

		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>0052092</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																																																			
Facility Name: <u>Park View Rehab Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/16</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>5888 North Ridge</u> <u>Chicago</u> <u>60660</u>																																																																																					
Number City Zip Code																																																																																					
County: <u>Cook</u>																																																																																					
Telephone Number: <u>(773) 769-2626</u> Fax # <u>(773) 769-2650</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>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____ *</td></tr><tr><td>* Subject to the attached Accountants Consulting Report (Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td colspan="2">Date of Initial License for Current Owners: <u>11/1/1992</u></td><td colspan="2">(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td></tr><tr><td colspan="2">Type of Ownership:</td><td colspan="2">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><tr><td colspan="2"><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 colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☒</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2">_____</td></tr></table></td><td colspan="2"></td></tr><tr><td colspan="2">In the event there are further questions about this report, please contact:</td><td colspan="2"></td></tr><tr><td colspan="2">Name: <u>Steven N. Lavenda</u></td><td colspan="2">Telephone Number: <u>(847) 282-6300</u></td></tr><tr><td colspan="2">Email Address: _____</td><td colspan="2">_____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Date) _____	Paid Preparer	(Signed) _____ *	* Subject to the attached Accountants Consulting Report (Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	Date of Initial License for Current Owners: <u>11/1/1992</u>		(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>		Type of Ownership:		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		<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 colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☒</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2">_____</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 _____	_____				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: _____		_____	
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Facility Name & ID Number Park View Rehab Center

0052092 Report Period Beginning: 01/01/16 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 <u>N/A</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>128</u>	Skilled (SNF)	<u>128</u>	<u>46,848</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>128</u>	TOTALS	<u>128</u>	<u>46,848</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>7,327</u>	<u>227</u>	<u>3,177</u>	<u>10,731</u>	8
9	SNF/PED					9
10	ICF	<u>33,813</u>	<u>170</u>	<u>135</u>	<u>34,118</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>41,140</u>	<u>397</u>	<u>3,312</u>	<u>44,849</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.73%

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 ☒

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 07/01/2002

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 07/01/2002 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 128 and days of care provided 3,177

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: 12/31/2016 Fiscal Year: 12/31/2016
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/16 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	205,562	30,908	9,217	245,687		245,687		245,687			1
2	Food Purchase		224,310		224,310		224,310	1,960	226,270			2
3	Housekeeping	119,475	19,275		138,750		138,750	1,536	140,286			3
4	Laundry	47,170	12,609		59,779		59,779		59,779			4
5	Heat and Other Utilities			125,252	125,252		125,252	(1,169)	124,083			5
6	Maintenance	49,252		85,330	134,582		134,582	4,878	139,460			6
7	Other (specify):*											7
8	TOTAL General Services	421,459	287,102	219,799	928,360		928,360	7,205	935,565			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,715,221	117,438	155,720	1,988,379		1,988,379	(41,526)	1,946,853			10
10a	Therapy	32,436			32,436		32,436		32,436			10a
11	Activities	111,330	20,120	2,448	133,898		133,898		133,898			11
12	Social Services	163,143		3,980	167,123		167,123		167,123			12
13	CNA Training											13
14	Program Transportation			2,000	2,000		2,000		2,000			14
15	Other (specify):*							11,201	11,201			15
16	TOTAL Health Care and Programs	2,022,130	137,558	182,148	2,341,836		2,341,836	(30,325)	2,311,511			16
	C. General Administration											
17	Administrative	188,370		481,200	669,570		669,570	(456,825)	212,745			17
18	Directors Fees											18
19	Professional Services			72,795	72,795	(4,552)	68,243	7,125	75,368			19
20	Dues, Fees, Subscriptions & Promotions			47,690	47,690		47,690	(4,920)	42,770			20
21	Clerical & General Office Expenses	79,115		160,553	239,668		239,668	(2,290)	237,378			21
22	Employee Benefits & Payroll Taxes			538,183	538,183		538,183		538,183			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,754	1,754		1,754	1,300	3,054			24
25	Other Admin. Staff Transportation			9,042	9,042		9,042	4,696	13,738			25
26	Insurance-Prop.Liab.Malpractice			105,802	105,802		105,802	954	106,756			26
27	Other (specify):*							27,779	27,779			27
28	TOTAL General Administration	267,485		1,417,019	1,684,504	(4,552)	1,679,952	(422,181)	1,257,771			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,711,074	424,660	1,818,966	4,954,700	(4,552)	4,950,148	(445,301)	4,504,847			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							142,317	142,317			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			774	774		774	323,845	324,619			32
33	Real Estate Taxes					4,552	4,552	144,792	149,344			33
34	Rent-Facility & Grounds			960,263	960,263		960,263	(953,431)	6,832			34
35	Rent-Equipment & Vehicles			2,301	2,301		2,301		2,301			35
36	Other (specify):*											36
37	TOTAL Ownership			963,338	963,338	4,552	967,890	(342,477)	625,413			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		101,150	529,459	630,609		630,609		630,609			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			322,106	322,106		322,106		322,106			42
43	Other (specify):*			31,214	31,214		31,214	(31,214)				43
44	TOTAL Special Cost Centers		101,150	882,779	983,929		983,929	(31,214)	952,715			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,711,074	525,810	3,665,083	6,901,967		6,901,967	(818,992)	6,082,975			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	(2,237)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(61,299)	30		9
10	Interest and Other Investment Income	(1,403)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(20)	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	(780)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(73,650)	21		24
25	Fund Raising, Advertising and Promotional	(2,839)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(73,206)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (215,434)		\$	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)	(603,558)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (603,558)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (818,992)		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	Medicare Sequestration	\$ (29,102)	21	1
2	Marketing Expense	(8,587)	43	2
3	Bank Charges	(7,339)	21	3
4	Non Allowable Legal Fees	(321)	19	4
5	PAC Dues	(4,061)	20	5
6	Medical Record Revenue	(677)	10	6
7	Building Co Professional Fees	(8,925)	19	7
8	Building Co Amortization	(14,194)	36	8
9				9
10				10
11				11
12				12
13				13
14				14
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(73,206)		49

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
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86				37
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89				40
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91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/16 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													1
2	Food Purchase	(20)		1,797		183							1,960	2
3	Housekeeping			1,536									1,536	3
4	Laundry													4
5	Heat and Other Utilities	(2,237)		1,068									(1,169)	5
6	Maintenance			4,830		48							4,878	6
7	Other (specify):*													7
8	TOTAL General Services	(2,257)		9,231		231							7,205	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(677)				(40,849)							(41,526)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					11,201							11,201	15
16	TOTAL Health Care and Programs	(677)				(29,648)							(30,325)	16
	C. General Administration													
17	Administrative			(456,825)									(456,825)	17
18	Directors Fees													18
19	Professional Services	(9,246)	8,925	1,245	329	5,872							7,125	19
20	Fees, Subscriptions & Promotions	(6,900)		1,918	25	37							(4,920)	20
21	Clerical & General Office Expenses	(110,871)		126,461		(17,880)							(2,290)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			584		716							1,300	24
25	Other Admin. Staff Transportation					4,696							4,696	25
26	Insurance-Prop.Liab.Malpractice			954									954	26
27	Other (specify):*			26,336		1,443							27,779	27
28	TOTAL General Administration	(127,017)	8,925	(299,327)	354	(5,116)							(422,181)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(129,951)	8,925	(290,096)	354	(34,533)							(445,301)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/16 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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(61,299)	198,758	2,078	2,779								142,317	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,403)	323,362		1,886								323,845	32
33	Real Estate Taxes		140,733		4,059								144,792	33
34	Rent-Facility & Grounds		(960,263)	14,951	(8,119)								(953,431)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(14,194)	14,194											36
37	TOTAL Ownership	(76,896)	(283,216)	17,029	606								(342,477)	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):*	(8,587)				(22,627)							(31,214)	43
44	TOTAL Special Cost Centers	(8,587)				(22,627)							(31,214)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(215,434)	(274,291)	(273,067)	960	(57,160)							(818,992)	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 Supplemental Schedule		See Supplemental Schedule		See Supplemental Schedule		

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	Rental Income	\$ 960,263	Park View Rehab Center Realty	100.00%	\$	\$(960,263)	1
2	V	19	Professional Fees		Park View Rehab Center Realty	100.00%	8,925	8,925	2
3	V	32	Interest Expense		Park View Rehab Center Realty	100.00%	323,362	323,362	3
4	V	30	Depreciation		Park View Rehab Center Realty	100.00%	198,758	198,758	4
5	V	36	Amortization		Park View Rehab Center Realty	100.00%	14,194	14,194	5
6	V	33	Real Estate Tax		Park View Rehab Center Realty	100.00%	140,733	140,733	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 960,263			\$ 685,972	\$ *(274,291)	14

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

VII. RELATED PARTIES (continued)

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

☒ 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	2	DIETARY	\$	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	\$ 1,797	\$	1,797 15
16	V	3	HOUSEKEEPING		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,536		1,536 16
17	V	5	UTILITIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,068		1,068 17
18	V	6	REPAIRS AND MAINTENANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	4,830		4,830 18
19	V	17	S WEBSTER SALARY		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	12,279		12,279 19
20	V	17	Y LEVOVITZ-SALARY		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	12,096		12,096 20
21	V	19	PROFESSIONAL FEES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,245		1,245 21
22	V	20	DUES FEES SUBSCRIPTIONS		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,918		1,918 22
23	V	21	CLERICAL AND GENERAL		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	7,008		7,008 23
24	V	21	CLERICAL & GENERAL SALARIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	119,452		119,452 24
25	V	24	SEMINARS & EDUCATION		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	584		584 25
26	V	26	INSURANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	954		954 26
27	V	27	EMPLOYEE BEN. GEN ADMIN.		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	26,336		26,336 27
28	V	30	DEPRECIATION		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	2,078		2,078 28
29	V	34	RENT		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	14,951		14,951 29
30	V								30
31	V	17	MANAGEMENT FEES	481,200	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%			(481,200) 31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 481,200			\$ 208,133	\$ *	(273,067) 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 HC REAL ESTATE, LLC	100.00%	329	\$	329
16	V	20	LICENSES & PERMITS		PREMIER HC REAL ESTATE, LLC	100.00%	25		25
17	V	30	DEPRECIATION		PREMIER HC REAL ESTATE, LLC	100.00%	2,779		2,779
18	V	32	INTEREST EXPENSE		PREMIER HC REAL ESTATE, LLC	100.00%	1,886		1,886
19	V	33	REAL ESTATE TAXES		PREMIER HC REAL ESTATE, LLC	100.00%	4,059		4,059
20	V								20
21	V	34	RENT	8,119	PREMIER HC REAL ESTATE, LLC	100.00%			(8,119)
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			\$ 8,119			\$ 9,079	\$ *	960

* 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	2	DIETARY	\$	iCare Consulting Services LLC	100.00%	\$ 183	\$ 183	15
16	V	6	REPAIRS AND MAINTENANCE		iCare Consulting Services LLC	100.00%	48	48	16
17	V	10	NURSING SALARIES	147,965	iCare Consulting Services LLC	100.00%	107,116	(40,849)	17
18	V	15	EMPLOYEE BEN. HC PROGRAMS		iCare Consulting Services LLC	100.00%	11,201	11,201	18
19	V	19	PROFESSIONAL FEES		iCare Consulting Services LLC	100.00%	5,872	5,872	19
20	V	20	DUES FEES SUBSCRIPTIONS		iCare Consulting Services LLC	100.00%	37	37	20
21	V	21	CLERICAL AND GENERAL	35,873	iCare Consulting Services LLC	100.00%	4,641	(31,232)	21
22	V	21	CLERICAL & GENERAL SALARIES		iCare Consulting Services LLC	100.00%	13,352	13,352	22
23	V	24	SEMINARS & EDUCATION		iCare Consulting Services LLC	100.00%	716	716	23
24	V	27	EMPLOYEE BEN. GEN ADMIN.		iCare Consulting Services LLC	100.00%	1,443	1,443	24
25	V	25	AUTO & TRAVEL		iCare Consulting Services LLC	100.00%	4,696	4,696	25
26	V	43	MARKETING	22,627	iCare Consulting Services LLC	100.00%		(22,627)	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			\$ 206,465			\$ 149,305	\$ * (57,160)	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.

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.

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.

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	Yeruchom Levovitz	15.92%	CENTER HOME HISPANIC ELDERLY	CHICAGO	PREMIER HEALTHCARE & FINANCIAL SERVICES		MANAGEMENT CONSULTING	1
2	Shimon Webster	19.84%	PINE CREST HEALTH CARE	HAZEL CREST	PREMIER HEALTHCARE REALTY, LLC		BUILDING CO.	2
3	Chaim O Levovitz	3.91%	RIVER VIEW REHAB CENTER	ELGIN	PARK VIEW REHAB CENTER REALTY		BUILDING CO.	3
4	Jeffrey Webster	4.84%	FOREST CITY REHAB & NURSING	ROCKFORD	ICARE CONSULTING		CONSULTING	4
5	Mikel Children 2012 Trust	6.25%	ROCK RIVER HEALTH CARE	ROCKFORD	LIFELINE LAB		LAB	5
6	Howard Wengrow	4.05%	BROOK CHATEAU	KANSAS CITY, MO	PHARMORE DRUGS		PHARMACY	6
7	Jay Wengrow	2.34%	LEISURE TERRACE	OVERLAND PARK,KS				7
8	David Wengrow	2.34%	BREEZY MEADOWS	BUTLER, MO				8
9	Dina Braunstein	2.34%	PEARL PAVILION	FREEPORT				9
10	GPN Family Trust	14.25%						10
11	Menachem Shabat	3.56%						11
12	Ahuva Shabat	3.56%						12
13	Eliana Shabat	3.56%						13
14	Ayelet Shabat	3.56%						14
15	Moshe Levovitz	1.56%						15
16	Yakov Kohen	1.56%						16
17	Sharon Hinkle	1.56%						17
18	Ari Shabat	2.50%						18
19	Shoshana R. Shabat	2.50%						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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/16 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	Shimon Webster	Owner	Administrative	19.84%	See Attachment	4.06	10.15%	Alloc Salary	\$ 12,279	17-7	1
2	Yeruchom Levovitz	Owner	Administrative	15.92%	See Attachment	4.06	10.15%	Alloc Salary	12,096	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	\$ 24,375		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 Park View Rehab Center # 0052092 Report Period Beginning: 01/01/16 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 _____
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 Park View Rehab Center # 0052092 Report Period Beginning: 01/01/16 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 & FINANCIAL SER
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	2	DIETARY	PATIENT DAYS	441,943	10	\$ 17,705	\$	44,849	\$ 1,797	1
2	3	HOUSEKEEPING	PATIENT DAYS	441,943	10	15,135		44,849	1,536	2
3	5	UTILITIES	PATIENT DAYS	441,943	10	10,527		44,849	1,068	3
4	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	441,943	10	47,591		44,849	4,830	4
5	17	S WEBSTER SALARY	PATIENT DAYS	441,943	10	120,995	120,995	44,849	12,279	5
6	17	Y LEVOVITZ-SALARY	PATIENT DAYS	441,943	10	119,190	119,190	44,849	12,096	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	441,943	10	12,272		44,849	1,245	7
8	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	441,943	10	18,896		44,849	1,918	8
9	21	CLERICAL AND GENERAL	PATIENT DAYS	441,943	10	69,058		44,849	7,008	9
10	21	CLERICAL & GENERAL SALA	PATIENT DAYS	441,943	10	1,177,077	1,177,077	44,849	119,452	10
11	24	SEMINARS & EDUCATION	PATIENT DAYS	441,943	10	5,755		44,849	584	11
12	26	INSURANCE	PATIENT DAYS	441,943	10	9,405		44,849	954	12
13	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	441,943	10	259,519		44,849	26,336	13
14	30	DEPRECIATION	PATIENT DAYS	441,943	10	20,479		44,849	2,078	14
15	34	RENT	PATIENT DAYS	441,943	10	147,325		44,849	14,951	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,050,929	\$ 1,417,262		\$ 208,133	25

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/16 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 HC REAL ESTATE, LLC
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	19	PROFESSIONAL FEES	PATIENT DAYS	441,943	10	3,241		44,849	329	1
2	20	LICENSES & PERMITS	PATIENT DAYS	441,943	10	250		44,849	25	2
3	30	DEPRECIATION	PATIENT DAYS	441,943	10	27,389		44,849	2,779	3
4	32	INTEREST EXPENSE	PATIENT DAYS	441,943	10	18,587		44,849	1,886	4
5	33	REAL ESTATE TAXES	PATIENT DAYS	441,943	10	40,000		44,849	4,059	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					\$ 89,467	\$		\$ 9,079	25

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/16 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 iCare Consulting Services LLC
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	2	DIETARY	PATIENT DAYS	441,943	10	\$ 1,804	\$	44,849	\$ 183	1
2	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	441,943	10	472		44,849	48	2
3	10	NURSING SALARIES	PATIENT DAYS	441,943	10	1,055,519	1,084,019	44,849	107,116	3
4	15	EMPLOYEE BEN. HC PROGRA	PATIENT DAYS	441,943	10	110,378		44,849	11,201	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	441,943	10	57,864		44,849	5,872	5
6	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	441,943	10	369		44,849	37	6
7	21	CLERICAL AND GENERAL	PATIENT DAYS	441,943	10	45,733		44,849	4,641	7
8	21	CLERICAL & GENERAL SALA	PATIENT DAYS	441,943	10	131,573	131,573	44,849	13,352	8
9	24	SEMINARS & EDUCATION	PATIENT DAYS	441,943	10	7,055		44,849	716	9
10	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	441,943	10	14,224		44,849	1,443	10
11	25	AUTO & TRAVEL	PATIENT DAYS	345,177	7	36,142		44,849	4,696	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,461,133	\$ 1,215,592		\$ 149,305	25

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/16 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 _____
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 Park View Rehab Center # 0052092 Report Period Beginning: 01/01/16 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 _____
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 Park View Rehab Center # 0052092 Report Period Beginning: 01/01/16 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 _____
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 Park View Rehab Center # 0052092 Report Period Beginning: 01/01/16 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 _____
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

Ending: 12/31/16

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/16 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 _____
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			\$	5,800,427			\$	323,362	1	
2													2	
3													3	
4													4	
5					-								5	
	Working Capital													
6	MB Financial		X	Line of Credit				2,974,167				774	6	
7	MB Financial		X	Note Payable				40,000					7	
8	Alloc Premier HC Realty	X			-							1,886	8	
9	TOTAL Facility Related						\$	8,814,594				\$	326,022	9
	B. Non-Facility Related*													
10	Interest Income		X									(1,403)	10	
11													11	
12													12	
13					-								13	
14	TOTAL Non-Facility Related						\$					\$	(1,403)	14
15	TOTALS (line 9+line14)						\$	8,814,594				\$	324,619	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 - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term												7
	Working Capital												
8							\$		\$			\$	8
9													9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital												14
	B. Non-Facility Related*												
15							\$		\$			\$	15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related												20

* 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' COMPILATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2015 report.			\$	133,637	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	144,792	2
3. Under or (over) accrual (line 2 minus line 1).			\$	11,155	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	133,637	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	4,552	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	149,344	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	109,794	8	
		2012	126,715	9	
		2013	128,430	10	
		2014	131,017	11	
		2015	140,733	12	
2016 Accrual = 2015 Accrual					
Allocated from Premier HC Realty = \$4059					

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$		16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park View Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0052092

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. 14-05-306-016-0000	Long Term Care Facility	\$ 140,732.85	\$ 140,732.85
2. 10-23-324-047-0000	Allocated from Home Office	\$ 38,132.87	\$ 3,869.78
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 178,865.72	\$ 144,602.63

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 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Park View Rehab Center

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0052092

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-6300

FAX #:

(847) 236-6301

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 Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.			\$	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$	\$

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 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 provide copies of their original second installment tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:	84,000	B. General Construction Type:	Exterior	Brick	Frame	Steel	Number of Stories	3
------------------------	---------------	--------------------------------------	-----------------	--------------	--------------	--------------	--------------------------	----------

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		1991	\$ 105,600	1
2	Allocated From Premier HC Realty			1,928	2
3	TOTALS			\$ 107,528	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	128		1991	1971	1,878,400	\$	39	\$ 48,164	\$ 48,164	\$ 1,373,371
5										
6										
7										
8										
	Improvement Type**									
9	Various		1993		22,988		20			22,988
10	Various		1994		38,610		20			38,610
11	Various		1995		68,517		20			68,517
12	Various		1996		107,653		20	3	3	107,653
13	Various		1997		32,071		20	1,598	1,598	32,067
14	Various		1998		19,271		20	964	964	18,311
15	Various		1999		16,863		20	844	844	15,182
16	Various		2000		50,104		20	2,506	2,506	42,591
17	Various		2001		9,165		20	458	458	7,331
18	Various		2002		38,362		20	1,919	1,919	28,775
19	Various		2003		20,009		20	1,000	1,000	14,008
20	Various		2004		38,100		20	1,906	1,906	24,770
21	Various		2005		127,366		20	6,369	6,369	76,423
22	Various		2006		2,900		20	145	145	1,595
23	Various		2007		3,348		20	167	167	1,672
24	Various		2008		32,480		20	1,624	1,624	14,616
25	Various		2009		33,390		20	2,417	2,417	19,332
26	Various		2010		17,840		20	892	892	6,244
27	Various		2012		32,072		20	1,604	1,604	8,020
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Park View Rehab Center

0052092

Report Period Beginning:

01/01/16

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	
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)		318,938			4,435	4,435	300,294	67
68	Related Party Allocations (Pages 12H & 12I)		114,635	4,761		4,818	57	24,062	68
69	Financial Statement Depreciation			198,758			(198,758)		69
70	TOTAL (lines 4 thru 69)		\$ 3,023,082	\$ 203,519		\$ 81,833	\$ (121,686)	\$ 2,246,432	70

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

Facility Name & ID Number Park View Rehab Center

0052092

Report Period Beginning:

01/01/16

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	
1	Totals from Page 12A, Carried Forward		\$ 3,023,082	\$ 203,519		\$ 81,833	\$ (121,686)	\$ 2,246,432	1
2	Brickwork And Exterior Work	2013	150,000		20	7,500	7,500	27,500	2
3	Corridors - Doors	2013	7,715		20	386	386	1,382	3
4	Decorative Lighting	2013	3,000		20	600	600	2,150	4
5	Sliding Doors	2013	10,932		20	547	547	1,959	5
6	Lighting And Electrical	2013	2,908		20	145	145	521	6
7	B&G Pump	2013	3,400		20	170	170	553	7
8	Heating And Boiler Work	2013	7,964		20	398	398	1,261	8
9	Dig Up Floor, Add Drain	2013	2,800		20	140	140	432	9
10	Lobby & Vestibule: New Ceiling & Lighting,Ceramic Tile Installa	2013	11,537		20	577	577	1,827	10
11	Conference & Reception:New Flooring, Wallcovering, Window Tr	2013	5,536		20	277	277	877	11
12	1St Floor Corridor:New Flooring, Wallcovering, Handrails, Bump	2013	27,899		20	1,395	1,395	4,417	12
13	1St Floor Dining Room: New Flooring, Wallcovering,Chair Rails,	2013	14,425		20	721	721	2,284	13
14	1St Floor Resident Rooms: Window Treatments, Cubicle Curtains	2013	21,825		20	1,091	1,091	3,456	14
15	Elevator: Replace Ceilings, Handrails, New Wall Panel System, Fl	2013	8,273		20	414	414	1,310	15
16	Basement Corridor:New Flooring, Handrails, Bumper Guards, Si	2013	17,767		20	888	888	2,813	16
17	Various Areas: Remove Old Wallcovering, Install New, & Paint V	2013	29,506		20	1,475	1,475	4,672	17
18	Elevator Repair- Cylinder And Piston Replacement	2013	32,400		20	1,620	1,620	5,805	18
19	Elevator Modernization-Car Operating Panel, Ball Fixtures, & So	2013	16,500		20	825	825	2,956	19
20	New Hardscaping And Softscaping	2013	42,900		20	2,145	2,145	8,044	20
21	Fire Sprinkler-Piping, Reducer, Extender, Heat Detector, Pump C	2014	6,588		20	329	329	769	21
22	Therapy Room - Install Ceiling Tile & Paint Ceiling	2014	5,111		20	256	256	660	22
23	Bathroom Wall / Supply Line / Shower Valve	2014	4,600		20	230	230	575	23
24	Paint Walls In Basement Corridor, 1St Flr Rms, Bathrooms, Ther	2014	9,852		20	493	493	1,026	24
25	Security Camera	2015	8,313		20	416	416	762	25
26	Install New Maxton Valve For Passenger Elevator	2016	3,900		20	195	195	195	26
27	Install New 2 Zone Fujitsu Btgu System	2016	5,450		20	273	273	273	27
28	Installed Flooring, Carpet, Corner Guards, 2Nd/3Rd Floor Corner	2016	261,797		20	13,090	13,090	13,090	28
29	Replace Supply Line Including 2 3 Bulb Valve	2016	3,440		20	172	172	172	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,749,420	\$ 203,519		\$ 118,600	\$ (84,919)	\$ 2,338,170	34

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

Facility Name & ID Number Park View Rehab Center

0052092

Report Period Beginning:

01/01/16

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 12B, Carried Forward		\$ 3,749,420	\$ 203,519		\$ 118,600	\$ (84,919)	\$ 2,338,170	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)		\$ 3,749,420	\$ 203,519		\$ 118,600	\$ (84,919)	\$ 2,338,170	34

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

Facility Name & ID Number Park View Rehab Center

0052092

Report Period Beginning:

01/01/16

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 12C, Carried Forward		\$ 3,749,420	\$ 203,519		\$ 118,600	\$ (84,919)	\$ 2,338,170	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)		\$ 3,749,420	\$ 203,519		\$ 118,600	\$ (84,919)	\$ 2,338,170	34

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

Facility Name & ID Number Park View Rehab Center

0052092

Report Period Beginning:

01/01/16

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 12D, Carried Forward		\$ 3,749,420	\$ 203,519		\$ 118,600	\$ (84,919)	\$ 2,338,170	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)		\$ 3,749,420	\$ 203,519		\$ 118,600	\$ (84,919)	\$ 2,338,170	34

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

Facility Name & ID Number Park View Rehab Center

0052092

Report Period Beginning:

01/01/16

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	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 Building Company		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8 Leasehold Improvements:								8
9 Heritage Nursing Center, Inc	1978	4,510		20			4,510	9
10 Heritage Nursing Center, Inc	1981	78,925		20			78,925	10
11 Heritage Nursing Center, Inc	1983	6,069		20			6,069	11
12 Heritage Nursing Center, Inc	1985	8,483		20			8,483	12
13 Heritage Nursing Center, Inc	1986	5,000		20			5,000	13
14 Heritage Nursing Center, Inc	1987	2,250		20			2,250	14
15 Heritage Nursing Center, Inc	1990	4,919		20			4,919	15
16 Heritage Nursing Center, Inc	1991	118,564		20			118,564	16
17 Heritage Nursing Center, Inc	1992	23,467		20			23,467	17
18 Heritage Nursing Center, Inc	2007	58,551		20	3,991	3,991	39,907	18
19 Heritage Nursing Center, Inc	2009	4,500		20			4,500	19
20 Heritage Nursing Center, Inc	2010	3,700		20	444	444	3,700	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)		\$ 318,938	\$		\$ 4,435	\$ 4,435	\$ 300,294	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		\$ 318,938	\$		\$ 4,435	\$ 4,435	\$ 300,294	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)		\$ 318,938	\$		\$ 4,435	\$ 4,435	\$ 300,294	34

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

Facility Name & ID Number Park View Rehab Center

0052092

Report Period Beginning:

01/01/16

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	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated From Premier Realty	2011	37,792	969	39	1,080	111	5,488	3
4	Allocated From Premier Realty	2012	4,812	123	39	137	14	688	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From Premier Realty	2011	67,216	1,602	20	3,361	1,759	17,084	9
10	Allocated From Premier Realty	2012	1,948	50	20	97	47	487	10
11									11
12	Allocated From Premier HC & Financial Services	2012	858	8	20	43	35	215	12
13	Allocated From Premier HC & Financial Services	2016	2,009	2,009	20	100	(1,909)	100	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)		\$ 114,635	\$ 4,761		\$ 4,818	\$ 57	\$ 24,062	34

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

Facility Name & ID Number Park View Rehab Center

0052092

Report Period Beginning:

01/01/16

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 12H, Carried Forward		\$ 114,635	\$ 4,761		\$ 4,818	\$ 57	\$ 24,062	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)		\$ 114,635	\$ 4,761		\$ 4,818	\$ 57	\$ 24,062	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	\$139,896	\$35	\$22,489	\$22,454	10	\$90,068	71
72	Current Year Purchases	12,269	61	1,227	1,166	10	1,227	72
73	Fully Depreciated Assets	283,173				10	283,173	73
74								74
75	TOTALS	\$435,338	\$96	\$23,716	\$23,620		\$374,468	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)	\$4,292,285	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$203,615	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$142,316	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(61,299)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,712,638	85

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

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

G. Construction-in-Progress

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

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

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

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?

YESNO
- If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from Premier				6,832			6
7	TOTAL				\$6,832			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:

YESNO

Terms: *

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

15. Is Movable equipment rental included in building rental?

YESNO
16. Rental Amount for movable equipment: \$2,301Description: See Attached Schedule
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	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. /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.
- HFS 3745 (N-4-99)
- IL478-2471

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.

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	\$		\$ 201,194	\$		\$ 201,194	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			100,597			100,597	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			227,668			227,668	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				94,361		94,361	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental						6,789		6,789	13
14	TOTAL			\$		\$ 529,459	\$ 101,150		\$ 630,609	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	\$ 10,296	\$ 55,173	1
2	Cash-Patient Deposits	100	100	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,356,313	1,356,313	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	201,201	201,201	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		65,527	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,567,910	\$ 1,678,314	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		292,400	13
14	Buildings, at Historical Cost		5,107,548	14
15	Leasehold Improvements, at Historical Cost	757,784	757,784	15
16	Equipment, at Historical Cost	42,018	490,018	16
17	Accumulated Depreciation (book methods)	(256,330)	(653,846)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	2,822	580,889	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 546,294	\$ 6,574,793	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,114,204	\$ 8,253,107	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 360,439	\$ 361,267	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,199	10,199	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	257,128	257,128	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,314	20,314	31
32	Accrued Real Estate Taxes(Sch.IX-B)		133,637	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	38,799	38,799	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 686,879	\$ 821,344	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	40,000	3,014,167	39
40	Mortgage Payable		5,800,427	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)	\$ 40,000	\$ 8,814,594	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 726,879	\$ 9,635,938	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,387,325	\$ (1,382,831)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,114,204	\$ 8,253,107	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,514,485	1
2	Restatements (describe):		2
3			3
4	Late Journal Entry	(194,973)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,319,512	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	965,093	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	(897,280)	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)	\$ 67,813	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)	\$ 1,387,325	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Park View Rehab Center

0052092

Report Period Beginning: 01/01/16

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	\$ 7,970,597	1
2	Discounts and Allowances for all Levels	(356,549)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,614,048	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	1,643	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)	\$ 1,643	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,403	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,403	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	249,966	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 249,966	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,867,060	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	928,360	31
32	Health Care	2,341,836	32
33	General Administration	1,684,504	33
	B. Capital Expense		
34	Ownership	963,338	34
	C. Ancillary Expense		
35	Special Cost Centers	661,823	35
36	Provider Participation Fee	322,106	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,901,967	40
41	Income before Income Taxes (line 30 minus line 40)**	965,093	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 965,093	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 5,871,965	44
45	Private Pay - Net Inpatient Revenue	70,200	45
46	Medicare - Net Inpatient Revenue	1,544,304	46
47	Other-(specify) Hospice	20,320	47
48	Other-(specify) Insurance	107,259	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,614,048	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	1,650	1,734	\$ 74,320	\$ 42.86	1
2	Assistant Director of Nursing	1,891	1,984	74,141	37.37	2
3	Registered Nurses	6,105	6,766	191,080	28.24	3
4	Licensed Practical Nurses	24,760	26,662	686,863	25.76	4
5	CNAs & Orderlies	53,035	57,552	666,204	11.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,841	2,370	32,436	13.69	8
9	Activity Director	1,998	2,130	39,199	18.40	9
10	Activity Assistants	5,841	6,401	72,131	11.27	10
11	Social Service Workers	8,628	9,094	163,143	17.94	11
12	Dietician					12
13	Food Service Supervisor	2,043	2,081	41,534	19.96	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,047	15,066	164,028	10.89	15
16	Dishwashers					16
17	Maintenance Workers	4,773	5,152	49,252	9.56	17
18	Housekeepers	9,728	10,425	119,475	11.46	18
19	Laundry	4,237	4,665	47,170	10.11	19
20	Administrator	2,008	2,082	103,268	49.60	20
21	Assistant Administrator	2,016	2,096	85,102	40.60	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,881	5,052	79,115	15.66	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,801	1,968	22,613	11.49	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	151,283	163,280	\$ 2,711,074 *	\$ 16.60	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	168	\$ 9,217	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant	Monthly	1,600	10-03	37
38	Nurse Consultant	Monthly	147,965	10-03	38
39	Pharmacist Consultant	Monthly	6,155	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	49	2,448	11-03	44
45	Social Service Consultant	67	3,980	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	284	\$ 189,365		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

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

** See instructions.

Facility Name & ID Number Park View Rehab Center	STATE OF ILLINOIS # 0052092	Report Period Beginning: 01/01/16	Ending: 12/31/16
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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. ICLTC \$12,306

(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. \$ 7,967 Line 10-02

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

(8) Are you presently operating under a sale and leaseback arrangement? No
 If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Heritage Healthcare Center License #38620 Through 11/01/1992

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 322,106
 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 benefit on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A

(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? No
 If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? 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? No
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

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

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

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