FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0052092

Facility Name: Park View Rehab Center

Address: 5888 North Ridge (Number) Chicago (City) 60660 (Zip Code)

County: Cook

Telephone Number: (773) 769-2626 **Fax #** (773) 769-2650

HFS ID Number:

Date of Initial License for Current Owners: 11/1/1992

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/13 to 12/31/13 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Richard S. Sgarlata, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	44	Skilled (SNF)	44	16,060	1
2		Skilled Pediatric (SNF/PED)			2
3	83	Intermediate (ICF)	83	30,295	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	127	TOTALS	127	46,355	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,884	37	2,591	9,512	8
9	SNF/PED					9
10	ICF	31,771	36	571	32,378	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,655	73	3,162	41,890	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.37%

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)
N/A

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 07/01/2002 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 21 and days of care provided 2,591

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	213,355	20,531	7,340	241,226		241,226		241,226			1
2	Food Purchase		221,144		221,144		221,144	1,311	222,455			2
3	Housekeeping	125,158	15,138		140,296		140,296	1,276	141,572			3
4	Laundry	46,465	7,189		53,654		53,654		53,654			4
5	Heat and Other Utilities			103,108	103,108		103,108	(543)	102,565			5
6	Maintenance	37,524		46,918	84,442		84,442	8,942	93,384			6
7	Other (specify):*											7
8	**TOTAL General Services**	422,502	264,002	157,366	843,870		843,870	10,986	854,856			8
	B. Health Care and Programs											
9	Medical Director			16,200	16,200		16,200		16,200			9
10	Nursing and Medical Records	1,507,020	32,489	15,446	1,554,955		1,554,955	29,287	1,584,242			10
10a	Therapy	15,907			15,907		15,907		15,907			10a
11	Activities	85,648	8,311	3,450	97,409		97,409		97,409			11
12	Social Services	132,908		3,791	136,699		136,699		136,699			12
13	CNA Training											13
14	Program Transportation			820	820		820		820			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,741,483	40,800	39,707	1,821,990		1,821,990	29,287	1,851,277			16
	C. General Administration											
17	Administrative	99,551		340,494	440,045		440,045	(274,284)	165,761			17
18	Directors Fees											18
19	Professional Services			63,305	63,305		63,305	(14,368)	48,937			19
20	Dues, Fees, Subscriptions & Promotions			20,347	20,347		20,347	(8,818)	11,529			20
21	Clerical & General Office Expenses	51,116		48,327	99,443		99,443	31,589	131,032			21
22	Employee Benefits & Payroll Taxes			338,868	338,868		338,868		338,868			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,668	2,668		2,668	900	3,568			24
25	Other Admin. Staff Transportation			279	279		279	3,426	3,705			25
26	Insurance-Prop.Liab.Malpractice			101,947	101,947		101,947	26,370	128,317			26
27	Other (specify):*							24,538	24,538			27
28	**TOTAL General Administration**	150,667		916,235	1,066,902		1,066,902	(210,647)	856,255			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,314,652	304,802	1,113,308	3,732,762		3,732,762	(170,374)	3,562,388			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Park View Rehab Center #0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			129,795	129,795		129,795	11,937	141,732			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,343	11,343		11,343	86,801	98,144			32
33	Real Estate Taxes							116,150	116,150			33
34	Rent-Facility & Grounds			649,697	649,697		649,697	(649,697)				34
35	Rent-Equipment & Vehicles			1,970	1,970		1,970		1,970			35
36	Other (specify):*							15,973	15,973			36
37	**TOTAL Ownership**			792,805	792,805		792,805	(418,836)	373,969			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		117,497	243,893	361,390		361,390		361,390			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			301,800	301,800		301,800		301,800			42
43	Other (specify):*			9,597	9,597		9,597	(9,597)	0			43
44	**TOTAL Special Cost Centers**		117,497	555,290	672,787		672,787	(9,597)	663,190			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,314,652	422,299	2,461,403	5,198,354		5,198,354	(598,807)	4,599,547			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,857)	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	(55,486)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4)	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				18
19	Entertainment				19
20	Contributions	(250)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,840)	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	(63,544)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (122,981)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(475,826)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (475,826)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (598,807)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Park View Rehab Center

ID# 0052092

Report Period Beginning: 01/01/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sequestration	$ (12,784)	21	1
2	Marketing Consultant	(7,636)	43	2
3	Marketing Expense	(1,961)	43	3
4	Bank Charges	(5,697)	21	4
5	Additional R&M	3,941	06	5
6	Medical Record Income	(20)	10	6
7	Misc Income	(9,287)	21	7
8	COPE Dues	(6,971)	20	8
9	Marketing Travel	(136)	25	9
10	Non Allowable Legal	(15,828)	19	10
11	Building Co - Amortization	(1,815)	36	11
12	Building Co - Professional Fees	(5,350)	19	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**	(63,544)		49

Park View Rehab Center

ID# 0052092

Report Period Beginning: 01/01/13

Ending: 12/31/13

	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**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park View Rehab Center # 0052092 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(4)		1,281		34							1,311	2
3	Housekeeping			1,276									1,276	3
4	Laundry													4
5	Heat and Other Utilities	(1,857)		1,314									(543)	5
6	Maintenance	3,941		4,935	66								8,942	6
7	Other (specify):*													7
8	**TOTAL General Services**	2,080		8,806	66	34							10,986	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(20)				29,307							29,287	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(20)				29,307							29,287	16
	C. General Administration													
17	Administrative			(215,900)		(58,384)							(274,284)	17
18	Directors Fees													18
19	Professional Services	(21,178)	5,350	843	398	219							(14,368)	19
20	Fees, Subscriptions & Promotions	(9,061)		104		139							(8,818)	20
21	Clerical & General Office Expenses	(27,768)		59,183		174							31,589	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			226		674							900	24
25	Other Admin. Staff Transportation	(136)				3,562							3,426	25
26	Insurance-Prop.Liab.Malpractice		26,370										26,370	26
27	Other (specify):*			16,645		7,893							24,538	27
28	**TOTAL General Administration**	(58,143)	31,720	(138,899)	398	(45,723)							(210,647)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(56,083)	31,720	(130,093)	464	(16,382)							(170,374)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park View Rehab Center **#** 0052092 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(55,486)	62,781	13	4,630								11,937	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		83,428		3,373								86,801	32
33	Real Estate Taxes		113,088		3,062								116,150	33
34	Rent-Facility & Grounds		(649,697)	10,036	(10,036)								(649,697)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(1,815)	17,788										15,973	36
37	TOTAL Ownership	(57,301)	(372,612)	10,049	1,028								(418,836)	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):*	(9,597)											(9,597)	43
44	TOTAL Special Cost Centers	(9,597)											(9,597)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(122,981)	(340,892)	(120,044)	1,492	(16,382)							(598,807)	45

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 649,697	Heritage Healthcare Center LLC	100.00%	$	$ (649,697)	1
2	V	32	Interest	919	Heritage Healthcare Center LLC	100.00%	84,347	83,428	2
3	V	36	Amortization		Heritage Healthcare Center LLC	100.00%	1,815	1,815	3
4	V	30	Depreciation		Heritage Healthcare Center LLC	100.00%	62,781	62,781	4
5	V	26	Insurance		Heritage Healthcare Center LLC	100.00%	26,370	26,370	5
6	V	36	MIP Insurance		Heritage Healthcare Center LLC	100.00%	15,973	15,973	6
7	V	19	Professional Fees		Heritage Healthcare Center LLC	100.00%	5,350	5,350	7
8	V	33	Real Estate Taxes	31,004	Heritage Healthcare Center LLC	100.00%	144,092	113,088	8
9	V	06	R&M		Heritage Healthcare Center LLC	100.00%			9
10	V	21	Misc. Expense		Heritage Healthcare Center LLC	100.00%			10
11	V								11
12	V								12
13	V								13
14	Total			$ 681,620			$ 340,728	$ * (340,892)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	DIETARY	$	Premier Healthcare & Financial Services, Inc.	100.00%	$ 1,281	$ 1,281	15
16	V	3	HOUSEKEEPING		Premier Healthcare & Financial Services, Inc.	100.00%	1,276	1,276	16
17	V	5	UTILITIES		Premier Healthcare & Financial Services, Inc.	100.00%	1,314	1,314	17
18	V	6	REPAIRS AND MAINTENANCE		Premier Healthcare & Financial Services, Inc.	100.00%	4,935	4,935	18
19	V	17	S WEBSTER SALARY		Premier Healthcare & Financial Services, Inc.	100.00%	21,716	21,716	19
20	V	17	Y LEVOVITZ-SALARY		Premier Healthcare & Financial Services, Inc.	100.00%	21,633	21,633	20
21	V	19	PROFESSIONAL FEES		Premier Healthcare & Financial Services, Inc.	100.00%	843	843	21
22	V	20	DUES FEES SUBSCRIPTIONS		Premier Healthcare & Financial Services, Inc.	100.00%	104	104	22
23	V	21	CLERICAL AND GENERAL		Premier Healthcare & Financial Services, Inc.	100.00%	4,906	4,906	23
24	V	21	CLERICAL & GENERAL SALARIES		Premier Healthcare & Financial Services, Inc.	100.00%	54,278	54,278	24
25	V	24	SEMINARS & EDUCATION		Premier Healthcare & Financial Services, Inc.	100.00%	226	226	25
26	V	27	EMPLOYEE BEN. GEN ADMIN.		Premier Healthcare & Financial Services, Inc.	100.00%	16,645	16,645	26
27	V	30	DEPRECIATION		Premier Healthcare & Financial Services, Inc.	100.00%	13	13	27
28	V	34	RENT		Premier Healthcare & Financial Services, Inc.	100.00%	10,036	10,036	28
29	V								29
30	V								30
31	V	17	MANAGEMENT FEES	259,249	Premier Healthcare & Financial Services, Inc.	100.00%		(259,249)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 259,249			$ 139,205	$ * (120,044)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	REPAIRS & MAINTENANCE	$	Premier Healthcare Realty, LLC	100.00%	$ 66	$ 66	15
16	V	19	PROFESSIONAL FEES		Premier Healthcare Realty, LLC		398	398	16
17	V	30	DEPRECIATION		Premier Healthcare Realty, LLC		4,630	4,630	17
18	V	32	INTEREST EXPENSE		Premier Healthcare Realty, LLC		3,373	3,373	18
19	V	33	REAL ESTATE TAXES		Premier Healthcare Realty, LLC		3,062	3,062	19
20	V	34	RENT	10,036	Premier Healthcare Realty, LLC			(10,036)	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			$ 10,036			$ 11,528	$ * 1,492	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	DIETARY	$	iCare Consulting Services LLC	100.00%	$ 34	$ 34	15
16	V	10	NURSING SALARIES		iCare Consulting Services LLC	100.00%	29,307	29,307	16
17	V	17	ADMIN SALARY NON-RELATED		iCare Consulting Services LLC	100.00%	22,861	22,861	17
18	V	19	PROFESSIONAL FEES		iCare Consulting Services LLC	100.00%	219	219	18
19	V	20	DUES FEES SUBSCRIPTIONS		iCare Consulting Services LLC	100.00%	139	139	19
20	V	21	CLERICAL AND GENERAL		iCare Consulting Services LLC	100.00%	2,828	2,828	20
21	V	21	CLERICAL & GENERAL SALARIES		iCare Consulting Services LLC	100.00%	8,238	8,238	21
22	V	24	SEMINARS & EDUCATION		iCare Consulting Services LLC	100.00%	674	674	22
23	V	25	AUTO EXPENSE		iCare Consulting Services LLC	100.00%	3,562	3,562	23
24	V	27	EMPLOYEE BEN. GEN ADMIN.		iCare Consulting Services LLC	100.00%	7,893	7,893	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V	17	MANAGEMENT FEES	81,245	iCare Consulting Services LLC	100.00%		(81,245)	30
31	V	21	ENVIROMENTAL CONSULTANT	10,893	iCare Consulting Services LLC	100.00%		(10,893)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 92,138			$ 75,755	$ * (16,382)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	SHIMON WEBSTER	19.84%	CENTER HOME HISPANIC ELDERLY,LLC	CHICAGO	PREMIER HEALTHC	SKOKIE, IL	MANAGEMENT C	1
2	YERUCHOM LEVOVITZ	15.92%	PINE CREST HEALTH CARE, LLC	HAZEL CREST	PREMIER HEALTHC	SKOKIE, IL	BUILDING CO.	2
3	CHAIM O. LEVOVITZ	3.91%	CEDAR POINTE REHAB & NURSING	CICERO	HERITAGE HEALTH	CHICAGO, IL	BUILDING CO.	3
4	JEFFREY WEBSTER	4.84%			LIFELINE LAB INC	SKOKIE, IL	LABORATORY	4
5	MIKEL CHILDREN 2012 TRUST	6.25%			ICARE	SKOKIE, IL	CONSULTING	5
6	HOWARD WENGROW	4.05%			PHARMORE DRUGS	SKOKIE, IL	PHARMACY	6
7	JAY WENGROW	2.34%						7
8	DAVID WENGROW	2.34%						8
9	DINA BRAUNSTEIN	2.34%						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	2.5%						18
19	SHOSHANA R. SHABAT	2.5%						19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Shimon Webster	Owner	Administrative	19.83%	See Attached	6.42	16.05%	Alloc Sal	$ 21,716	17-7	1
2	Yeruchom Levovitz	Owner	Administrative	15.91%	See Attached	6.42	16.05%	Alloc Sal	21,633	17-7	2
3	Yakov Kohen	Owner	Clerical	1.56%	See Attached	6.42	16.05%	Alloc Sal	13,078	21-7	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	$ 56,427		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 [X]

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 [X] NO [ ]

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

Name of Related Organization: PREMIER HEALTHCARE & FINANCIAL SER
Street Address: 8153 N. LAWNDALE
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (773) 945-1000
Fax Number: (773) 751-2027

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	DIETARY	PATIENT DAYS	260,876	4	$ 7,978	$	41,890	$ 1,281	1
2	3	HOUSEKEEPING	PATIENT DAYS	260,876	4	7,949		41,890	1,276	2
3	5	UTILITIES	PATIENT DAYS	260,876	4	8,182		41,890	1,314	3
4	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	260,876	4	30,733		41,890	4,935	4
5	17	S WEBSTER SALARY	PATIENT DAYS	260,876	4	135,240	135,240	41,890	21,716	5
6	17	Y LEVOVITZ-SALARY	PATIENT DAYS	260,876	4	134,720	134,720	41,890	21,633	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	260,876	4	5,250		41,890	843	7
8	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	260,876	4	650		41,890	104	8
9	21	CLERICAL AND GENERAL	PATIENT DAYS	260,876	4	30,551		41,890	4,906	9
10	21	CLERICAL & GENERAL SALA	PATIENT DAYS	260,876	4	338,022	338,022	41,890	54,278	10
11	24	SEMINARS & EDUCATION	PATIENT DAYS	260,876	4	1,405		41,890	226	11
12	27	EMPLOYEE BEN. GEN ADMIN	PATIENT DAYS	260,876	4	103,662		41,890	16,645	12
13	30	DEPRECIATION	PATIENT DAYS	260,876	4	79		41,890	13	13
14	34	RENT	PATIENT DAYS	260,876	4	62,503		41,890	10,036	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 866,924	$ 607,982		$ 139,205	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 [X] NO [ ]

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

Name of Related Organization: Premier Healthcare Realty, LLC
Street Address: 8153 N. LAWNDALE
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((773) 945-1000
Fax Number: ((773) 751-2027

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	REPAIRS & MAINTENANCE	PATIENT DAYS	260,876	4	$ 408	$	41,890	$ 66	1
2	20	PROFESSIONAL FEES	PATIENT DAYS	260,876	4	2,480		41,890	398	2
3	30	DEPRECIATION	PATIENT DAYS	260,876	4	28,831		41,890	4,630	3
4	32	INTEREST EXPENSE	PATIENT DAYS	260,876	4	21,006		41,890	3,373	4
5	33	REAL ESTATE TAXES	PATIENT DAYS	260,876	4	19,067		41,890	3,062	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					$ 71,792	$		$ 11,528	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 [X] NO [ ]

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

Name of Related Organization: iCare Consulting Services LLC
Street Address: 8153 N. LAWNDALE
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (773) 945-1000
Fax Number: (773) 751-2027

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	DIETARY	PATIENT DAYS	260,876	4	$ 211	$	41,890	$ 34	1
2	10	NURSING SALARIES	PATIENT DAYS	260,876	4	182,513	182,513	41,890	29,307	2
3	17	ADMIN SALARY NON-RELAT	PATIENT DAYS	260,876	4	142,370	142,370	41,890	22,861	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	260,876	4	1,363		41,890	219	4
5	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	260,876	4	863		41,890	139	5
6	21	CLERICAL AND GENERAL	PATIENT DAYS	260,876	4	17,606		41,890	2,828	6
7	21	CLERICAL & GENERAL SALA	PATIENT DAYS	260,876	4	51,306	51,306	41,890	8,238	7
8	24	SEMINARS & EDUCATION	PATIENT DAYS	260,876	4	4,199		41,890	674	8
9	25	AUTO EXPENSE	PATIENT DAYS	260,876	4	22,181		41,890	3,562	9
10	27	EMPLOYEE BEN. GEN ADMIN	PATIENT DAYS	260,876	4	49,157		41,890	7,893	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					$ 471,769	$ 376,189		$ 75,755	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Heartland Bank		X	Mortgage			$	$ 3,013,027			$ 84,347	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB Financial		X	Capital Expenditures			500,000	322,158	1/15/2018	4.5%	4,059	6
7	MB Financial		X	Line of Credit			1,000,000	200,000	1/15/2014	4.0%	7,284	7
8	See Supplemental Schedule										3,373	8
9	TOTAL Facility Related						$ 1,500,000	$ 3,535,185			$ 99,063	9
	B. Non-Facility Related*											
10	Interest Income- Bldg Co.		X								(919)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (919)	14
15	TOTALS (line 9+line14)						$ 1,500,000	$ 3,535,185			$ 98,144	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 15,973 Line # 36

* 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.)

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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	Allocated from Premier		X				$	$			$ 3,373	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										3,373	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.)

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 144,143	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 129,777	2
3. Under or (over) accrual (line 2 minus line 1).		$ (14,366)	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 130,516	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 116,150	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	134,720	8
	2009	104,396	9
	2010	110,253	10
	2011	109,794	11
	2012	126,715	12

Beginning Accrual Adjusted
Allocated From Premier: $3,062

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2012 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) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-05-306-016-0000	Long Term Care Property	$ 126,714.99	$ 126,714.99
2.	10-23-324-003-0000	Home Office Allocation	$ 2,427.62	$ 389.88
3.	10-23-324-042-0000	Home Office Allocation	$ 20,996.47	$ 3,372.03
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 150,139.08	$ 130,476.90

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. 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 Office of Health Finance at (217) 782-1630.

2012 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 - 1111 FAX #: (847) 236 - 1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$

4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facillity		1991	$ 105,600	1
2	Premier Healthcare & Financial Services, Inc.			3,051	2
3	TOTALS			$ 108,651	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	127		1991	1971	$ 1,878,400	$ 62,781	39	$ 48,164	$ (14,617)	$ 1,228,879	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	1,931	1,931	38,611	10
11	Various			1995	68,517		20	3,427	3,427	65,092	11
12	Various			1996	107,653		20	5,382	5,382	96,887	12
13	Various			1997	32,071		20	1,604	1,604	27,261	13
14	Various			1998	19,271		20	964	964	15,419	14
15	Various			1999	16,863		20	844	844	12,650	15
16	Various			2000	50,104		20	2,506	2,506	35,073	16
17	Various			2001	9,165		20	458	458	5,957	17
18	Various			2002	38,362		20	1,919	1,919	23,018	18
19	Various			2003	20,009		20	1,000	1,000	11,008	19
20	Various			2004	38,100		20	1,906	1,906	19,052	20
21	Various			2005	127,366		20	6,369	6,369	57,316	21
22	Various			2006	12,900		20	645	645	5,160	22
23	Various			2007	21,148		20	1,057	1,057	7,401	23
24	Various			2008	36,464		20	1,823	1,823	10,939	24
25	Various			2009	52,161		20	2,610	2,610	13,042	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		387,751			6,779	6,779	291,272	67
68	Related Party Allocations (Pages 12H & 12I)		178,208	4,355		7,467	3,112	15,516	68
69	Financial Statement Depreciation			129,795			(129,795)		69
70	TOTAL (lines 4 thru 69)		$ 3,156,111	$ 196,931		$ 96,855	$ (100,076)	$ 2,002,541	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,156,111	$ 196,931		$ 96,855	$ (100,076)	$ 2,002,541	1
2	Reception Area Door, Glass Wall, Countertop, Carpeting, Painting	2010	13,340		20	667	667	2,668	2
3	Sewer Line	2010	4,500		20	225	225	900	3
4	Fusible Links- Fire Dampers	2012	13,680		20	684	684	1,368	4
5	Plumbing/Hot Water Tanks	2012	15,500		20	775	775	1,550	5
6	Elevator Door Edge	2012	2,892		20	145	145	290	6
7	Fence	2012	9,352		20	468	468	936	7
8	Brickwork And Exterior Work	2013	150,000		20	5,000	5,000	5,000	8
9	Corridors - Doors	2013	7,715		20	225	225	225	9
10	Decorative Lighting-Outdoor/Canopy/Ramp	2013	3,000		20	350	350	350	10
11	Sliding Doors	2013	10,932		20	319	319	319	11
12	Lighting And Electrical	2013	2,908		20	85	85	85	12
13	B&G Pump	2013	3,400		20	43	43	43	13
14	Heating And Boiler Work	2013	7,964		20	66	66	66	14
15	Dig Up Floor, Add Drain	2013	2,800		20	12	12	12	15
16	Lobby & Vestibule: New Ceiling & Lighting, Ceramic Tile Installa	2013	10,023		20	501	501	501	16
17	Conference & Reception:New Flooring, Wallcovering, Window Tre	2013	5,296		20	265	265	265	17
18	1St Floor Corridor:New Flooring, Wallcovering, Handrails, Bumpe	2013	28,607		20	1,430	1,430	1,430	18
19	1St Floor Dining Room: New Flooring, Wallcovering,Chair Rails, V	2013	13,765		20	688	688	688	19
20	1St Floor Resident Rooms: Window Treatments, Cubicle Curtains	2013	20,876		20	1,044	1,044	1,044	20
21	Elevator: Replace Ceilings, Handrails, New Wall Panel System, Flo	2013	7,913		20	396	396	396	21
22	Basement Corridor:New Flooring, Handrails, Bumper Guards, Sin	2013	16,725		20	836	836	836	22
23	Various Areas: Remove Old Wallcovering, Install New, & Paint Va	2013	28,223		20	1,411	1,411	1,411	23
24	Elevator Repair- Cylinder And Piston Replacement	2013	32,400		20	1,620	1,620	1,620	24
25	Elevartor Modernization-Car Operating Panel, Ball Fixtures, & So	2013	16,500		20	825	825	825	25
26	New Hardscaping And Softscaping	2013	42,900		20	2,145	2,145	2,145	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,627,323	$ 196,931		$ 117,079	$ (79,852)	$ 2,027,513	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,627,323	$ 196,931		$ 117,079	$ (79,852)	$ 2,027,513	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,627,323	$ 196,931		$ 117,079	$ (79,852)	$ 2,027,513	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,627,323	$ 196,931		$ 117,079	$ (79,852)	$ 2,027,513	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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16									16
17									17
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19									19
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,627,323	$ 196,931		$ 117,079	$ (79,852)	$ 2,027,513	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,627,323	$ 196,931		$ 117,079	$ (79,852)	$ 2,027,513	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,627,323	$ 196,931		$ 117,079	$ (79,852)	$ 2,027,513	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information		$	$		$	$	$	1
2	Buildings:								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	79,811		20	3,991	3,991	27,934	18
19	Walk in Cooler	2010	35,374		20	1,769	1,769	7,075	19
20	Cable TV Install	2010	10,850		20	543	543	2,170	20
21	Kitchen Cooling/Heating Unit	2010	9,529		20	476	476	1,906	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

SEE ACCOUNTANTS' COMPILATION REPORT

**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: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$ 387,751	$		$ 6,779	$ 6,779	$ 291,272	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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: 01/01/13 Ending: 12/31/13

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 Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Premier HC Realty, LLC	2011	59,799	1,533	35	1,709	176	3,558	3
4	Allocated from Premier HC Realty, LLC	2012	7,613	195	35	218	23	435	4
5									5
6									6
7									7
8	Leasehold Information								8
9	Premier Healthcare & Financial Services, Inc.	2012	1,357	13	20	68	55	136	9
10	Allocated from Premier HC Realty, LLC	2011	106,356	2,535	20	5,318	2,783	11,079	10
11	Allocated from Premier HC Realty, LLC	2012	3,083	79	20	154	75	308	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
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28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

**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: 01/01/13 Ending: 12/31/13

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 Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 178,208	$ 4,355		$ 7,467	$ 3,112	$ 15,516	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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: 01/01/13 Ending: 12/31/13

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	$ 141,179	$ 98	$ 14,825	$ 14,727	10	$ 93,227	71
72	Current Year Purchases	78,976	190	9,828	9,638	10	9,828	72
73	Fully Depreciated Assets	211,332				10	211,332	73
74								74
75	TOTALS	$ 431,487	$ 288	$ 24,654	$ 24,366		$ 314,387	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)	$ 4,167,461	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 197,219	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 141,733	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (55,486)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,341,900	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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. [X] YES [ ] NO

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

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

9. Option to Buy: [ ] YES [ ] NO Terms: *

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.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 1,970 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			243,893			243,893	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				114,020		114,020	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental						3,477		3,477	13
14	TOTAL			$		$ 243,893	$ 117,497		$ 361,390	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 27,305	$ 378,242	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	976,870	976,870	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	125,549	125,549	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		154,000	8
9	Other(specify): See Attached Schedule	153	740,715	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,129,877	$ 2,375,376	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		105,600	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	462,552	2,676,909	15
16	Equipment, at Historical Cost	39,023	330,274	16
17	Accumulated Depreciation (book methods)	(136,836)	(1,750,529)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		51,741	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	255,610	610	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 620,349	$ 1,414,605	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,750,226	$ 3,789,981	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 508,581	$ 508,581	26
27	Officer's Accounts Payable		383,046	27
28	Accounts Payable-Patient Deposits	6,185	6,185	28
29	Short-Term Notes Payable	522,158	618,821	29
30	Accrued Salaries Payable	227,330	227,330	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		130,516	32
33	Accrued Interest Payable		6,905	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	57,723	62,973	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,321,977	$ 1,944,357	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,916,365	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)**	$	$ 2,916,365	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,321,977	$ 4,860,722	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 428,249	$ (1,070,741)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,750,226	$ 3,789,981	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 295,930	1
2	Restatements (describe):		2
3	**Rounding**	3	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 295,933	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	277,579	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	(145,263)	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)**	$ 132,316	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)**	$ 428,249	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,740,341	1
2	Discounts and Allowances for all Levels	(273,715)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,466,626	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	9,307	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,307	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,475,933	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	843,870	31
32	Health Care	1,821,990	32
33	General Administration	1,066,902	33
	B. Capital Expense		
34	Ownership	792,805	34
	C. Ancillary Expense		
35	Special Cost Centers	370,987	35
36	Provider Participation Fee	301,800	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,198,354	40
41	**Income before Income Taxes (line 30 minus line 40)****	277,579	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 277,579	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,413,585	44
45	Private Pay - Net Inpatient Revenue	10,880	45
46	Medicare - Net Inpatient Revenue	980,967	46
47	Other-(specify) Hospice	61,194	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,466,626	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,877	2,021	$ 75,138	$ 37.18	1
2	Assistant Director of Nursing	1,776	1,951	67,430	34.56	2
3	Registered Nurses	8,421	8,737	309,690	35.45	3
4	Licensed Practical Nurses	18,372	19,774	468,270	23.68	4
5	CNAs & Orderlies	49,940	53,829	564,628	10.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	747	866	15,907	18.37	8
9	Activity Director	1,613	1,715	25,526	14.88	9
10	Activity Assistants	4,782	5,180	60,122	11.61	10
11	Social Service Workers	7,737	8,046	132,908	16.52	11
12	Dietician					12
13	Food Service Supervisor	1,939	2,067	30,296	14.66	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,886	15,192	183,059	12.05	15
16	Dishwashers					16
17	Maintenance Workers	1,913	2,079	37,524	18.05	17
18	Housekeepers	9,895	10,680	125,158	11.72	18
19	Laundry	4,337	4,588	46,465	10.13	19
20	Administrator	2,071	2,102	91,696	43.62	20
21	Assistant Administrator	177	180	7,855	43.64	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,739	4,065	51,116	12.57	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	1,739	1,923	21,864	11.37	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	134,961	144,995	$ 2,314,652 *	$ 15.96	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	133	$ 7,340	01-03	35
36	Medical Director	Monthly	16,200	09-03	36
37	Medical Records Consultant	Monthly	1,560	10-03	37
38	Nurse Consultant	Monthly	7,838	10-03	38
39	Pharmacist Consultant	Monthly	6,048	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	69	3,450	11-03	44
45	Social Service Consultant	64	3,791	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	267	$ 46,227		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sue Bohne	Administrator	0	$ 91,696
Olivia Carey	Asst Admin	0	7,855
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 99,551

B. Administrative - Other

Description	Amount
Premier Healthcare & Financial Services, Inc- Mgmt Fees	$ 259,249
iCare Consulting Services LLC- Mgmt Fees	81,245
TOTAL (agree to Schedule V, line 17, col. 3)	$ 340,494
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Reliable Health System	Computer Services-Charts	$ 12,105
FR&R	Accounting	15,000
MTS Consulting	Tax Consulting	327
Keller Kempster	Immigration Consulting	5,165
Beech Street Capital	TPA Process	3,000
Aharon Diena	Outside Façade	2,500
SHO Designs	Interior Design	510
Tik Tek It Solutions	Computer Services	718
MDI Achieve	Computer Software	1,855
Various	Legal	22,125
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 63,306

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 25,799
Unemployment Compensation Insurance	20,083
FICA Taxes	177,071
Employee Health Insurance	105,921
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	6,059
Other Employee Benefits	591
Holiday Expense	3,343
TOTAL (agree to Schedule V, line 22, col.8)	$ 338,867

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	194
Health Care Worker Background Check	1,685
(Indicate # of checks performed 169)	
Patient Background Checks	
Dues & Subscriptions	5,877
Licenses and Permits	1,720
Allocated from iCare Consulting	139
Allocated from Premier	104
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,709

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,668
Allocated from iCare Consulting	674
Allocated from Premier	226
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,568

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/13 Ending: 12/31/13

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. **IL Council on LTC $12,668**

(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. $ **2,950** Line **10-2**

(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. $ **301,800**
This amount is to be recorded on line 42 of Schedule V.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 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 out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.