

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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	128	Skilled (SNF)	128	46,848	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	128	TOTALS	128	46,848	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	7,327	227	3,177	10,731	8
9	SNF/PED					9
10	ICF	33,813	170	135	34,118	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,140	397	3,312	44,849	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.)

		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	(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

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)	(603,558)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (603,558)		36
	(sum of SUBTOTALS			
37	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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	

Park View Rehab Center

ID# 0052092

Report Period Beginning: 01/01/16

Ending: 12/31/16

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
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	(73,206)		49

Park View Rehab Center

ID# 0052092

Report Period Beginning: 01/01/16

Ending: 12/31/16

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
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
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 (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
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: 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	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. 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
16	V	3 HOUSEKEEPING		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,536	1,536
17	V	5 UTILITIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,068	1,068
18	V	6 REPAIRS AND MAINTENANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	4,830	4,830
19	V	17 S WEBSTER SALARY		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	12,279	12,279
20	V	17 Y LEVOVITZ-SALARY		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	12,096	12,096
21	V	19 PROFESSIONAL FEES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,245	1,245
22	V	20 DUES FEES SUBSCRIPTIONS		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,918	1,918
23	V	21 CLERICAL AND GENERAL		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	7,008	7,008
24	V	21 CLERICAL & GENERAL SALARIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	119,452	119,452
25	V	24 SEMINARS & EDUCATION		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	584	584
26	V	26 INSURANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	954	954
27	V	27 EMPLOYEE BEN. GEN ADMIN.		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	26,336	26,336
28	V	30 DEPRECIATION		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	2,078	2,078
29	V	34 RENT		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	14,951	14,951
30	V						
31	V	17 MANAGEMENT FEES	481,200	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%		(481,200)
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 481,200			\$ 208,133	\$ * (273,067)

* 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	15
16	V	20 LICENSES & PERMITS		PREMIER HC REAL ESTATE, LLC	100.00%	25		25	16
17	V	30 DEPRECIATION		PREMIER HC REAL ESTATE, LLC	100.00%	2,779		2,779	17
18	V	32 INTEREST EXPENSE		PREMIER HC REAL ESTATE, LLC	100.00%	1,886		1,886	18
19	V	33 REAL ESTATE TAXES		PREMIER HC REAL ESTATE, LLC	100.00%	4,059		4,059	19
20	V								20
21	V	34 RENT	8,119	PREMIER HC REAL ESTATE, LLC	100.00%			(8,119)	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		\$ 8,119			\$ 9,079	\$ *	960	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	2 DIETARY	\$	iCare Consulting Services LLC	100.00%	\$ 183	\$ 183
16	V	6 REPAIRS AND MAINTENANCE		iCare Consulting Services LLC	100.00%	48	48
17	V	10 NURSING SALARIES	147,965	iCare Consulting Services LLC	100.00%	107,116	(40,849)
18	V	15 EMPLOYEE BEN. HC PROGRAMS		iCare Consulting Services LLC	100.00%	11,201	11,201
19	V	19 PROFESSIONAL FEES		iCare Consulting Services LLC	100.00%	5,872	5,872
20	V	20 DUES FEES SUBSCRIPTIONS		iCare Consulting Services LLC	100.00%	37	37
21	V	21 CLERICAL AND GENERAL	35,873	iCare Consulting Services LLC	100.00%	4,641	(31,232)
22	V	21 CLERICAL & GENERAL SALARIES		iCare Consulting Services LLC	100.00%	13,352	13,352
23	V	24 SEMINARS & EDUCATION		iCare Consulting Services LLC	100.00%	716	716
24	V	27 EMPLOYEE BEN. GEN ADMIN.		iCare Consulting Services LLC	100.00%	1,443	1,443
25	V	25 AUTO & TRAVEL		iCare Consulting Services LLC	100.00%	4,696	4,696
26	V	43 MARKETING	22,627	iCare Consulting Services LLC	100.00%		(22,627)
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		\$ 206,465			\$ 149,305	\$ * (57,160)

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

Facility Name & ID Number

Park View Rehab Center

0052092

Report Period Beginning:

01/01/16

Ending:

12/31/16

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: 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		
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: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

Park View Rehab Center

0052092

Report Period Beginning:

01/01/16

Ending:

12/31/16

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: 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		
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: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number

Park View Rehab Center

0052092

Report Period Beginning:

01/01/16

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	Yeruchom Levovitz	15.92%	CENTER HOME HISPANIC ELDERLY	CHICAGO	PREMIER HEALTHCARE & FINANCIAL S		MANAGEMENT C	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

Facility Name & ID Number

Park View Rehab Center

0052092

Report Period Beginning:

01/01/16

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								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 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	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 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	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

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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	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	
Line Reference									
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
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
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:

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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

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

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		X	Mortgage			\$	\$ 5,800,427			\$	323,362						
2																		
3																		
4																		
5					-													
Working Capital																		
6	MB Financial		X	Line of Credit				2,974,167				774						
7	MB Financial		X	Note Payable				40,000										
8	Alloc Premier HC Realty	X										1,886						
9	TOTAL Facility Related						\$	\$ 8,814,594			\$	326,022						
B. Non-Facility Related*																		
10	Interest Income		X									(1,403)						
11																		
12																		
13					-													
14	TOTAL Non-Facility Related						\$	\$			\$	(1,403)						
15	TOTALS (line 9+line14)						\$	\$ 8,814,594			\$	324,619						

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.)

Facility Name & ID Number

Park View Rehab Center

0052092

Report Period Beginning:

01/01/16

Ending:

12/31/16

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.)

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

Facility Name & ID Number Park View Rehab Center

0052092 Report Period Beginning:

01/01/16 Ending:

12/31/16

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	<u>Facility</u>		<u>1991</u>	<u>\$ 105,600</u>	<u>1</u>
2	<u>Allocated From Premier HC Realty</u>			<u>1,928</u>	<u>2</u>
3	TOTALS			\$ 107,528	3

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		
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	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1993	22,988		20			22,988	9
10	Various		1994	38,610		20			38,610	10
11	Various		1995	68,517		20			68,517	11
12	Various		1996	107,653		20	3	3	107,653	12
13	Various		1997	32,071		20	1,598	1,598	32,067	13
14	Various		1998	19,271		20	964	964	18,311	14
15	Various		1999	16,863		20	844	844	15,182	15
16	Various		2000	50,104		20	2,506	2,506	42,591	16
17	Various		2001	9,165		20	458	458	7,331	17
18	Various		2002	38,362		20	1,919	1,919	28,775	18
19	Various		2003	20,009		20	1,000	1,000	14,008	19
20	Various		2004	38,100		20	1,906	1,906	24,770	20
21	Various		2005	127,366		20	6,369	6,369	76,423	21
22	Various		2006	2,900		20	145	145	1,595	22
23	Various		2007	3,348		20	167	167	1,672	23
24	Various		2008	32,480		20	1,624	1,624	14,616	24
25	Various		2009	33,390		20	2,417	2,417	19,332	25
26	Various		2010	17,840		20	892	892	6,244	26
27	Various		2012	32,072		20	1,604	1,604	8,020	27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number 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	
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		318,938			4,435	4,435	300,294	67
68		114,635	4,761		4,818	57	24,062	68
69			198,758			(198,758)		69
70		\$ 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.

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		\$ 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		\$ 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.

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		\$ 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		\$ 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.

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		\$ 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		\$ 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	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	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		\$ 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.

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.

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		\$ 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.

Facility Name & ID Number Park View Rehab Center

0052092

Report Period Beginning:

01/01/16

Ending:

12/31/16

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?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from Premier				6,832			6
7	TOTAL				\$ 6,832			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. _____ /2017 \$ _____

13. _____ /2018 \$ _____

14. _____ /2019 \$ _____

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: \$ 2,301 Description: 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

* 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.

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.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			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 prescripts							94,361				94,361	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 Supplemental</u>									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.

Facility Name & ID Number Park View Rehab Center

0052092

Report Period Beginning: 01/01/16

Ending:

12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/16

(last day of reporting year)

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) <u>Hospice</u>	20,320	47
48	Other-(specify) <u>Insurance</u>	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.

Facility Name & ID Number Park View Rehab Center

0052092

Report Period Beginning:

01/01/16

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	1,650	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

* 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	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

Facility Name & ID Number **Park View Rehab Center**

0052092

Report Period Beginning: **01/01/16**

Ending: **12/31/16**

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		
Sue Bohne	Administrator	0	\$ 103,268	Workers' Compensation Insurance	\$ 87,795	IDPH License Fee	\$ 3,980		
Olivia Carey	Asst Admin	0	85,102	Unemployment Compensation Insurance	32,074	Advertising: Employee Recruitment	22,877		
				FICA Taxes	202,668	Health Care Worker Background Check (Indicate # of checks performed <u>254</u>)	2,538		
				Employee Health Insurance	181,273	Patient Background Checks			
				Employee Meals		Dues - ICLTC	8,245		
				Illinois Municipal Retirement Fund (IMRF)*		License and Fees	3,150		
				Employee Pension	16,893	Allocated from Premier HC Financial	1,918		
				Employee Expense	13,973	Allocated from iCare Consulting	37		
				Christmas Expense	3,507	See Supplemental Schedule	25		
						Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 188,370	TOTAL (agree to Schedule V, line 22, col.8)		\$ 538,183	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 42,770
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Management Fees - Premier Healthcare & Financial			\$ 481,200				Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 481,200				Seminar Expense	1,754	
							Allocated From Premier HC & Financial	584	
							Allocated from Icare Consulting	716	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 72,794	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 3,054

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Park View Rehab Center# 0052092Report Period Beginning: 01/01/16Ending: 12/31/16**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 benefits 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