEES	217,600	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		3,032	(214,568)	19
20	V	20	DUES FEES SUBSCRIPTIONS		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		81	81	20
21	V	21	CLERICAL AND GENERAL		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		7,157	7,157	21
22	V	21	CLERICAL & GENERAL SALARIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		120,637	120,637	22
23	V	24	SEMINARS & EDUCATION		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		574	574	23
24	V	26	INSURANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		1,241	1,241	24
25	V	27	EMPLOYEE BEN. GEN ADMIN.		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		29,950	29,950	25
26	V	32	INTEREST		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		4	4	26
27	V	34	RENT		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		21,971	21,971	27
28	V	17	CONSULTING FEES	54,000	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.			(54,000)	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			\$ 271,600			\$ 248,628	\$ * (22,972)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES		PREMIER HEALTHCARE REALTY, LLC		1,170	\$	1,170
16	V	20	LICENSES & PERMITS		PREMIER HEALTHCARE REALTY, LLC				
17	V	30	DEPRECIATION		PREMIER HEALTHCARE REALTY, LLC				
18	V	32	INTEREST EXPENSE		PREMIER HEALTHCARE REALTY, LLC		1,670		1,670
19	V	33	REAL ESTATE TAXES		PREMIER HEALTHCARE REALTY, LLC		1,922		1,922
20	V								
21	V								
22	V								
23	V								
24	V								
25	V	34	RENT	9,517	PREMIER HEALTHCARE REALTY, LLC				(9,517)
26	V								
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ 9,517			\$ 4,763	\$ *	(4,754)

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS AND MAINTENANCE	\$ 25,200	ICARE CONSULTING SERVICES LLC		\$ 17,204	\$ (7,996)	15
16	V	7	R&M EMPLOYEE BENEFITS		ICARE CONSULTING SERVICES LLC		2,036	2,036	16
17	V	10	NURSING SALARIES	128,000	ICARE CONSULTING SERVICES LLC		39,825	(88,175)	17
18	V	15	EMPLOYEE BEN. HC PROGRAMS		ICARE CONSULTING SERVICES LLC		5,064	5,064	18
19	V	17	ADMINISTRATIVE WAGES		ICARE CONSULTING SERVICES LLC		27,514	27,514	19
20	V	19	PROFESSIONAL FEES		ICARE CONSULTING SERVICES LLC		2,044	2,044	20
21	V	20	DUES FEES SUBSCRIPTIONS		ICARE CONSULTING SERVICES LLC		64	64	21
22	V	21	CLERICAL AND GENERAL	34,400	ICARE CONSULTING SERVICES LLC		2,485	(31,915)	22
23	V	21	CLERICAL & GENERAL WAGES		ICARE CONSULTING SERVICES LLC		74,033	74,033	23
24	V	24	SEMINARS & EDUCATION		ICARE CONSULTING SERVICES LLC		130	130	24
25	V	25	AUTO EXPENSE		ICARE CONSULTING SERVICES LLC		4,244	4,244	25
26	V	26	INSURANCE		ICARE CONSULTING SERVICES LLC		2,359	2,359	26
27	V	27	EMPLOYEE BEN. GEN ADMIN.		ICARE CONSULTING SERVICES LLC		12,036	12,036	27
28	V	43	MARKETING	16,800	ICARE CONSULTING SERVICES LLC			(16,800)	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			\$ 204,400			\$ 189,038	\$ * (15,362)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V	19	PROFESSIONAL FEES		8131 MONTICELLO REALTY, LLC				16
17	V	20	LICENSES & PERMITS		8131 MONTICELLO REALTY, LLC				17
18	V	30	DEPRECIATION		8131 MONTICELLO REALTY, LLC				18
19	V	32	INTEREST EXPENSE		8131 MONTICELLO REALTY, LLC		4,125	4,125	19
20	V	33	REAL ESTATE TAXES		8131 MONTICELLO REALTY, LLC		5,630	5,630	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	12,454	8131 MONTICELLO REALTY, LLC			(12,454)	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			\$ 12,454			\$ 9,755	\$ * (2,699)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	Insurance	\$ 592,494	ICARE HEALTH SERVICES INCORPORATED CELL		\$ 592,494	\$	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			\$ 592,494			\$ 592,494	\$ *	39

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

YESNO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

Facility Name & ID Number Center Home Hispanic Elderly # 0050989 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Shimon Webster	Member	Administrative	20.00%	See Attached	4.38	10.94%	Alloc Salary	\$ 15,232	17-7	1
2	Yeruchom Levovitz	Member	Administrative	20.00%	See Attached	4.38	10.94%	Alloc Salary	14,231	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 29,463		13

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

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

Facility Name & ID Number Center Home Hispanic Elderly # 0050989 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Facility Name & ID Number Center Home Hispanic Elderly # 0050989 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization PREMIER HEALTHCARE & FIN. SVCS, INC.
Street Address 8131 MONTICELLO
City / State / Zip Code SKOKIE, IL 60076
Phone Number (773) 945-1000
Fax Number (773) 751-2027

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	3	HOUSEKEEPING	PATIENT DAYS	358,626	8	\$ 27,572	\$	39,229	\$ 3,016	1
2	5	UTILITIES	PATIENT DAYS	358,626	8	17,798		39,229	1,947	2
3	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	358,626	8	20,184		39,229	2,208	3
4	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	358,626	8	519,346	519,346	39,229	56,810	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	358,626	8	27,719		39,229	3,032	5
6	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	358,626	8	738		39,229	81	6
7	21	CLERICAL AND GENERAL	PATIENT DAYS	358,626	8	65,429	1,102,850	39,229	7,157	7
8	21	CLERICAL & GENERAL SALA	PATIENT DAYS	358,626	8	1,102,850		39,229	120,637	8
9	24	SEMINARS & EDUCATION	PATIENT DAYS	358,626	8	5,249		39,229	574	9
10	26	INSURANCE	PATIENT DAYS	358,626	8	11,347		39,229	1,241	10
11	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	358,626	8	273,803		39,229	29,950	11
12	32	INTEREST	PATIENT DAYS	358,626	8	39		39,229	4	12
13	34	RENT	PATIENT DAYS	358,626	8	200,851		39,229	21,971	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					\$ 2,272,926	\$ 1,622,196		\$ 248,628	25

Facility Name & ID Number Center Home Hispanic Elderly # 0050989 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization PREMIER HEALTHCARE REALTY, LLC
Street Address 8153 LAWNDALE
City / State / Zip Code SKOKIE, IL 60076
Phone Number (773) 945-1000
Fax Number (773) 945-6107

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	19	PROFESSIONAL FEES	PATIENT DAYS	358,626	8	10,700		39,229	1,170	1
2	20	LICENSES & PERMITS	PATIENT DAYS	358,626	8			39,229		2
3	30	DEPRECIATION	PATIENT DAYS	358,626	8			39,229		3
4	32	INTEREST EXPENSE	PATIENT DAYS	358,626	8	15,267		39,229	1,670	4
5	33	REAL ESTATE TAXES	PATIENT DAYS	358,626	8	17,574		39,229	1,922	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					\$ 43,541	\$		\$ 4,763	25

Facility Name & ID Number Center Home Hispanic Elderly # 0050989 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization ICARE CONSULTING SERVICES LLC
Street Address 8131 MONTICELLO
City / State / Zip Code SKOKIE, IL 60076
Phone Number (773) 945-1000
Fax Number (773) 945-6107

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	6	REPAIRS AND MAINTENANCE	CONSULTING FEES	1,730,000	8	\$ 145,610	\$ 145,409	204,400	\$ 17,204	1
2	7	R&M EMPLOYEE BENEFITS	CONSULTING FEES	1,730,000	8	17,235		204,400	2,036	2
3	10	NURSING SALARIES	CONSULTING FEES	1,730,000	8	337,071	337,071	204,400	39,825	3
4	15	EMPLOYEE BEN. HC PROGRA	CONSULTING FEES	1,730,000	8	42,861		204,400	5,064	4
5	17	ADMINISTRATIVE WAGES	CONSULTING FEES	1,730,000	8	232,870	232,870	204,400	27,514	5
6	19	PROFESSIONAL FEES	CONSULTING FEES	1,730,000	8	17,301		204,400	2,044	6
7	20	DUES FEES SUBSCRIPTIONS	CONSULTING FEES	1,730,000	8	538		204,400	64	7
8	21	CLERICAL AND GENERAL	CONSULTING FEES	1,730,000	8	21,035		204,400	2,485	8
9	21	CLERICAL & GENERAL WAGI	CONSULTING FEES	1,730,000	8	626,600	626,600	204,400	74,033	9
10	24	SEMINARS & EDUCATION	CONSULTING FEES	1,730,000	8	1,099		204,400	130	10
11	25	AUTO EXPENSE	CONSULTING FEES	1,730,000	8	35,917		204,400	4,244	11
12	26	INSURANCE	CONSULTING FEES	1,730,000	8	19,965		204,400	2,359	12
13	27	EMPLOYEE BEN. GEN ADMIN.	CONSULTING FEES	1,730,000	8	101,871		204,400	12,036	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,599,973	\$ 1,341,950		\$ 189,038	25

Facility Name & ID Number Center Home Hispanic Elderly # 0050989 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 8131 MONTICELLO REALTY, LLC
Street Address 8131 MONTICELLO
City / State / Zip Code SKOKIE, IL 60076
Phone Number (773) 945-1000
Fax Number (773) 945-6107

	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	19	PROFESSIONAL FEES	PATIENT DAYS	358,626	8			39,229		2
3	20	LICENSES & PERMITS	PATIENT DAYS	358,626	8			39,229		3
4	30	DEPRECIATION	PATIENT DAYS	358,626	8			39,229		4
5	32	INTEREST EXPENSE	PATIENT DAYS	358,626	8	37,708		39,229	4,125	5
6	33	REAL ESTATE TAXES	PATIENT DAYS	358,626	8	51,468		39,229	5,630	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					\$ 89,176	\$		\$ 9,755	25

Facility Name & ID Number Center Home Hispanic Elderly # 0050989 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization ICARE HEALTH SERVICES INCORP. CELL
Street Address 30 MAIN STREET, SUITE 330
City / State / Zip Code BURLINGTON, VERMONT 05401
Phone Number ()
Fax Number ()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	26	INSURANCE	DIRECT ALLOCATION			\$	\$		\$ 592,494	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					\$	\$		\$ 592,494	25

Facility Name & ID Number Center Home Hispanic Elderly # 0050989 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Facility Name & ID Number Center Home Hispanic Elderly # 0050989 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

Facility Name & ID Number Center Home Hispanic Elderly # 0050989 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Facility Name & ID Number Center Home Hispanic Elderly # 0050989 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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	MB Financial		X	Mortgage			\$	10,774,594			\$	607,970	1
2													2
3													3
4													4
5													5
	Working Capital												
6	MB Financial		X	Line of Credit								8,342	6
7	Capex - Interest Expense		X	Capex Loan								257	7
8	See Supplemental Schedule											5,799	8
9	TOTAL Facility Related						\$	10,774,594			\$	622,368	9
	B. Non-Facility Related*												
10	Interest Income		X									(20,771)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$	(20,771)	14
15	TOTALS (line 9+line14)						\$	10,774,594			\$	601,597	15

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

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

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

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

B. Real Estate Taxes

[illegible]

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Center Home Hispanic Elderly COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050989

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 16-01-208-016-0000	Long Term Care Property	\$ 148,111.85	\$ 148,111.85
2. 16-01-208-035-0000	Long Term Care Property	\$ 181,773.29	\$ 181,773.29
3. 10-23-324-047-0000	Home Office Allocation	\$ 34,381.62	\$ 3,760.90
4. 10-23-325-045-0000	Monticello Realty, Inc	\$ 51,467.63	\$ 5,629.89
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 415,734.39	\$ 339,275.93

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? X YES NO

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

C. Tax Bills

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

FACILITY NAME Center Home Hispanic Elderly COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050989

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE () FAX #: ()

Enter the tax index number and real estate tax assessed for 2015 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 2015.

B. Real Estate Tax Cost Allocations

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.)

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.

A. Square Feet: 59,149

B. General Construction Type: Exterior BrickFrame SteelNumber of Stories 4

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2017	\$ 153,799	1
2	See attached allocations		see attached	7,356	2
3	TOTALS			\$ 161,155	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	156		2017	1954	\$ 7,541,585	\$	39	\$ 193,374	\$ 193,374	\$ 773,496	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2011	266,941		20	12,998	12,998	112,047	9
10	Various			2012	27,435		20	1,372	1,372	9,717	10
11	Various			2013	296,958		20	14,735	14,735	108,657	11
12	Various			2014	109,757		20	5,488	5,488	31,466	12
13	Various			2015	117,467		20	8,615	8,615	36,917	13
14	Various			2016	70,044		20	3,502	3,502	12,037	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Center Home Hispanic Elderly

0050989

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									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	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		213,291			7,758	7,758	48,222	68
69	Financial Statement Depreciation			71,525			(71,525)		69
70	TOTAL (lines 4 thru 69)		\$ 8,643,477	\$ 71,525		\$ 247,841	\$ 176,316	\$ 1,132,558	70

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

Facility Name & ID Number Center Home Hispanic Elderly

0050989

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,643,477	\$ 71,525		\$ 247,841	\$ 176,316	\$ 1,132,558	1
2	Sewer Backup - Rod Floor Drain And Cleanout	2017	2,728		20	136	136	409	2
3	Boiler Repair - Patch Leaks, Flush	2017	4,400		20	220	220	495	3
4	Replace 2 Ejector Pumps With Panel Boards/Piping/Electrical	2018	7,365		20	368	368	430	4
5	Install 4 Ball Valves To Isolate Each Boiler-Firebox & Steel Patch	2018	6,980		20	349	349	378	5
6	Torch-Cut/Seal Boiler Wall W/ New Boiler Plates Inside Firebox	2018	4,580		20	229	229	248	6
7	Trap Replacement In Therapy Room-South End; Condensate Pump	2018	4,077		20	204	204	221	7
8	Replacement Of Sewer Pumps	2018	8,780		20	439	439	585	8
9	2Nd Fl Sun Room-Replace Ac Condensor/Line Dryer	2018	4,250		20	213	213	425	9
10	Mechanical Room-Replaced 4"Pipes-Overhead Ejector Pumps	2019	2,740		20	126	126	126	10
11	Repair And Replacement Of Sewer Line - Se Corner	2019	8,500		20	283	283	283	11
12	Repair 2 Boilers	2019	12,258		20	153	153	153	12
13	American Standard Water Heater	2019	3,963		20	99	99	99	13
14	Welding/Fabrication Repairs - Commercial Water Heater	2019	6,176		20	77	77	77	14
15	Fl #3 Therapy Rm/Office/Hallway-Repair Radiators-Pumps/Traps	2019	4,028		20	201	201	201	15
16	Mechanical Room- Boiler- 5" Valve Replacement/Installation	2019	4,962		20	248	248	248	16
17	Generator And Ats Repairs- Fuel Analysis And Load Banks	2019	2,851		20	143	143	143	17
18	Bathroom And Shower Rooms On Ground, 1St, 2Nd, 3Rd Floors:	2019			20				18
19	Flooring, Wall Tile, Partitions, Sinks, Faucets, Doors Mirrors,	2019			20				19
20	Lighting, Fire Sprinkler System (Complete Renovation)	2019	609,741		20	30,487	30,487	30,487	20
21	2Nd/3Rd Floor Corridors,Dining Rm,Dayroom & Resident Rooms	2019			20				21
22	Cove Base, Walls, Handrails, Corner Guards, Door Frames,	2019			20				22
23	Nursing Stations, Radiators, Flooring, Borders,Window	2019			20				23
24	Treatments, Sinks, Faucets, Painting	2019	199,138		20	9,957	9,957	9,957	24
25	Boiler #1 And # 2 Repairs-Tubes,Plates,Leaks	2020	26,154		20	1,308	1,308	1,308	25
26	New Concrete Ramp	2020	3,950		20	198	198	198	26
27	Ejector Pump Repair - Replace Pipe And Valve	2020	6,007		20	300	300	300	27
28	Air Conditioner - 36,000 Btu	2020	2,547		20	127	127	127	28
29	Circulating Pump Replacement	2020	3,230		20	162	162	162	29
30	2Nd/3Rd Floor Corridors,Dining Rm,Dayroom & Resident Rooms	2020			20				30
31	Cove Base, Walls, Handrails, Corner Guards, Door Frames,	2020			20				31
32	Nursing Stations, Radiators, Flooring, Borders,Window	2020			20				32
33	Treatments, Sinks, Faucets, Painting	2020	539,430		20	26,972	26,972	26,972	33
34	TOTAL (lines 1 thru 33)		\$ 10,122,311	\$ 71,525		\$ 320,840	\$ 249,315	\$ 1,206,590	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 10,122,311	\$ 71,525		\$ 320,840	\$ 249,315	\$ 1,206,590	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,122,311	\$ 71,525		\$ 320,840	\$ 249,315	\$ 1,206,590	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$10,122,311	\$71,525		\$320,840	\$249,315	\$1,206,590	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$10,122,311	\$71,525		\$320,840	\$249,315	\$1,206,590	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$10,122,311	\$71,525		\$320,840	\$249,315	\$1,206,590	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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$10,122,311	\$71,525		\$320,840	\$249,315	\$1,206,590	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$		1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Center Home Hispanic Elderly

0050989

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated Premiere Healthcare Realty, LLC	2011	40,737		20	1,164	1,164	10,571	3
4	Allocated Premiere Healthcare Realty, LLC	2012	5,186		20	148	148	1,334	4
5	Allocated from 8131 N. Monticello	2019	89,725		20	2,564	2,564	5,127	5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	Allocated from Premier HC & Financial Services	2012	924		20	46	46	416	10
11	Allocated from Premier HC & Financial Services	2016	2,166		20	108	108	541	11
12	Allocated Premiere Healthcare Realty, LLC	2011	72,452		20	3,623	3,623	29,287	12
13	Allocated Premiere Healthcare Realty, LLC	2012	2,100		20	105	105	945	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 213,291	\$		\$ 7,758	\$ 7,758	\$ 48,222	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$213,291	\$		\$7,758	\$7,758	\$48,222	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
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$213,291	\$		\$7,758	\$7,758	\$48,222	34

**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	\$ 2,119,753	\$	\$ 212,036	\$ 212,036	10	\$ 806,498	71
72	Current Year Purchases	40,028		4,003	4,003	10	4,003	72
73	Fully Depreciated Assets	172,262				10	172,262	73
74								74
75	TOTALS	\$ 2,332,042	\$	\$ 216,039	\$ 216,039		\$ 982,763	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)	\$ 12,615,509	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 71,525	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 536,879	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 465,354	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,189,352	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	CIP	\$ 860,000	92
93			93
94			94
95		\$ 860,000	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

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

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$ 3,312
- Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2021	\$
13.	/2022	\$
14.	/2023	\$

* 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.

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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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

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

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

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

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

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

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		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	\$		\$ 272,942	\$		\$ 272,942	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			119,231			119,231	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			258,533			258,533	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				70,406		70,406	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached			10,847		29,434	1,489		41,770	13
14	TOTAL			\$ 10,847		\$ 680,140	\$ 71,895		\$ 762,882	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,829,648	\$ 1,912,972	1
2	Cash-Patient Deposits	3,334	3,334	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,478,761	1,478,761	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	574,287	574,287	6
7	Other Prepaid Expenses	98,920	98,920	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached		927,035	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,984,950	\$ 4,995,309	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,367,142	13
14	Buildings, at Historical Cost		6,096,114	14
15	Leasehold Improvements, at Historical Cost	954,420	1,309,581	15
16	Equipment, at Historical Cost	277,093	2,646,085	16
17	Accumulated Depreciation (book methods)	(919,719)	(2,906,400)	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 Attached	759,105	1,154,229	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,070,899	\$ 9,666,751	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,055,849	\$ 14,662,060	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 949,115	\$ 949,116	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	339,155	339,155	30
31	Accrued Taxes Payable (excluding real estate taxes)	200,237	200,237	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,462,245	1,468,444	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,950,752	\$ 2,956,952	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,774,594	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	68,930	68,930	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 68,930	\$ 10,843,524	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,019,682	\$ 13,800,476	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,036,167	\$ 861,584	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,055,849	\$ 14,662,060	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,121,223	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,121,223	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	914,944	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)	\$ 914,944	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,036,167	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Center Home Hispanic Elderly

0050989

Report Period Beginning: 01/01/20

Ending:

12/31/20

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,003,296	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,003,296	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	447,539	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 447,539	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***	20,771	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 20,771	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	1,791,951	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,791,951	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,263,557	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,744,020	31
32	Health Care	3,498,684	32
33	General Administration	2,653,863	33
	B. Capital Expense		
34	Ownership	1,337,992	34
	C. Ancillary Expense		
35	Special Cost Centers	781,080	35
36	Provider Participation Fee	332,974	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,348,613	40
41	Income before Income Taxes (line 30 minus line 40)**	914,944	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 914,944	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 6,381,202	44
45	Private Pay - Net Inpatient Revenue	35,010	45
46	Medicare - Net Inpatient Revenue	2,326,290	46
47	Other-(specify) Hospice	225,559	47
48	Other-(specify) Insurance	35,235	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,003,296	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

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

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

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	1,567	1,693	\$ 86,096	\$ 50.85	1
2	Assistant Director of Nursing	1,479	1,598	68,398	42.80	2
3	Registered Nurses	19,880	21,486	701,377	32.64	3
4	Licensed Practical Nurses	29,998	32,422	907,262	27.98	4
5	CNAs & Orderlies	70,132	75,799	1,029,460	13.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	863	933	17,787	19.06	8
9	Activity Director	1,954	2,112	37,201	17.61	9
10	Activity Assistants	7,547	8,157	112,313	13.77	10
11	Social Service Workers	5,006	5,411	133,004	24.58	11
12	Dietician					12
13	Food Service Supervisor	2,461	2,659	70,389	26.47	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,833	24,678	352,815	14.30	15
16	Dishwashers					16
17	Maintenance Workers	3,902	4,217	101,017	23.95	17
18	Housekeepers	26,265	28,387	394,674	13.90	18
19	Laundry	9,480	10,246	146,052	14.25	19
20	Administrator	1,254	1,355	92,315	68.13	20
21	Assistant Administrator	1,302	1,408	46,529	33.05	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,420	12,343	196,589	15.93	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	838	905	12,001	13.26	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	802	867	10,847	12.51	33
34	TOTAL (lines 1 - 33)	218,983	236,676	\$ 4,516,126 *	\$ 19.08	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	292	\$ 13,818	01-03	35
36	Medical Director	Monthly	12,000	09-03	36
37	Medical Records Consultant	Monthly	4,800	10-03	37
38	Nurse Consultant	Monthly	130,300	10-03	38
39	Pharmacist Consultant	Monthly	9,580	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	46	2,717	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	339	\$ 173,215		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

STATE OF ILLINOIS

Facility Name & ID Number

Center Home Hispanic Elderly

0050989

Report Period Beginning:

01/01/20

Ending:

12/31/20

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount	
Juvenal Gonzalez		Administrator	0	\$ 92,315	Workers' Compensation Insurance		\$ 119,751	IDPH License Fee		\$ 1,990	
Sonia Alonzo		Assistant Admin	0	46,529	Unemployment Compensation Insurance		30,663	Advertising: Employee Recruitment		32,409	
					FICA Taxes		345,484	Health Care Worker Background Check		600	
					Employee Health Insurance		181,583	(Indicate # of checks performed 60)			
					Employee Meals			Patient Background Checks			
					Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions		14,383	
					Pension Expense		39,278	Licenses & Fees		3,208	
					Other Employee Expense		22,724				
					Holiday Expense		2,704				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 138,844							
B. Administrative - Other											
Description			Amount								
Consulting Fees - Premier HC & Financial Services			\$ 54,000								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 54,000	TOTAL (agree to Schedule V, line 22, col.8)			\$ 742,187	TOTAL (agree to Sch. V, line 20, 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	
Marcum LLP		Accounting	\$ 67,650					Out-of-State Travel		\$	
Premier Healthcare		Bookkeeping Fees	217,600								
Point Click Care		Data Processing	30,206								
Reliable Health Care		Data Processing	15,940					In-State Travel			
Creative Technologies		IT Support	12,026								
EON Applications		Computer Services	978								
Ability Network		Medicare Billing	1,917								
OnShift		HR Consulting	11,052					Seminar Expense			
Zirmed		Data Processing	640								
Prospect Resources		Energy Consulting	1,300								
See Attached		Legal	55,611					See Supplemental Schedule		704	
See Supplemental Schedule			1,700					Entertainment Expense		()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 416,620	TOTAL			\$	(agree to Sch. V, line 24, col. 8)		\$ 704	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number <u>Center Home Hispanic Elderly</u>	STATE OF ILLINOIS # <u>0050989</u>	Report Period Beginning: <u>01/01/20</u>	Ending: <u>12/31/20</u>
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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? Yes
 If YES, give association name and amount. HCCI - \$28,766

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,227 Line 10

(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. \$ 332,974
 This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____

(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? No
 If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
 d. Have vehicle usage logs been maintained? No
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? No
 Firm Name: N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
 Attach invoices and a summary of services for all architect and appraisal fees.