

Facility Name & ID Number Gardenview Manor

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

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	118	Skilled (SNF)	118	43,188	1
2		Skilled Pediatric (SNF/PED)			2
3	95	Intermediate (ICF)	95	34,770	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	213	TOTALS	213	77,958	7

B. Census-For the entire report period.

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

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

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

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

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO Non-allowable costs have been eliminated in Schedule V, Column 7

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

YES NO

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

Date started 08/01/2013

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

YES Date 08/01/2013 NO

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

YES NO If YES, enter number of beds certified 118 and days of care provided 3,513

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number

Gardenview Manor

#0052456

Report Period Beginning:

1/1/16

Ending:

12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							300,388	300,388			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			62,657	62,657		62,657	344,097	406,754			32
33	Real Estate Taxes			54,169	54,169		54,169		54,169			33
34	Rent-Facility & Grounds			345,056	345,056		345,056	(329,342)	15,714			34
35	Rent-Equipment & Vehicles			9,679	9,679		9,679		9,679			35
36	Other (specify):*											36
37	TOTAL Ownership			471,561	471,561		471,561	315,143	786,704			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		285,230	656,075	941,305		941,305		941,305			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			350,316	350,316		350,316		350,316			42
43	Other (specify):* Nonallowable Exp	15,432	8,896	166,823	191,151		191,151	(191,151)				43
44	TOTAL Special Cost Centers	15,432	294,126	1,173,214	1,482,772		1,482,772	(191,151)	1,291,621			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,529,433	904,952	3,664,248	8,098,633		8,098,633	371,001	8,469,634			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gardenview Manor

0052456

Report Period Beginning:

1/1/16

Ending:

12/31/16

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	300,388	30		9
10	Interest and Other Investment Income	(708)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(532)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(16,513)	43		18
19	Entertainment				19
20	Contributions	(28,800)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,340)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(82,500)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(65,079)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 103,916		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	267,085		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 267,085		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 371,001		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

BHF USE ONLY							
48		49		50		51	

Gardenview Manor

ID# 0052456

Report Period Beginning: 1/1/16

Ending: 12/31/16

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Gardenview Manor

0052456

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

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

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Gardenview Manor

0052456

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	300,388	0	0	0	0	0	0	0	0	0	0	300,388	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(708)	344,805	0	0	0	0	0	0	0	0	0	344,097	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(345,056)	15,714	0	0	0	0	0	0	0	0	(329,342)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	299,680	(251)	15,714	0	0	0	0	0	0	0	0	315,143	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(191,151)	0	0	0	0	0	0	0	0	0	0	(191,151)	43
44	TOTAL Special Cost Centers	(191,151)	0	0	0	0	0	0	0	0	0	0	(191,151)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	103,916	(251)	277,017	(9,681)	0	371,001	45						

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	32 Interest	251	Gardenview Manor Realty, LLC	100.00%	345,056	\$ 344,805	1
2	V	34 Rent-Facility & Grounds	345,056	Gardenview Manor Realty, LLC	100.00%		(345,056)	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 345,307			\$ 345,056	\$ * (251)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 Heat and Other Utilities	\$	Premier Healthcare Management, LLC	100.00%	\$ 449	\$	449	15
16	V	6 Maintenance		Premier Healthcare Management, LLC	100.00%	161		161	16
17	V	10 Nursing and Medical Records		Premier Healthcare Management, LLC	100.00%	71,226		71,226	17
18	V	15 Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	100.00%	11,647		11,647	18
19	V	17 Administrative	47,939	Premier Healthcare Management, LLC	100.00%	82,586		34,647	19
20	V	19 Professional Services		Premier Healthcare Management, LLC	100.00%	8,760		8,760	20
21	V	20 Dues, Fees, Subs & Promo		Premier Healthcare Management, LLC	100.00%	1,089		1,089	21
22	V	21 Clerical & Gen Office Expenses		Premier Healthcare Management, LLC	100.00%	103,049		103,049	22
23	V	24 Travel and Seminar		Premier Healthcare Management, LLC	100.00%	525		525	23
24	V	25 Other Admin. Staff Trans		Premier Healthcare Management, LLC	100.00%	764		764	24
25	V	27 Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	28,986		28,986	25
26	V	34 Rent-Facility & Grounds		Premier Healthcare Management, LLC	100.00%	15,714		15,714	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 47,939			\$ 324,956	\$ *	277,017	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 Nursing and Medical Records	\$ 15,264	Premier Healthcare Supplies, LLC	100.00%	\$ 5,583	\$ (9,681)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 15,264			\$ 5,583	\$ * (9,681)

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Gardenview Manor

0052456

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Gardenview Manor

0052456

Report Period Beginning:

1/1/16

Ending:

12/31/16

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	David Cheplowitz	Shareholder	Administrative	50.00%	See Att Sch 7A	4.81	12%	Alloc Salary	\$ 18,759	17-7	1
2	Barak Bayer	Shareholder	Administrative	50.00%	See Att Sch 7A	4.81	12%	Alloc Salary	18,759	17-7	2
3	Sara Bayer	Relative	Clerical	0	See Att Sch 7A	4.81	12%	Alloc Salary	5,315	21-7	3
4	Yocheved Bayer	Relative	Consultant	0.00	9,750			Consulting	9,000	19-3	4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 51,833		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gardenview Manor

0052456

Report Period Beginning:

1/1/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Premier Healthcare Management, LLC
 Street Address 8170 N. McCormick Blvd. Suite 137
 City / State / Zip Code Skokie, IL 60076
 Phone Number (847) 674-2800
 Fax Number (847) 674-4133

1	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	5	Heat and Other Utilities	Census Days	348,950	11	\$ 3,732	\$ 41,961	\$ 449	1
2	6	Maintenance	Census Days	348,950	11	1,338	41,961	161	2
3	10	Nursing and Medical Records	Census Days	348,950	11	592,321	41,961	71,226	3
4	15	Emp Benefit Alloc-Healthcare	Census Days	348,950	11	96,859	41,961	11,647	4
5	17	Administrative	Census Days	348,950	11	686,791	41,961	82,586	5
6	19	Professional Services	Census Days	348,950	11	72,849	41,961	8,760	6
7	20	Dues, Fees, Subs & Promo	Census Days	348,950	11	9,057	41,961	1,089	7
8	21	Clerical & Gen Office Expenses	Census Days	348,950	11	856,961	41,961	103,049	8
9	24	Travel and Seminar	Census Days	348,950	11	4,369	41,961	525	9
10	25	Other Admin. Staff Trans	Census Days	348,950	11	6,355	41,961	764	10
11	27	Emp Benefit Alloc-Gen Admin	Census Days	348,950	11	241,050	41,961	28,986	11
12	34	Rent-Facility & Grounds	Census Days	348,950	11	130,681	41,961	15,714	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,702,363	\$ 2,066,407	\$ 324,956	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gardenview Manor

0052456

Report Period Beginning:

1/1/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Premier Healthcare Supplies, LLC
 Street Address 8170 N. McCormick Blvd. Suite 137
 City / State / Zip Code Skokie, IL 60076
 Phone Number (847) 674-2800
 Fax Number (847) 674-4133

1	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	10	Nursing and Medical Records	Revenue	111,222	11	\$ 40,679	\$ 15,264	\$ 5,583	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					\$ 40,679	\$	\$ 5,583	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Gardenview Manor

0052456

Report Period Beginning:

1/1/16

Ending:

12/31/16

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	MB Financial Bank		X	Mortgage		4/30/2015	\$ 8,000,000	\$ 8,000,000	5/5/2020		\$ 345,056	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	MB Financial Bank		X	Line of Credit				670,438			42,657	6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 8,000,000	\$ 8,670,438			\$ 387,713	9						
B. Non-Facility Related*																		
10												10						
11											20,000	11						
12											(959)	12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 19,041	14						
15	TOTALS (line 9+line14)						\$ 8,000,000	\$ 8,670,438			\$ 406,754	15						

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

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

(See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

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

(See instructions.)

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.		\$	55,870	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.)	2015	\$	55,869	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(1)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	54,170	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	54,169	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2011	_____	8	
	2012	_____	9	
	2013	_____	10	
	2014	53,054	11	
	2015	55,869	12	
Accrual based on prior year tax bill.				
Note: Adjust beginning accrual balance to actual.				

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.

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Gardenview Manor COUNTY Vermilion

FACILITY IDPH LICENSE NUMBER 0052456

CONTACT PERSON REGARDING THIS REPORT Larry Templin

TELEPHONE (630) 361-2868 FAX #: _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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.**

Facility Name & ID Number Gardenview Manor

0052456 Report Period Beginning:

1/1/16 Ending:

12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 74,000 B. General Construction Type: Exterior Brick Frame Single Story Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

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			<u>2015</u>	<u>\$ 327,415</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			<u>\$ 327,415</u>	<u>3</u>

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number **Gardenview Manor**# **0052456**

Report Period Beginning:

1/1/16

Ending:

12/31/16**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

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

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gardenview Manor

0052456

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Prep Floor For Tile	2014	\$	\$	20	\$	\$	\$	37
38	Demo Walls And Ceilings, Frame All Walls	2014	117,500		20	5,875	5,875	17,625	38
39	Interior Doors, Floor Tiles In Bathrooms	2014			20				39
40	Installation Exhaust Grill To Ptac Unit	2014	7,082		20	354	354	1,062	40
41	Nursing Home And Garage Painting	2014	5,035		20	252	252	756	41
42	Wallpaper, Paint And Wallpaper Hanging	2014	12,310		20	616	616	1,847	42
43	Hollow Metal Frames And Wooden Doors	2014	30,177		20	1,509	1,509	4,527	43
44	Paint ,etal Roofing Around Nursing Home	2014	12,760		20	638	638	1,914	44
45	Break Out Concrete In Garden Area & Entrance Door Stoop	2014	2,675		20	134	134	402	45
46	Acoustic Ceiling Tile And Grid	2014	30,986		20	1,549	1,549	4,648	46
47	Shower Faucets, Trims, Vacuum Brackets, Gender Sinks	2014	3,789		20	189	189	568	47
48	Window Treatments	2014	4,532		20	227	227	680	48
49	Security System	2014	28,704		20	1,435	1,435	4,305	49
50	30 Sprinkler Heads	2014	3,225		20	161	161	484	50
51	Installed One New Letter Wall Sign	2014	2,790		20	140	140	419	51
52	Installed 6" Dark Bronze Gutter	2014	3,141		20	157	157	471	52
53	B-Wing Nurse Call Station	2014	3,994		20	200	200	599	53
54	Installed Corian Countertop	2014	4,279		20	214	214	642	54
55	Installed Villa Door Closers, Grab Bars, Tiles, Doors	2014	3,375		20	169	169	507	55
56	Nurse Call Station	2014	5,052		20	253	253	758	56
57	Front Entrance Landscaping	2014	5,956		20	298	298	894	57
58	Installed New Sink In Salon	2014	6,200		20	310	310	930	58
59	Security System	2014	10,745		20	537	537	1,612	59
60	Repaired Air Compressor	2014	7,095		20	355	355	1,065	60
61	Security System	2014	10,290		20	515	515	1,544	61
62	Door Repairs	2014	7,380		20	369	369	1,107	62
63	Removed Concrete	2014	8,200		20	410	410	1,230	63
64	Door Repairs	2014	13,965		20	698	698	2,095	64
65	Door Repairs	2014	14,361		20	718	718	2,154	65
66	Therapy Room Carpeting	2014	15,855		20	793	793	2,378	66
67	Paving - Patchwork And Asphalt	2014	16,700		20	835	835	2,505	67
68	Hallway Handrails, Doors, Bathrm Sinks, Paint Therapy Rm	2014	18,410		20	921	921	2,762	68
69	Annunciator System	2014	57,201		20	2,860	2,860	8,580	69
70	TOTAL (lines 4 thru 69)		\$ 6,736,513	\$		\$ 175,921	\$ 174,443	\$ 443,165	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Gardenview Manor

0052456

Report Period Beginning:

1/1/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

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

1	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	\$ 6,736,513	\$		\$ 175,921	\$ 175,921	\$ 443,165	1	
2	B-Wing Nurse Call Station	2014 3,346		20	335	335	1,004	2	
3	8 Dining Metal Chairs	2015 3,150		20	158	158	316	3	
4	Architectural Design And Contract	2015 33,390		20	1,670	1,670	3,340	4	
5	Double Headed Led Lights Above Exit Lights	2015 3,700		20	185	185	370	5	
6	2 Power Generators Load Test And Repair	2015 4,350		20	218	218	436	6	
7	Install 2 Digital Duplex Speakerphones And Phone System	2015 20,390		20	1,020	1,020	2,040	7	
8	Water/Fire Restoration - Fire Damaged Roof	2016 7,418		20	185	185	185	8	
9	Repair Generator	2016 3,727		20	93	93	93	9	
10	Replace Electrical from Gear to Front Office Panels	2016 18,975		20	474	474	474	10	
11	Replaced Compressors	2016 11,650		20	291	291	291	11	
12								12	
13								13	
14								14	
15								15	
16								16	
17								17	
18								18	
19								19	
20								20	
21								21	
22								22	
23								23	
24								24	
25								25	
26								26	
27								27	
28								28	
29								29	
30								30	
31								31	
32								32	
33								33	
34	TOTAL (lines 1 thru 33)	\$ 6,846,609	\$		\$ 180,550	\$ 180,550	\$ 451,714	34	

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 6,846,609	\$		\$ 180,550	\$ 180,550	\$ 451,714	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9	Allocated from Premier HC Management	2013	2,992		20	149	149	478	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,849,601	\$		\$ 180,699	\$ 180,699	\$ 452,192	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

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

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 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)	\$ 8,392,550	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 300,388	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 300,388	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 714,710	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gardenview Manor

0052456

Report Period Beginning: 1/1/16

Ending: 12/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	<u>Allocated from Management Co.</u>				<u>15,714</u>			5
6								6
7	TOTAL				\$ 15,714			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	<u>/2017</u>	\$ _____
13.	<u>/2018</u>	\$ _____
14.	<u>/2019</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 4,691 Description: Nursing Equipment \$4275; Maint Equip \$416

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	<u>Facility</u>	<u>2014 Land Rover</u>	<u>1,663</u>	<u>4,988</u>	18
19					19
20					20
21	TOTAL		\$ 1,663.00	\$ 4,988	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' PREPARATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$		\$ 268,514	\$		\$ 268,514	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs			76,336			76,336	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs			299,553			299,553	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				281,364		281,364	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Attached Scheule 16A</u>					11,672	3,866		15,538	13
14	TOTAL			\$		\$ 656,075	\$ 285,230		\$ 941,305	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Schedule 16A

XIV. Special Services
Line 13 Other Services

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 19,662	\$ 19,726	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>925,833</u>)	3,675,527	3,675,527	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	39,013	39,013	6
7	Other Prepaid Expenses	7,727	7,727	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,741,929	\$ 3,741,993	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		327,415	13
14	Buildings, at Historical Cost		5,198,595	14
15	Leasehold Improvements, at Historical Cost	1,732,011	1,651,006	15
16	Equipment, at Historical Cost	753,433	1,215,534	16
17	Accumulated Depreciation (book methods)	(495,143)	(714,710)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule 17A</u>	7,553	3,199,605	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,997,854	\$ 10,877,445	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,739,783	\$ 14,619,438	25

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

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

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

Schedule 17A

XV. Balance Sheet

Line 23 Other Assets (specify):

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

Line 36 Other Current Liabilities (specify):

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (305,807)	1
2	Restatements (describe): Bad Debt Expense		2
3	Prior Period Adjustments - Bad Debt Expense	(750,000)	3
4	Prior Period Adjustments - Other Expenses	(812,283)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,868,090)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(616,686)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (616,686)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,484,776)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,185,130	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,185,130	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	274,170	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 274,170	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	21,945	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(6)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 21,939	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	708	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 708	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,481,947	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,249,874	31
32	Health Care	3,158,635	32
33	General Administration	1,735,791	33
B. Capital Expense			
34	Ownership	471,561	34
C. Ancillary Expense			
35	Special Cost Centers	1,132,456	35
36	Provider Participation Fee	350,316	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,098,633	40
41	Income before Income Taxes (line 30 minus line 40)**	(616,686)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (616,686)	43

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gardenview Manor

0052456

Report Period Beginning:

1/1/16

Ending:

12/31/16

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

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

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

** See instructions.

B. CONSULTANT SERVICES

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

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

Gardenview Manor

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

Schedule 20A

XVIII. Staffing and Salary Costs

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Russell Elmore	Administrator	0	\$ 15,683	Workers' Compensation Insurance	\$ 90,452	IDPH License Fee	\$ 829	
Troy Gibbs	Administrator	0	42,269	Unemployment Compensation Insurance	106,105	Advertising: Employee Recruitment	37,652	
Patricia Heidenreich	Administrator	0	10,265	FICA Taxes	262,655	Health Care Worker Background Check		
Lonnie Nichols	Administrator	0	58,250	Employee Health Insurance	138,860	(Indicate # of checks performed <u>48</u>)	(9)	
Adam Zanger	Administrator	0	26,838	Employee Meals	1,055	Patient Background Checks <u>124</u>	3,590	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	1,956	
				Other Employee Benfits	7,932	Licenses & Permits	954	
				Employee Physical Exam	1,410	IL Council on LTC	6,076	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 153,305			Allocated from Management Co.	1,089	
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount			Non-allowable advertising	()	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 47,939			Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 47,939			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 52,137	
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
See Attached	Legal Fees		16,252				Out-of-State Travel	\$
Richard Peelo & Associates	Accounting Services		4,200	N/A				
FR&R/Marcum LLP	Accounting Services		11,130					
Cohn Reznick	Accounting Services		11,000				In-State Travel	
LTC	Med Billing & Data Processing		189,555					
Personnel Planners Inc	Unemployment Consultant		2,250				Seminar Expense	3,077
Sharon Lofgren	Medicare Billing		600				Allocated from Management Co.	525
Ability Network Inc	Data Processing		5,664					
ADP	Data Processing		15,398				Entertainment Expense	()
eHealth Data Solutions	Data Processing		2,729				(agree to Sch. V, line 24, col. 8)	
HDSI	Data Processing		7,000				TOTAL	\$ 3,602
See Attached Schedule 21A			93,577					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 359,355	TOTAL		\$		
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

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

Schedule 21A

XIX. Support Schedules

C. Professional Services

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

Facility Name & ID Number Gardenview Manor# 0052456

Report Period Beginning:

1/1/16

Ending:

12/31/16**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 6,076 IL Council on LTC
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? 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. \$ 30,438 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 350,316
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' PREPARATION REPORT