

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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>0052456</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Gardenview Manor</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/16</u> to <u>12/31/16</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>14792 Catlin Tilton</u> <u>Danville</u> <u>61834</u>																									
Number City Zip Code																									
County: <u>Vermilion</u>																									
Telephone Number: <u>(217) 443-6430</u> Fax # <u>(217) 443-1558</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>SEE ACCOUNTANTS' COMPILATION REPORT</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Larry Templin Partner</u></td></tr><tr><td>(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 9, Dunlap, IL 61525</u></td></tr><tr><td>(Telephone) <u>(630) 361-2868</u> Fax # ()</td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	Paid Preparer	(Print Name and Title) <u>Larry Templin Partner</u>	(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 9, Dunlap, IL 61525</u>	(Telephone) <u>(630) 361-2868</u> Fax # ()	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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Date of Initial License for Current Owners: <u>8/1/2013</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</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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	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Larry Templin</u> Telephone Number: <u>(630) 361-2868</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gardenview Manor

0052456 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 _____					
	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>118</u>	Skilled (SNF)	<u>118</u>	<u>43,188</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>95</u>	Intermediate (ICF)	<u>95</u>	<u>34,770</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>213</u>	TOTALS	<u>213</u>	<u>77,958</u>	7

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>4,055</u>	<u>4,055</u>	8
9	SNF/PED					9
10	ICF	<u>34,308</u>	<u>2,352</u>	<u>1,246</u>	<u>37,906</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>34,308</u>	<u>2,352</u>	<u>5,301</u>	<u>41,961</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.83%

SEE ACCOUNTANTS' PREPARATION REPORT

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒ Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location?
Date started 08/01/2013

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 08/01/2013 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 118 and days of care provided 3,513

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Gardenview Manor # 0052456 Report Period Beginning: 1/1/16 Ending: 12/31/16
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	319,057	26,426	12,438	357,921		357,921		357,921			1
2	Food Purchase		268,262		268,262		268,262		268,262			2
3	Housekeeping		37,614	246,793	284,407		284,407		284,407			3
4	Laundry		7,326		7,326		7,326		7,326			4
5	Heat and Other Utilities			199,897	199,897		199,897	449	200,346			5
6	Maintenance	62,830		50,881	113,711		113,711	881	114,592			6
7	Other (specify):* Waste Removal			18,350	18,350		18,350		18,350			7
8	TOTAL General Services	381,887	339,628	528,359	1,249,874		1,249,874	1,330	1,251,204			8
	B. Health Care and Programs											
9	Medical Director			23,200	23,200		23,200		23,200			9
10	Nursing and Medical Records	2,498,508	250,567	77,669	2,826,744		2,826,744	61,545	2,888,289			10
10a	Therapy	67,603	1,262	18,885	87,750		87,750		87,750			10a
11	Activities	113,991		2,738	116,729		116,729		116,729			11
12	Social Services	75,493		1,798	77,291		77,291		77,291			12
13	CNA Training											13
14	Program Transportation	20,404		6,517	26,921		26,921		26,921			14
15	Other (specify):*							11,647	11,647			15
16	TOTAL Health Care and Programs	2,775,999	251,829	130,807	3,158,635		3,158,635	73,192	3,231,827			16
	C. General Administration											
17	Administrative	153,305		47,939	201,244		201,244	34,647	235,891			17
18	Directors Fees											18
19	Professional Services			359,355	359,355		359,355	6,420	365,775			19
20	Dues, Fees, Subscriptions & Promotions			54,041	54,041		54,041	(1,904)	52,137			20
21	Clerical & General Office Expenses	202,810	19,369	70,241	292,420		292,420	103,049	395,469			21
22	Employee Benefits & Payroll Taxes			608,469	608,469		608,469		608,469			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,077	3,077		3,077	525	3,602			24
25	Other Admin. Staff Transportation			43,009	43,009		43,009	764	43,773			25
26	Insurance-Prop.Liab.Malpractice			174,176	174,176		174,176		174,176			26
27	Other (specify):*							28,986	28,986			27
28	TOTAL General Administration	356,115	19,369	1,360,307	1,735,791		1,735,791	172,487	1,908,278			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,514,001	610,826	2,019,473	6,144,300		6,144,300	247,009	6,391,309			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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							300,388	300,388			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			62,657	62,657		62,657	344,097	406,754			32
33	Real Estate Taxes			54,169	54,169		54,169		54,169			33
34	Rent-Facility & Grounds			345,056	345,056		345,056	(329,342)	15,714			34
35	Rent-Equipment & Vehicles			9,679	9,679		9,679		9,679			35
36	Other (specify):*											36
37	TOTAL Ownership			471,561	471,561		471,561	315,143	786,704			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		285,230	656,075	941,305		941,305		941,305			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			350,316	350,316		350,316		350,316			42
43	Other (specify):* Nonallowable Exp	15,432	8,896	166,823	191,151		191,151	(191,151)				43
44	TOTAL Special Cost Centers	15,432	294,126	1,173,214	1,482,772		1,482,772	(191,151)	1,291,621			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,529,433	904,952	3,664,248	8,098,633		8,098,633	371,001	8,469,634			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	300,388	30		9
10	Interest and Other Investment Income	(708)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(532)	43		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	(16,513)	43		18
19	Entertainment				19
20	Contributions	(28,800)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,340)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(82,500)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(65,079)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 103,916		\$	30

BHF USE ONLY							
48		49		50		51	

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)	267,085		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 267,085		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 371,001		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing Salary	(15,432)	43	1
2	Marketing Expense	(47,277)	43	2
3	Theft & Damage Loss	(97)	43	3
4	Additional R&M	720	6	4
5	PAC Dues	(2,993)	20	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(65,079)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Gardenview Manor # 0052456 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	449	0	0	0	0	0	0	0	0	449	5
6	Maintenance	720	0	161	0	0	0	0	0	0	0	0	881	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	720	0	610	0	0	0	0	0	0	0	0	1,330	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	71,226	(9,681)	0	0	0	0	0	0	0	61,545	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	11,647	0	0	0	0	0	0	0	0	11,647	15
16	TOTAL Health Care and Programs	0	0	82,873	(9,681)	0	0	0	0	0	0	0	73,192	16
	C. General Administration													
17	Administrative	0	0	34,647	0	0	0	0	0	0	0	0	34,647	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,340)	0	8,760	0	0	0	0	0	0	0	0	6,420	19
20	Fees, Subscriptions & Promotions	(2,993)	0	1,089	0	0	0	0	0	0	0	0	(1,904)	20
21	Clerical & General Office Expenses	0	0	103,049	0	0	0	0	0	0	0	0	103,049	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	525	0	0	0	0	0	0	0	0	525	24
25	Other Admin. Staff Transportation	0	0	764	0	0	0	0	0	0	0	0	764	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	28,986	0	0	0	0	0	0	0	0	28,986	27
28	TOTAL General Administration	(5,333)	0	177,820	0	0	0	0	0	0	0	0	172,487	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(4,613)	0	261,303	(9,681)	0	0	0	0	0	0	0	247,009	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Gardenview Manor # 0052456 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	300,388	0	0	0	0	0	0	0	0	0	0	300,388	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(708)	344,805	0	0	0	0	0	0	0	0	0	344,097	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(345,056)	15,714	0	0	0	0	0	0	0	0	(329,342)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	299,680	(251)	15,714	0	0	0	0	0	0	0	0	315,143	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(191,151)	0	0	0	0	0	0	0	0	0	0	(191,151)	43
44	TOTAL Special Cost Centers	(191,151)	0	0	0	0	0	0	0	0	0	0	(191,151)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	103,916	(251)	277,017	(9,681)	0	0	0	0	0	0	0	371,001	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	32	Interest	251	Gardenview Manor Realty, LLC	100.00%	345,056	\$ 344,805	1
2	V	34	Rent-Facility & Grounds	345,056	Gardenview Manor Realty, LLC	100.00%		(345,056)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 345,307			\$ 345,056	\$ * (251)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Heat and Other Utilities	\$	Premier Healthcare Management, LLC	100.00%	\$ 449	\$ 449	15
16	V	6	Maintenance		Premier Healthcare Management, LLC	100.00%	161	161	16
17	V	10	Nursing and Medical Records		Premier Healthcare Management, LLC	100.00%	71,226	71,226	17
18	V	15	Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	100.00%	11,647	11,647	18
19	V	17	Administrative	47,939	Premier Healthcare Management, LLC	100.00%	82,586	34,647	19
20	V	19	Professional Services		Premier Healthcare Management, LLC	100.00%	8,760	8,760	20
21	V	20	Dues, Fees, Subs & Promo		Premier Healthcare Management, LLC	100.00%	1,089	1,089	21
22	V	21	Clerical & Gen Office Expenses		Premier Healthcare Management, LLC	100.00%	103,049	103,049	22
23	V	24	Travel and Seminar		Premier Healthcare Management, LLC	100.00%	525	525	23
24	V	25	Other Admin. Staff Trans		Premier Healthcare Management, LLC	100.00%	764	764	24
25	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	28,986	28,986	25
26	V	34	Rent-Facility & Grounds		Premier Healthcare Management, LLC	100.00%	15,714	15,714	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			\$ 47,939			\$ 324,956	\$ * 277,017	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

X 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	10	Nursing and Medical Records	\$ 15,264	Premier Healthcare Supplies, LLC	100.00%	\$ 5,583	\$ (9,681)	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			\$ 15,264			\$ 5,583	\$ * (9,681)	39

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	<u>Barak Bayer</u>	<u>50.00%</u>	<u>Gilman Healthcare Center</u>	<u>Gilman</u>	<u>Premier Healthcare</u>	<u>Skokie</u>	<u>Management Co.</u>	1
2	<u>David Cheplowitz</u>	<u>50.00%</u>	<u>Champaign Urbana Nursing & Rehab</u>	<u>Savoy</u>	<u>Management, LLC</u>			2
3			<u>Winfield Woods Healthcare Center</u>	<u>Winfield</u>	<u>Premier Healthcare</u>	<u>Skokie</u>	<u>Medical Supply</u>	3
4			<u>Pershing Gardens Healthcare Center</u>	<u>Stickney</u>	<u>Supplies, LLC</u>			4
5			<u>Courtyard Healthcare</u>	<u>Danville</u>	<u>Gardenview Manor</u>	<u>Danville</u>	<u>Lessor</u>	5
6			<u>Norridge Gardens</u>	<u>Norridge</u>	<u>Realty, LLC</u>			6
7			<u>Premier Healthcare of Fort Wayne, LLC</u>	<u>Fort Wayne, IN</u>	<u>REX Therapeutics</u>	<u>Skokie</u>	<u>Therapy</u>	7
8			<u>Premier Healthcare of North Vernon, LLC</u>	<u>North Vernon, IN</u>				8
9			<u>Premier Healthcare of Sheridan, LLC</u>	<u>Sheridan, IN</u>				9
10			<u>Premier Healthcare of Connersville, LLC</u>	<u>Connersville, IN</u>				10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gardenview Manor # 0052456 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	David Cheplowitz	Shareholder	Administrative	50.00%	See Att Sch 7A	4.81	12%	Alloc Salary	\$ 18,759	17-7	1
2	Barak Bayer	Shareholder	Administrative	50.00%	See Att Sch 7A	4.81	12%	Alloc Salary	18,759	17-7	2
3	Sara Bayer	Relative	Clerical	0	See Att Sch 7A	4.81	12%	Alloc Salary	5,315	21-7	3
4	Yocheved Bayer	Relative	Consultant	0.00	9,750			Consulting	9,000	19-3	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	\$ 51,833		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number	Gardenview Manor
--------------------------------------	-------------------------

0052456

Report Period Beginning:

1/1/16

Ending: 12/31/16

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 Management, LLC

Street Address

8170 N. McCormick Blvd. Suite 137

City / State / Zip Code

Skokie, IL 60076

Phone Number

(847) 674-2800

Fax Number

(847) 674-4133

	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	5	Heat and Other Utilities	Census Days	348,950	11	\$ 3,732	\$	41,961	\$ 449	1
2	6	Maintenance	Census Days	348,950	11	1,338		41,961	161	2
3	10	Nursing and Medical Records	Census Days	348,950	11	592,321	592,321	41,961	71,226	3
4	15	Emp Benefit Alloc-Healthcare	Census Days	348,950	11	96,859		41,961	11,647	4
5	17	Administrative	Census Days	348,950	11	686,791	686,791	41,961	82,586	5
6	19	Professional Services	Census Days	348,950	11	72,849		41,961	8,760	6
7	20	Dues, Fees, Subs & Promo	Census Days	348,950	11	9,057		41,961	1,089	7
8	21	Clerical & Gen Office Expenses	Census Days	348,950	11	856,961	787,295	41,961	103,049	8
9	24	Travel and Seminar	Census Days	348,950	11	4,369		41,961	525	9
10	25	Other Admin. Staff Trans	Census Days	348,950	11	6,355		41,961	764	10
11	27	Emp Benefit Alloc-Gen Admin	Census Days	348,950	11	241,050		41,961	28,986	11
12	34	Rent-Facility & Grounds	Census Days	348,950	11	130,681		41,961	15,714	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					\$ 2,702,363	\$ 2,066,407		\$ 324,956	25

SEE ACCOUNTANTS' PREPARATION REPORT

Ending: 12/31/16

(847) 674-4133

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 Bank		X	Mortgage		4/30/2015	\$ 8,000,000	\$ 8,000,000	5/5/2020		\$ 345,056	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	MB Financial Bank		X	Line of Credit				670,438			42,657	6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 8,000,000	\$ 8,670,438			\$ 387,713	9	
	B. Non-Facility Related*												
10												10	
11								Loan Cost Amortization			20,000	11	
12								Offset Interest Income			(959)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 19,041	14	
15	TOTALS (line 9+line14)						\$ 8,000,000	\$ 8,670,438			\$ 406,754	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.) SEE ACCOUNTANTS' PREPARATION REPORT

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Gardenview Manor COUNTY Vermilion

FACILITY IDPH LICENSE NUMBER 0052456

CONTACT PERSON REGARDING THIS REPORT Larry Templin

TELEPHONE (630) 361-2868 FAX #:

A. Summary of Real Estate Tax Cost

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.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 22-24-200-020-0060	Long Term Care Property	\$ 55,869.58	\$ 55,869.58
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 55,869.58	\$ 55,869.58

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 74,000

B. General Construction Type: Exterior BrickFrame Single StoryNumber of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility☐ (b) Rent from a Related Organization.☒ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment☒ (b) Rent equipment from a Related Organization.☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

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			2015	\$ 327,415	1
2					2
3	TOTALS			\$ 327,415	3

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	213		2015	1974	\$ 5,198,585	\$	35	\$ 99,021	\$ 99,021	\$ 198,042
5										
6										
7										
8										
	Improvement Type**									
9	Illuminated Outdoor Sign Installed In Concrete			2013	6,895		20	345	345	1,380
10	South Lot Ground Level Up, North Tear Out Asphalt Drive			2013	293,700		20	14,685	14,685	58,740
11	And Brick Wall And Put Dirt			2013			20			
12	Removal Of Damaged Areas In Existing Stucco			2013	76,600		20	3,830	3,830	15,320
13	And Recoat With Dryvit			2013			20			
14	New Drain, Waste And Vent Pvc Piping			2014	130,000		20	6,500	6,500	19,500
15	And New Water Supply Tubing			2014			20			
16	New Gas Line From Mechanical Room			2014	8,700		20	435	435	1,305
17	To 4 Rooftop Heating Units			2014			20			
18	Furnish & Install 4 13 Seer Rooftops, Ductwork			2014	75,600		20	3,780	3,780	11,340
19	& Install 4 Programmable Thermostats For All The Rooftops			2014			20			
20	Installation Of New Light Fixtures: Pendant, Wall Mount:			2014	70,400		20	3,520	3,520	10,560
21	Bronze Aluminum Doors And Windows With Clear Glass			2014	180,363		20	9,018	9,018	27,054
22	Mirrors			2014	4,125		20	206	206	618
23	Replace Grease Trap			2014	4,200		20	210	210	630
24	Saw Cut 6 Rooms Break Out Haul Debris Concrete Chuncks			2014	11,500		20	575	575	1,725
25	24 8'X8' Concrete Pads			2014	14,070		20	704	704	2,111
26	Concrete Sidewalk On North & East Side Of Building			2014	7,450		20	373	373	1,118
27	Breaking Out Of Concrete In 2 Bathrooms & 1 Sitting Area			2014	3,365		20	168	168	505
28	Carpet For Bedrms, Living Area, Lobby, Planks For Hallway			2014	37,441		20	1,872	1,872	5,616
29	Brick And Wooden Flooring			2014	16,899		20	845	845	2,535
30	Privacy Fence On East Side Of Building			2014	16,475		20	824	824	2,472
31	Indoor Doorguards, Door Contacts, Momentary Key Switch			2014	11,590		20	579	579	1,738
32	Toilets, Tanks, Seats,Faucets And Valves			2014	10,227		20	511	511	1,534
33	2 Split Systems, Thermostats, Ductwork Fireplaces Ptac Units			2014	8,581		20	429	429	1,287
34	Landscaping And Cleanup			2014	38,054		20	1,903	1,903	5,708
35	Bronze Cabinet Set In Concrete			2014	8,379		20	419	419	1,257
36	Frame And Dry Wall, Prep Hallways For Wallpaper			2014	29,550		20	1,478		

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

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

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gardenview Manor

0052456

Report Period Beginning:

1/1/16

Ending:

12/31/16

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	
37	Prep Floor For Tile	2014	\$	\$	20	\$	\$	\$	37
38	Demo Walls And Ceilings, Frame All Walls	2014	117,500		20	5,875	5,875	17,625	38
39	Interior Doors, Floor Tiles In Bathrooms	2014			20				39
40	Installation Exhaust Grill To Ptac Unit	2014	7,082		20	354	354	1,062	40
41	Nursing Home And Garage Painting	2014	5,035		20	252	252	756	41
42	Wallpaper, Paint And Wallpaper Hanging	2014	12,310		20	616	616	1,847	42
43	Hollow Metal Frames And Wooden Doors	2014	30,177		20	1,509	1,509	4,527	43
44	Paint ,Etal Roofing Around Nursing Home	2014	12,760		20	638	638	1,914	44
45	Break Out Concrete In Garden Area & Entrance Door Stoop	2014	2,675		20	134	134	402	45
46	Acoustic Ceiling Tile And Grid	2014	30,986		20	1,549	1,549	4,648	46
47	Shower Faucets, Trims, Vacuum Brackets, Gender Sinks	2014	3,789		20	189	189	568	47
48	Window Treatments	2014	4,532		20	227	227	680	48
49	Security System	2014	28,704		20	1,435	1,435	4,305	49
50	30 Sprinkler Heads	2014	3,225		20	161	161	484	50
51	Installed One New Letter Wall Sign	2014	2,790		20	140	140	419	51
52	Installed 6" Dark Bronze Gutter	2014	3,141		20	157	157	471	52
53	B-Wing Nurse Call Station	2014	3,994		20	200	200	599	53
54	Installed Corian Countertop	2014	4,279		20	214	214	642	54
55	Installed Villa Door Closers, Grab Bars, Tiles, Doors	2014	3,375		20	169	169	507	55
56	Nurse Call Station	2014	5,052		20	253	253	758	56
57	Front Entrance Landscaping	2014	5,956		20	298	298	894	57
58	Installed New Sink In Salon	2014	6,200		20	310	310	930	58
59	Security System	2014	10,745		20	537	537	1,612	59
60	Repaired Air Compressor	2014	7,095		20	355	355	1,065	60
61	Security System	2014	10,290		20	515	515	1,544	61
62	Door Repairs	2014	7,380		20	369	369	1,107	62
63	Removed Concrete	2014	8,200		20	410	410	1,230	63
64	Door Repairs	2014	13,965		20	698	698	2,095	64
65	Door Repairs	2014	14,361		20	718	718	2,154	65
66	Therapy Room Carpeting	2014	15,855		20	793	793	2,378	66
67	Paving - Patchwork And Asphalt	2014	16,700		20	835	835	2,505	67
68	Hallway Handrails, Doors, Bathrm Sinks, Paint Therapy Rm	2014	18,410		20	921	921	2,762	68
69	Annunciator System	2014	57,201		20	2,860	2,860	8,580	69
70	TOTAL (lines 4 thru 69)		\$ 6,736,513	\$		\$ 175,921	\$ 174,443	\$ 443,165	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Gardenview Manor

0052456

Report Period Beginning:

1/1/16

Ending:

12/31/16

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 12A, Carried Forward		\$ 6,736,513	\$		\$ 175,921	\$ 175,921	\$ 443,165	1
2	B-Wing Nurse Call Station	2014	3,346		20	335	335	1,004	2
3	8 Dining Metal Chairs	2015	3,150		20	158	158	316	3
4	Architectural Design And Contract	2015	33,390		20	1,670	1,670	3,340	4
5	Double Headed Led Lights Above Exit Lights	2015	3,700		20	185	185	370	5
6	2 Power Generators Load Test And Repair	2015	4,350		20	218	218	436	6
7	Install 2 Digital Duplex Speakerphones And Phone System	2015	20,390		20	1,020	1,020	2,040	7
8	Water/Fire Restoration - Fire Damaged Roof	2016	7,418		20	185	185	185	8
9	Repair Generator	2016	3,727		20	93	93	93	9
10	Replace Electrical from Gear to Front Office Panels	2016	18,975		20	474	474	474	10
11	Replaced Compressors	2016	11,650		20	291	291	291	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)		\$ 6,846,609	\$		\$ 180,550	\$ 180,550	\$ 451,714	34

SEE ACCOUNTANTS' PREPARATION REPORT

**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 12B, Carried Forward		\$ 6,846,609	\$		\$ 180,550	\$ 180,550	\$ 451,714	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9 Allocated from Premier HC Management	2013	2,992		20	149	149	478	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)		\$ 6,849,601	\$		\$ 180,699	\$ 180,699	\$ 452,192	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)
C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,178,243	\$	\$ 117,824	\$ 117,824	10	\$ 260,653	71
72	Current Year Purchases	37,291		1,865	1,865	10	1,865	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,215,534	\$	\$ 119,689	\$ 119,689		\$ 262,518	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,392,550	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 300,388	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 300,388	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 714,710	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	Allocated from Management Co.				15,714			5
6								6
7	TOTAL				\$ 15,714			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: \$ 4,691 Description: Nursing Equipment \$4275; Maint Equip \$416
(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	Facility	2014 Land Rover	1,663	4,988	18
19					19
20					20
21	TOTAL		\$ 1,663.00	\$ 4,988	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. | /2017 | \$ |
| 13. | /2018 | \$ |
| 14. | /2019 | \$ |

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

12345678										
	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(3)	hrs	\$		\$ 268,514	\$		\$ 268,514	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs			76,336			76,336	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs			299,553			299,553	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				281,364		281,364	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached Scheule 16A					11,672	3,866		15,538	13
14	TOTAL			\$		\$ 656,075	\$ 285,230		\$ 941,305	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name:

Gardenview Manor

IDPH License ID Number:

0052456

Fiscal Year End:

12/31/16

Schedule 16A

XIV. Special Services

Line 13 Other Services

Description	Schedule V	
	Line & Column	
	Reference	Amount
Lab & Xray	39(3)	9,163
Rentals-Medicare	39(3)	249
Outside MD Service-MCA	39(3)	2,260
Medical Supplies - MCA	39(2)	3,866
Total - Line 13		15,538

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	\$ 19,662	\$ 19,726	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 925,833)	3,675,527	3,675,527	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	39,013	39,013	6
7	Other Prepaid Expenses	7,727	7,727	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,741,929	\$ 3,741,993	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		327,415	13
14	Buildings, at Historical Cost		5,198,595	14
15	Leasehold Improvements, at Historical Cost	1,732,011	1,651,006	15
16	Equipment, at Historical Cost	753,433	1,215,534	16
17	Accumulated Depreciation (book methods)	(495,143)	(714,710)	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 Schedule 17A	7,553	3,199,605	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,997,854	\$ 10,877,445	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,739,783	\$ 14,619,438	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,083,839	\$ 1,083,839	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	670,438	670,438	29
30	Accrued Salaries Payable	362,131	362,131	30
31	Accrued Taxes Payable (excluding real estate taxes)	426,907	426,907	31
32	Accrued Real Estate Taxes(Sch.IX-B)		54,170	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	5,681,244	5,444,238	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 8,224,559	\$ 8,041,723	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,000,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 8,000,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,224,559	\$ 16,041,723	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,484,776)	\$ (1,422,285)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,739,783	\$ 14,619,438	48

Facility Name: Gardenview Manor
IDPH License ID Number: 0052456
Fiscal Year End: 12/31/16

Schedule 17A

XV. Balance Sheet

Line 23 Other Assets (specify):

Description	Operating	After Consolidation
Loan Closing Costs	27,553	134,934
Accum. Amorization-Lo	(20,000)	(34,317)
Intangibles - GV Realty		1,596,400
Reserves/Escrows		1,502,588
Total - Line 23	7,553	3,199,605

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Accrued MDS Tax	96,792	96,792
Accrued Expenses	177,938	177,938
Accrued Bed Tax	39,299	39,299
Payroll Withholdings	356,015	356,015
Due to Related Parties	5,011,200	4,774,194
Total - Line 36	5,681,244	5,444,238

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (305,807)	1
2	Restatements (describe): Bad Debt Expense		2
3	Prior Period Adjustments - Bad Debt Expense	(750,000)	3
4	Prior Period Adjustments - Other Expenses	(812,283)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,868,090)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(616,686)	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)	\$ (616,686)	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)	\$ (2,484,776)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gardenview Manor

0052456

Report Period Beginning:

1/1/16

Ending:

12/31/16

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	\$ 7,185,130	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,185,130	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	274,170	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 274,170	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	21,945	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(6)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 21,939	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	708	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 708	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,481,947	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,249,874	31
32	Health Care	3,158,635	32
33	General Administration	1,735,791	33
	B. Capital Expense		
34	Ownership	471,561	34
	C. Ancillary Expense		
35	Special Cost Centers	1,132,456	35
36	Provider Participation Fee	350,316	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,098,633	40
41	Income before Income Taxes (line 30 minus line 40)**	(616,686)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (616,686)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 4,279,592	44
45	Private Pay - Net Inpatient Revenue	517,382	45
46	Medicare - Net Inpatient Revenue	1,793,053	46
47	Other-(specify) <u>Insurance</u>	429,860	47
48	Other-(specify) <u>Veterans</u>	165,243	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,185,130	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	1,671	1,775	\$ 77,302	\$ 43.55	1
2	Assistant Director of Nursing	1,884	1,916	68,555	35.78	2
3	Registered Nurses	18,332	19,364	592,121	30.58	3
4	Licensed Practical Nurses	21,964	22,635	592,121	26.16	4
5	CNAs & Orderlies	74,838	77,254	975,933	12.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,140	5,467	67,603	12.37	8
9	Activity Director	1,904	2,040	31,276	15.33	9
10	Activity Assistants	8,718	9,099	82,715	9.09	10
11	Social Service Workers	3,973	4,120	75,493	18.32	11
12	Dietician					12
13	Food Service Supervisor	1,088	1,136	44,780	39.42	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,504	29,216	274,277	9.39	15
16	Dishwashers					16
17	Maintenance Workers	4,318	4,535	62,830	13.85	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,914	3,176	153,305	48.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,452	9,939	202,810	20.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,797	4,098	54,821	13.38	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch 20A</u>	5,624	5,906	173,491	29.38	33
34	TOTAL (lines 1 - 33)	194,121	201,676	\$ 3,529,433 *	\$ 17.50	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	254	\$ 12,438	L1, C3	35
36	Medical Director	Monthly	23,200	L9, C3	36
37	Medical Records Consultant	27	1,844	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	17,714	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,239	L11, C3	44
45	Social Service Consultant	Monthly	1,798	L12, C3	45
46	Other(specify) <u>Rehab Mgmt</u>	Monthly	22,000	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	281	\$ 80,233		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	259	\$ 12,539	L10, C3	50
51	Licensed Practical Nurses	428	17,977	L10, C3	51
52	Certified Nurse Assistants/Aides	224	5,595	L10, C3	52
53	TOTAL (lines 50 - 52)	911	\$ 36,111		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Gardenview Manor

Period Beginning 1/1/16
Period End 12/31/16

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	2,991	3,222	137,655	42.72
Transportation	2,124	2,148	20,404	9.50
Marketing	509	536	15,432	28.79
TOTAL	5,624	5,906	173,491	

Facility Name & ID Number		Gardenview Manor		STATE OF ILLINOIS		# 0052456		Report Period Beginning:		1/1/16		Ending:		Page 21		12/31/16	
XIX. SUPPORT SCHEDULES																	
A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions							
Name		Function		%		Amount		Description		Amount		Description		Amount			
Russell Elmore		Administrator		0		\$ 15,683		Workers' Compensation Insurance		\$ 90,452		IDPH License Fee		\$ 829			
Troy Gibbs		Administrator		0		42,269		Unemployment Compensation Insurance		106,105		Advertising: Employee Recruitment		37,652			
Patricia Heidenreich		Administrator		0		10,265		FICA Taxes		262,655		Health Care Worker Background Check					
Lonnie Nichols		Administrator		0		58,250		Employee Health Insurance		138,860		(Indicate # of checks performed 48)		(9)			
Adam Zanger		Administrator		0		26,838		Employee Meals		1,055		Patient Background Checks 124		3,590			
								Illinois Municipal Retirement Fund (IMRF)*				Dues & Subscriptions		1,956			
								Other Employee Benfits		7,932		Licenses & Permits		954			
								Employee Physical Exam		1,410		IL Council on LTC		6,076			
												Allocated from Management Co.		1,089			
												Less: Public Relations Expense		()			
												Non-allowable advertising		()			
												Yellow page advertising		()			
		</															

* Attach copy of IMRF notifications

SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name:

Gardenview Manor

IDPH License ID Number:

0052456

Fiscal Year End:

12/31/16

Schedule 21A

XIX. Support Schedules

C. Professional Services

Vendor/Payee	Type	Amount
Change Healthcare	Data Processing	679
Matrixcare	Data Processing	38,259
Singer Networks	Data Processing	11,950
Baver, Yocheved	Website Services	9,000
Terrill Consulting Services, Inc.	Billing Consultant	27,969
M & M Financial	Accounting/Tax	5,720
Total		93,577

XX. GENERAL INFORMATION:

STATE OF ILLINOIS

0052456

Report Period Beginning:

1/1/16

Ending:

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12/31/16

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. 6,076 IL Council on LTC
- (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?
What was the average life used for new equipment added during this period? Yes
10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. \$ 30,438 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. \$ 350,316
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' PREPARATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees