FOR BHF USE

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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

I. IDPH License ID Number: 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 01/01/14 to 12/31/14 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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12/4/2014

	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)	128	18,412	1
2		Skilled Pediatric (SNF/PED)			2
3	83	Intermediate (ICF)		27,971	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	127	TOTALS	128	46,383	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	7,116	4	3,004	10,124	8
9	SNF/PED					9
10	ICF	32,840	3	339	33,182	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,956	7	3,343	43,306	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.37%

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)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 128 and days of care provided 3,004

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	209,038	20,573	8,675	238,286		238,286		238,286			1
2	Food Purchase		198,017		198,017		198,017	1,246	199,263			2
3	Housekeeping	125,843	16,125		141,968		141,968	1,008	142,976			3
4	Laundry	47,062	8,601		55,663		55,663		55,663			4
5	Heat and Other Utilities			130,379	130,379		130,379	(1,024)	129,355			5
6	Maintenance	84,605		85,621	170,226		170,226	(19,947)	150,279			6
7	Other (specify):*											7
8	TOTAL General Services	466,548	243,316	224,675	934,539		934,539	(18,717)	915,822			8
	B. Health Care and Programs											
9	Medical Director			19,500	19,500		19,500		19,500			9
10	Nursing and Medical Records	1,569,553	49,952	8,304	1,627,809		1,627,809	(9,357)	1,618,452			10
10a	Therapy	28,995			28,995		28,995		28,995			10a
11	Activities	82,064	13,075	2,400	97,539		97,539		97,539			11
12	Social Services	125,012		3,535	128,547		128,547		128,547			12
13	CNA Training											13
14	Program Transportation			2,592	2,592		2,592		2,592			14
15	Other (specify):*							6,546	6,546			15
16	TOTAL Health Care and Programs	1,805,624	63,027	36,331	1,904,982		1,904,982	(2,811)	1,902,171			16
	C. General Administration											
17	Administrative	160,737		376,494	537,231		537,231	(340,686)	196,545			17
18	Directors Fees											18
19	Professional Services			98,470	98,470		98,470	(26,460)	72,010			19
20	Dues, Fees, Subscriptions & Promotions			25,119	25,119		25,119	(10,674)	14,445			20
21	Clerical & General Office Expenses	48,860		66,972	115,832		115,832	31,605	147,437			21
22	Employee Benefits & Payroll Taxes			444,251	444,251		444,251		444,251			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,919	1,919		1,919	440	2,359			24
25	Other Admin. Staff Transportation			4,230	4,230		4,230	4,108	8,338			25
26	Insurance-Prop.Liab.Malpractice			119,489	119,489		119,489	181	119,670			26
27	Other (specify):*							15,863	15,863			27
28	TOTAL General Administration	209,597		1,136,944	1,346,541		1,346,541	(325,623)	1,020,918			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,481,769	306,343	1,397,950	4,186,062		4,186,062	(347,151)	3,838,911			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Park View Rehab Center #0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			91,635	91,635		91,635	43,228	134,863			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,171	20,171		20,171	83,628	103,799			32
33	Real Estate Taxes			119,486	119,486		119,486	136,090	255,576			33
34	Rent-Facility & Grounds			524,040	524,040		524,040	(524,040)	0			34
35	Rent-Equipment & Vehicles			2,364	2,364		2,364		2,364			35
36	Other (specify):*							14,762	14,762			36
37	**TOTAL Ownership**			757,696	757,696		757,696	(246,332)	511,364			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		95,550	387,464	483,014		483,014		483,014			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			312,661	312,661		312,661		312,661			42
43	Other (specify):*			15,641	15,641		15,641	(15,641)				43
44	**TOTAL Special Cost Centers**		95,550	715,766	811,316		811,316	(15,641)	795,675			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,481,769	401,893	2,871,412	5,755,074		5,755,074	(609,124)	5,145,950			45

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,000)	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	(20,913)	30		9
10	Interest and Other Investment Income	(5)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		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	(200)	21		18
19	Entertainment				19
20	Contributions	(1,649)	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	(1,947)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(106,677)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (140,391)		$	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)	(468,732)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (468,732)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (609,124)		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

Park View Rehab Center

ID# 0052092

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Medicare Sequestration	$ (25,020)	21	1
2	Food Rebates	(154)	02	2
3	Other Marketing Expenses	(6,067)	43	3
4	Bank Charges	(6,443)	21	4
5	Capitalized R&M	(23,363)	06	5
6	Additional R&M	1,849	06	6
7	Miscellaneous Income	(1,314)	21	7
8	Medical Record Revenue	(832)	10	8
9	Non-Allowable Legal	(28,002)	19	9
10	PAC Dues	(7,420)	20	10
11	Building Company Accounting Fees	(5,250)	19	11
12	Building Company Annual Report	(250)	20	12
13	Building Company Amortization	(2,911)	31	13
14	Building Company Income Taxes	(1,500)	21	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**	(106,677)		49

Park View Rehab Center

ID# 0052092

Report Period Beginning: 01/01/14

Ending: 12/31/14

	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:** 01/01/14 **Ending:** 12/31/14

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	(154)		1,302		98							1,246	2
3	Housekeeping			1,008									1,008	3
4	Laundry													4
5	Heat and Other Utilities	(2,000)		976									(1,024)	5
6	Maintenance	(21,514)		1,557		10							(19,947)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(23,668)		4,843		108							(18,717)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(832)				(8,525)							(9,357)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					6,546							6,546	15
16	**TOTAL Health Care and Programs**	(832)				(1,979)							(2,811)	16
	C. General Administration													
17	Administrative			(342,699)		2,013							(340,686)	17
18	Directors Fees													18
19	Professional Services	(33,252)	5,250	262		1,280							(26,460)	19
20	Fees, Subscriptions & Promotions	(11,266)	250	155	151	36							(10,674)	20
21	Clerical & General Office Expenses	(41,477)	1,500	70,422		1,160							31,605	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			139		301							440	24
25	Other Admin. Staff Transportation					4,108							4,108	25
26	Insurance-Prop.Liab.Malpractice			181									181	26
27	Other (specify):*			14,802		1,061							15,863	27
28	**TOTAL General Administration**	(85,995)	7,000	(256,738)	151	9,959							(325,623)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(110,495)	7,000	(251,895)	151	8,088							(347,151)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park View Rehab Center **#** 0052092 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(20,913)	60,694		3,447								43,228	30
31	Amortization of Pre-Op. & Org.	(2,911)	2,911											31
32	Interest	(5)	81,102	12	2,519								83,628	32
33	Real Estate Taxes		130,196		5,894								136,090	33
34	Rent-Facility & Grounds		(524,040)	9,223	(9,223)								(524,040)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*		14,762										14,762	36
37	**TOTAL Ownership**	(23,829)	(234,375)	9,235	2,637								(246,332)	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):*	(6,067)				(9,574)							(15,641)	43
44	**TOTAL Special Cost Centers**	(6,067)				(9,574)							(15,641)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(140,391)	(227,375)	(242,660)	2,788	(1,486)							(609,124)	45

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Rental Income	$ 524,040	Heritage Healthcare Center LLC	100.00%	$	$ (524,040)	1
2	V	32	Interest Income	1,015	Heritage Healthcare Center LLC	100.00%		(1,015)	2
3	V	19	Accounting Fees		Heritage Healthcare Center LLC	100.00%	5,250	5,250	3
4	V	20	Annual Report		Heritage Healthcare Center LLC	100.00%	250	250	4
5	V	36	MIP Expense		Heritage Healthcare Center LLC	100.00%	14,762	14,762	5
6	V	33	RE Taxes		Heritage Healthcare Center LLC	100.00%	130,196	130,196	6
7	V	30	Depreciation		Heritage Healthcare Center LLC	100.00%	60,694	60,694	7
8	V	31	Amortization		Heritage Healthcare Center LLC	100.00%	2,911	2,911	8
9	V	32	Interest Expense		Heritage Healthcare Center LLC	100.00%	82,117	82,117	9
10	V	21	Income Taxes		Heritage Healthcare Center LLC	100.00%	1,500	1,500	10
11	V								11
12	V								12
13	V								13
14	Total			$ 525,055			$ 297,680	$ * (227,375)	14

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 1,302	$ 1,302	15
16	V	3	HOUSEKEEPING		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,008	1,008	16
17	V	5	UTILITIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	976	976	17
18	V	6	REPAIRS AND MAINTENANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,557	1,557	18
19	V	17	S WEBSTER SALARY		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	16,873	16,873	19
20	V	17	Y LEVOVITZ-SALARY		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	16,922	16,922	20
21	V	19	PROFESSIONAL FEES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	262	262	21
22	V	20	DUES FEES SUBSCRIPTIONS		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	155	155	22
23	V	21	CLERICAL AND GENERAL		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	6,376	6,376	23
24	V	21	CLERICAL & GENERAL SALARIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	64,046	64,046	24
25	V	24	SEMINARS & EDUCATION		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	139	139	25
26	V	26	INSURANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	181	181	26
27	V	27	EMPLOYEE BEN. GEN ADMIN.		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	14,802	14,802	27
28	V	32	INTEREST		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	12	12	28
29	V	34	RENT		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	9,223	9,223	29
30	V								30
31	V	17	MANAGEMENT FEES	376,494	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%		(376,494)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 376,494			$ 133,834	$ * (242,660)	39

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	20	PROFESSIONAL FEES		PREMIER HC REAL ESTATE, LLC	100.00%	151	$ 151	15
16	V	30	DEPRECIATION		PREMIER HC REAL ESTATE, LLC	100.00%	3,447	3,447	16
17	V	32	INTEREST EXPENSE		PREMIER HC REAL ESTATE, LLC	100.00%	2,519	2,519	17
18	V	33	REAL ESTATE TAXES		PREMIER HC REAL ESTATE, LLC	100.00%	5,894	5,894	18
19	V								19
20	V	34	RENT	9,223	PREMIER HC REAL ESTATE, LLC	100.00%		(9,223)	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			$ 9,223			$ 12,011	$ * 2,788	39

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 98	$ 98	15
16	V	6	REPAIRS AND MAINTENANCE		iCare Consulting Services LLC	100.00%	10	10	16
17	V	10	NURSING SALARIES	67,694	iCare Consulting Services LLC	100.00%	59,169	(8,525)	17
18	V	15	EMPLOYEE BEN. HC PROGRAMS		iCare Consulting Services LLC	100.00%	6,546	6,546	18
19	V	17	ADMIN SALARY NON-RELATED		iCare Consulting Services LLC	100.00%	2,013	2,013	19
20	V	19	PROFESSIONAL FEES		iCare Consulting Services LLC	100.00%	1,280	1,280	20
21	V	20	DUES FEES SUBSCRIPTIONS		iCare Consulting Services LLC	100.00%	36	36	21
22	V	21	CLERICAL AND GENERAL		iCare Consulting Services LLC	100.00%	2,842	2,842	22
23	V	21	CLERICAL & GENERAL SALARIES		iCare Consulting Services LLC	100.00%	7,573	7,573	23
24	V	24	SEMINARS & EDUCATION		iCare Consulting Services LLC	100.00%	301	301	24
25	V	25	AUTO EXPENSE		iCare Consulting Services LLC	100.00%	4,108	4,108	25
26	V	27	EMPLOYEE BEN. GEN ADMIN.		iCare Consulting Services LLC	100.00%	1,061	1,061	26
27	V								27
28	V	21	ENVIRONMENTAL CONSULTANT	9,255	iCare Consulting Services LLC	100.00%		(9,255)	28
29	V	43	MARKETING CONSULTANT	9,574	iCare Consulting Services LLC	100.00%		(9,574)	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			$ 86,523			$ 85,037	$ * (1,486)	39

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.**

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	RIVER VIEW REHAB CENTER	ELGIN	LIFELINE LAB INC	SKOKIE, IL	LABORATORY	4
5	MIKEL CHILDREN 2012 TRUST	6.25%	FOREST CITY REHAB & NURSING CENTER	ROCKFORD	ICARE	SKOKIE, IL	CONSULTING	5
6	HOWARD WENGROW	4.05%	ROCK RIVER HEALTH CARE	ROCKFORD	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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	19.84%	See Attached	4.99	12.48%	Alloc Sal	$ 16,873	17-7	1
2	Yeruchom Levovitz	Owner	Administrative	15.92%	See Attached	4.99	12.48%	Alloc Sal	16,922	17-7	2
3	Yakov Kohen	Owner	Clerical	1.56%	See Attached	4.99	12.48%	Alloc Sal	10,907	21-7	3
4	Moshe Levovitz	Owner	Clerical	1.56%	See Attached	1.25	3.13%	Alloc Sal	432	21-7	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	$ 45,134		13

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

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	347,452	7	$ 10,450	$	43,306	$ 1,302	1
2	3	HOUSEKEEPING	PATIENT DAYS	347,452	7	8,084		43,306	1,008	2
3	5	UTILITIES	PATIENT DAYS	347,452	7	7,831		43,306	976	3
4	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	347,452	7	12,495		43,306	1,557	4
5	17	S WEBSTER SALARY	PATIENT DAYS	347,452	7	135,377	135,377	43,306	16,873	5
6	17	Y LEVOVITZ-SALARY	PATIENT DAYS	347,452	7	135,768	135,768	43,306	16,922	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	347,452	7	2,104		43,306	262	7
8	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	347,452	7	1,246		43,306	155	8
9	21	CLERICAL AND GENERAL	PATIENT DAYS	347,452	7	51,157		43,306	6,376	9
10	21	CLERICAL & GENERAL SALA	PATIENT DAYS	347,452	7	513,852	513,852	43,306	64,046	10
11	24	SEMINARS & EDUCATION	PATIENT DAYS	347,452	7	1,118		43,306	139	11
12	26	INSURANCE	PATIENT DAYS	347,452	7	1,450		43,306	181	12
13	27	EMPLOYEE BEN. GEN ADMIN	PATIENT DAYS	347,452	7	118,755		43,306	14,802	13
14	32	INTEREST	PATIENT DAYS	347,452	7	96		43,306	12	14
15	34	RENT	PATIENT DAYS	347,452	7	74,000		43,306	9,223	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,073,783	$ 784,997		$ 133,834	25

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 HC REAL ESTATE, 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	20	PROFESSIONAL FEES	PATIENT DAYS	347,452	7	1,210		43,306	151	1
2	30	DEPRECIATION	PATIENT DAYS	347,452	7	27,658		43,306	3,447	2
3	32	INTEREST EXPENSE	PATIENT DAYS	347,452	7	20,211		43,306	2,519	3
4	33	REAL ESTATE TAXES	PATIENT DAYS	347,452	7	47,288		43,306	5,894	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					$ 96,367	$		$ 12,011	25

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	297,996	5	$ 676	$	43,306	$ 98	1
2	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	297,996	5	68		43,306	10	2
3	10	NURSING SALARIES	PATIENT DAYS	297,996	5	407,152	407,152	43,306	59,169	3
4	15	EMPLOYEE BEN. HC PROGRA	PATIENT DAYS	297,996	5	45,046		43,306	6,546	4
5	17	ADMIN SALARY NON-RELAT	PATIENT DAYS	297,996	5	13,853		43,306	2,013	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	297,996	5	8,806		43,306	1,280	6
7	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	297,996	5	250		43,306	36	7
8	21	CLERICAL AND GENERAL	PATIENT DAYS	297,996	5	19,558	19,558	43,306	2,842	8
9	21	CLERICAL & GENERAL SALA	PATIENT DAYS	297,996	5	52,114		43,306	7,573	9
10	24	SEMINARS & EDUCATION	PATIENT DAYS	297,996	5	2,068		43,306	301	10
11	25	AUTO EXPENSE	PATIENT DAYS	297,996	5	28,266		43,306	4,108	11
12	27	EMPLOYEE BEN. GEN ADMIN	PATIENT DAYS	297,996	5	7,298		43,306	1,061	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					$ 585,155	$ 426,710		$ 85,037	25

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			$	$ 2,916,365			$ 82,117	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB Financial		X	Capital Expenditures			500,000		1/15/2018	4.5%	8,615	6
7	MB Financial		X	Line of Credit			1,000,000	115,000	1/15/2014	4.0%	11,556	7
8	See Supplemental Schedule										2,531	8
9	TOTAL Facility Related						$ 1,500,000	$ 3,031,365			$ 104,819	9
	B. Non-Facility Related*											
10	Interest Income		X								(5)	10
11	Interest Income- Bldg Co		X								(1,015)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,020)	14
15	TOTALS (line 9+line14)						$ 1,500,000	$ 3,031,365			$ 103,799	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 14,762 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.)

** 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: 01/01/14 Ending: 12/31/14

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 HC		X				$	$			$ 12	8
9	Allocated From Premier RE		X								2,519	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										2,531	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:** 01/01/14 **Ending:** 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 11,031	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.)		$ 134,324	2
3. Under or (over) accrual (line 2 minus line 1).		$ 123,293	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 132,283	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.		$ 255,576	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	104,396	8
	2010	110,253	9
	2011	109,794	10
	2012	126,715	11
	2013	128,430	12

Beginning Accrual Adjusted
Allocated From Premier: $5,894

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 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 2013 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 2013.

	(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	$ 128,429.92	$ 128,429.92
2.	10-23-324-047-0000	Home Office Allocation	$ 37,288.03	$ 4,647.54
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 165,717.95	$ 133,077.46

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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.

2000 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: 01/01/14 Ending: 12/31/14

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	Facility		1991	$ 105,600	1
2	Allocated From Premier			2,368	2
3	TOTALS			$ 107,968	3

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 60,694	39	$ 48,164	$ (12,530)	$ 1,277,043	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	22,988		20			22,988	9
10	Various			1994	38,610		20			38,610	10
11	Various			1995	68,517		20	3,424	3,424	68,516	11
12	Various			1996	107,653		20	5,382	5,382	102,269	12
13	Various			1997	32,071		20	1,604	1,604	28,865	13
14	Various			1998	19,271		20	964	964	16,383	14
15	Various			1999	16,863		20	844	844	13,494	15
16	Various			2000	50,104		20	2,506	2,506	37,579	16
17	Various			2001	9,165		20	458	458	6,415	17
18	Various			2002	38,362		20	1,919	1,919	24,937	18
19	Various			2003	20,009		20	1,000	1,000	12,008	19
20	Various			2004	38,100		20	1,906	1,906	20,958	20
21	Various			2005	127,366		20	6,369	6,369	63,685	21
22	Various			2006	2,900		20	145	145	1,305	22
23	Various			2007	3,348		20	167	167	1,338	23
24	Various			2008	32,480		20	1,624	1,624	11,368	24
25	Various			2009	33,390		20	2,417	2,417	14,498	25
26	Various			2010	17,840		20	892	892	4,460	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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		318,938			6,779	6,779	298,051	67
68	Related Party Allocations (Pages 12H & 12I)		138,327	3,369		5,796	2,427	17,839	68
69	Financial Statement Depreciation			91,635			(91,635)		69
70	TOTAL (lines 4 thru 69)		$ 3,014,702	$ 155,698		$ 92,360	$ (63,338)	$ 2,082,609	70

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 3,014,702	$ 155,698		$ 92,360	$ (63,338)	$ 2,082,609	1
2	Fusible Links- Fire Dampers	2012	13,680		20	684	684	2,052	2
3	Plumbing/Hot Water Tanks	2012	15,500		20	775	775	2,325	3
4	Elevator Door Edge	2012	2,892		20	145	145	435	4
5	Brickwork And Exterior Work	2013	150,000		20	7,500	7,500	12,500	5
6	Corridors - Doors	2013	7,715		20	386	386	611	6
7	Decorative Lighting	2013	3,000		20	600	600	950	7
8	Sliding Doors	2013	10,932		20	547	547	865	8
9	Lighting And Electrical	2013	2,908		20	145	145	230	9
10	B&G Pump	2013	3,400		20	170	170	213	10
11	Heating And Boiler Work	2013	7,964		20	398	398	465	11
12	Dig Up Floor, Add Drain	2013	2,800		20	140	140	152	12
13	Lobby & Vestibule: New Ceiling & Lighting, Ceramic Tile Installa	2013	11,537		20	501	501	1,002	13
14	Conference & Reception:New Flooring, Wallcovering, Window Tr	2013	5,536		20	265	265	530	14
15	1St Floor Corridor:New Flooring, Wallcovering, Handrails, Bump	2013	27,899		20	1,430	1,430	2,860	15
16	1St Floor Dining Room: New Flooring, Wallcovering,Chair Rails,	2013	14,425		20	688	688	1,376	16
17	1St Floor Resident Rooms: Window Treatments, Cubicle Curtains	2013	21,825		20	1,044	1,044	2,088	17
18	Elevator: Replace Ceilings, Handrails, New Wall Panel System, Flo	2013	8,273		20	396	396	792	18
19	Basement Corridor:New Flooring, Handrails, Bumper Guards, Sin	2013	17,767		20	836	836	1,672	19
20	Various Areas: Remove Old Wallcovering, Install New, & Paint Va	2013	29,506		20	1,411	1,411	2,822	20
21	Elevator Repair- Cylinder And Piston Replacement	2013	32,400		20	1,620	1,620	3,240	21
22	Elevartor Modernization-Car Operating Panel, Ball Fixtures, & So	2013	16,500		20	825	825	1,650	22
23	New Hardscaping And Softscaping	2013	42,900		20	2,145	2,145	4,290	23
24	Fire Sprinkler- Piping/Reducer/Extender/Heat Detector/Pump Cor	2014	6,588		20	6	6	6	24
25	Therapy Room Install Ceiling Tile& Paint Ceiling	2014	5,111		20	256	256	256	25
26	Bathroom Wall/Supply Line/Shower Valve	2014	4,600		20	230	230	230	26
27	Paint Walls In Basement Corridor/1St Fl Res Rms/Bathrooms/The	2014	9,852		20	493	493	493	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,490,212	$ 155,698		$ 115,996	$ (39,702)	$ 2,126,713	34

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 3,490,212	$ 155,698		$ 115,996	$ (39,702)	$ 2,126,713	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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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)		$ 3,490,212	$ 155,698		$ 115,996	$ (39,702)	$ 2,126,713	34

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 3,490,212	$ 155,698		$ 115,996	$ (39,702)	$ 2,126,713	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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19									19
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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)		$ 3,490,212	$ 155,698		$ 115,996	$ (39,702)	$ 2,126,713	34

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 3,490,212	$ 155,698		$ 115,996	$ (39,702)	$ 2,126,713	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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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)		$ 3,490,212	$ 155,698		$ 115,996	$ (39,702)	$ 2,126,713	34

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12E, Carried Forward		$	$		$	$	$	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	58,551		20	3,991	3,991	31,925	18
19	Heritage Nursing Center, Inc	2009	4,500		20	1,769	1,769	8,844	19
20	Heritage Nursing Center, Inc	2010	3,700		20	543	543	2,713	20
21					20	476	476	2,382	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 318,938	$		$ 6,779	$ 6,779	$ 298,051	34

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12F, Carried Forward		$ 318,938	$		$ 6,779	$ 6,779	$ 298,051	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 318,938	$		$ 6,779	$ 6,779	$ 298,051	34

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3	Allocated From Premier Realty	2011	46,416	1,190	35	1,326	136	4,088	3
4	Allocated From Premier Realty	2012	5,910	151	35	169	18	507	4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated From Premier HC & Financial Services	2012	1,053		20	53	53	158	9
10	Allocated From Premier Realty	2011	82,555	1,967	20	4,128	2,161	12,727	10
11	Allocated From Premier Realty	2012	2,393	61	20	120	59	359	11
12									12
13									13
14									14
15									15
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 138,327	$ 3,369		$ 5,796	$ 2,427	$ 17,839	34

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 138,327	$ 3,369		$ 5,796	$ 2,427	$ 17,839	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 138,327	$ 3,369		$ 5,796	$ 2,427	$ 17,839	34

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 149,621	$ 77	$ 18,866	$ 18,789	10	$ 56,770	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	271,744				10	271,744	73
74								74
75	TOTALS	$ 421,365	$ 77	$ 18,866	$ 18,789		$ 328,514	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)	$ 4,019,545	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 155,775	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 134,862	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (20,913)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,455,227	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								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.	/2015	$
13.	/2016	$
14.	/2017	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 2,364 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.

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 147,236	$		$ 147,236	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			73,618			73,618	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			166,610			166,610	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				90,526		90,526	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						5,024		5,024	13
14	TOTAL			$		$ 387,464	$ 95,550		$ 483,014	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.

STATE OF ILLINOIS

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/14 (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	$ 58,183	$ 457,761	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,263,006	1,263,006	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	135,612	142,872	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	233	802,179	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,457,034	$ 2,665,818	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		1,878,400	14
15	Leasehold Improvements, at Historical Cost	470,990	806,947	15
16	Equipment, at Historical Cost	39,023	330,274	16
17	Accumulated Depreciation (book methods)	(220,404)	(1,896,879)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	250,000	472,118	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 539,609	$ 1,696,460	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,996,643	$ 4,362,278	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 373,314	$ 382,552	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,284	5,284	28
29	Short-Term Notes Payable	115,000	115,000	29
30	Accrued Salaries Payable	272,416	272,416	30
31	Accrued Taxes Payable (excluding real estate taxes)	321	321	31
32	Accrued Real Estate Taxes(Sch.IX-B)		132,283	32
33	Accrued Interest Payable		6,683	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	46,636	51,636	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 812,971	$ 966,175	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			633,112	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 3,549,477	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 812,971	$ 4,515,652	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,183,672	$ (153,374)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,996,643	$ 4,362,278	48

*(See instructions.)

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 428,249	1
2	Restatements (describe):		2
3	**Prior Year Journal Entries- PPD Ins/AP/Bed Tax**	8,067	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 436,316	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	867,356	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	(120,000)	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)**	$ 747,356	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,183,672	24 *

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 6,734,089	1
2	Discounts and Allowances for all Levels	(307,908)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,426,181	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	164,122	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 164,122	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	831	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)**	$ 831	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	31,291	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 31,291	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,622,430	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	934,539	31
32	Health Care	1,904,982	32
33	General Administration	1,346,541	33
	B. Capital Expense		
34	Ownership	757,696	34
	C. Ancillary Expense		
35	Special Cost Centers	498,655	35
36	Provider Participation Fee	312,661	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,755,074	40
41	**Income before Income Taxes (line 30 minus line 40)****	867,356	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 867,356	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,190,153	44
45	Private Pay - Net Inpatient Revenue	25,616	45
46	Medicare - Net Inpatient Revenue	1,150,140	46
47	Other-(specify)	43,856	47
48	Other-(specify)	16,416	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,426,181	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.**

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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	2,032	2,081	$ 87,347	$ 41.97	1
2	Assistant Director of Nursing	1,898	2,023	68,159	33.69	2
3	Registered Nurses	9,146	10,159	345,208	33.98	3
4	Licensed Practical Nurses	19,369	20,505	485,020	23.65	4
5	CNAs & Orderlies	53,086	56,813	561,809	9.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,681	1,952	28,995	14.85	8
9	Activity Director	1,827	2,032	23,488	11.56	9
10	Activity Assistants	4,662	5,216	58,576	11.23	10
11	Social Service Workers	7,087	7,604	125,012	16.44	11
12	Dietician					12
13	Food Service Supervisor	1,950	2,051	31,636	15.42	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,226	16,342	177,402	10.86	15
16	Dishwashers					16
17	Maintenance Workers	4,664	5,084	84,605	16.64	17
18	Housekeepers	10,071	11,514	125,843	10.93	18
19	Laundry	4,322	4,862	47,062	9.68	19
20	Administrator	2,052	2,083	90,157	43.28	20
21	Assistant Administrator	2,064	2,092	70,580	33.74	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,294	3,575	48,860	13.67	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	1,879	2,323	22,010	9.47	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	145,310	158,311	$ 2,481,769 *	$ 15.68	34

* 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	157	$ 8,675	01-03	35
36	Medical Director	Monthly	19,500	09-03	36
37	Medical Records Consultant	Monthly	1,600	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,704	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	48	2,400	11-03	44
45	Social Service Consultant	60	3,535	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	265	$ 42,414		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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sue Bohne	Administrator	0.00%	$ 90,156
Olivia Carey	Asst. Admin	0.00%	70,580
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 160,736

B. Administrative - Other

Description	Amount
Premier Healthcare & Financial Services, Inc- Mgmt Fees	$ 376,494
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 376,494

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 15,000
Legal	See Attached	49,546
Reliable Health Systems	Computer Systems- Charts	12,420
Prospect Resources	Energy Consulting	1,300
MTS	Tax Consulting	195
Point Click Care	Software	16,122
SHO Designs	Interior Design	539
Legat Architects	Architecture	3,349
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 98,471

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,275
Unemployment Compensation Insurance	21,601
FICA Taxes	181,191
Employee Health Insurance	176,195
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	15,766
Other Employee Benefits	2,656
Holiday Expense	5,567
TOTAL (agree to Schedule V, line 22, col.8)	$ 444,251

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	702
Health Care Worker Background Check	3,490
(Indicate # of checks performed 349)	
Patient Background Checks	
Advertising & Promotions	1,947
Dues & Subscriptions	5,176
Licenses & Fees	4,735
Allocated From Premier HC & Financial	155
See Supplemental Schedule	187
Less: Public Relations Expense	( )
Non-allowable advertising	(1,947)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,445

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,919
Allocated From Premier HC & Financial	139
Allocated From iCare	301
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,359

**See instructions.

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/14 Ending: 12/31/14

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													
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11													
12													
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14													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Park View Rehab Center # 0052092 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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 $12,596**

(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. $ **3,787** Line **10-02**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **312,661**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 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% ln14**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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