FOR BHF USE

LL1

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

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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) 282-6300
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 01/01/15 to 12/31/15 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)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	128	Skilled (SNF)	128	46,720	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	128	TOTALS	128	46,720	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	7,154	105	3,267	10,526	8
9	SNF/PED					9
10	ICF	33,015	79	184	33,278	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,169	184	3,451	43,804	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.76%

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 3,267

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: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Park View Rehab Center # 0052092 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	203,692	25,059	7,837	236,588		236,588		236,588			1
2	Food Purchase		220,926		220,926		220,926	1,547	222,473			2
3	Housekeeping	114,455	19,066		133,521		133,521	902	134,423			3
4	Laundry	47,704	8,788		56,492		56,492		56,492			4
5	Heat and Other Utilities			114,143	114,143		114,143	(1,406)	112,737			5
6	Maintenance	41,022	87	88,058	129,167		129,167	(10,887)	118,280			6
7	Other (specify):*											7
8	**TOTAL General Services**	406,873	273,926	210,038	890,837		890,837	(9,844)	880,993			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,601,617	81,925	117,235	1,800,777		1,800,777	(34,620)	1,766,157			10
10a	Therapy	30,207			30,207		30,207		30,207			10a
11	Activities	106,055	16,260	2,500	124,815		124,815		124,815			11
12	Social Services	132,928		2,830	135,758		135,758		135,758			12
13	CNA Training											13
14	Program Transportation			1,092	1,092		1,092		1,092			14
15	Other (specify):*							9,246	9,246			15
16	**TOTAL Health Care and Programs**	1,870,807	98,185	141,657	2,110,649		2,110,649	(25,374)	2,085,275			16
	C. General Administration											
17	Administrative	176,164		452,878	629,042		629,042	(423,462)	205,580			17
18	Directors Fees											18
19	Professional Services			90,658	90,658	(2,970)	87,688	(15,081)	72,607			19
20	Dues, Fees, Subscriptions & Promotions			39,547	39,547		39,547	(8,036)	31,511			20
21	Clerical & General Office Expenses	68,048		81,758	149,806		149,806	36,956	186,762			21
22	Employee Benefits & Payroll Taxes			502,449	502,449		502,449		502,449			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,262	2,262		2,262	900	3,162			24
25	Other Admin. Staff Transportation			4,838	4,838		4,838	5,333	10,171			25
26	Insurance-Prop.Liab.Malpractice			129,393	129,393		129,393	737	130,130			26
27	Other (specify):*							19,557	19,557			27
28	**TOTAL General Administration**	244,212		1,303,783	1,547,995	(2,970)	1,545,025	(383,097)	1,161,928			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,521,892	372,111	1,655,478	4,549,481	(2,970)	4,546,511	(418,314)	4,128,197			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: 01/01/15 Ending: 12/31/15

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			27,859	27,859		27,859	106,914	134,773			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			689	689		689	188,496	189,185			32
33	Real Estate Taxes			134,094	134,094	2,970	137,064	3,797	140,861			33
34	Rent-Facility & Grounds			721,589	721,589		721,589	(721,589)				34
35	Rent-Equipment & Vehicles			2,017	2,017		2,017		2,017			35
36	Other (specify):*											36
37	**TOTAL Ownership**			886,248	886,248	2,970	889,218	(422,382)	466,836			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		124,659	556,566	681,225		681,225		681,225			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			313,413	313,413		313,413		313,413			42
43	Other (specify):*			24,349	24,349		24,349	(24,349)				43
44	**TOTAL Special Cost Centers**		124,659	894,328	1,018,987		1,018,987	(24,349)	994,638			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,521,892	496,770	3,436,054	6,454,716		6,454,716	(865,045)	5,589,671			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: 01/01/15 Ending: 12/31/15

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	(2,161)	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	(95,406)	30		9
10	Interest and Other Investment Income	(223)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(9)	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	(864)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,225)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(92,344)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (195,232)		$	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)	(669,813)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (669,813)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (865,045)		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: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Medicare Sequestration	$ (25,869)	21	1
2	Food Rebates	(111)	02	2
3	Other Marketing Expenses	(6,462)	43	3
4	Bank Charges	(6,801)	21	4
5	Building Company Amortization	(14,194)	36	5
6	Capitalized R&M	(12,528)	06	6
7	Medical Record Revenue	(1,065)	10	7
8	Non-Allowable Legal	(12,693)	19	8
9	PAC Dues	(7,361)	20	9
10	Non-Allowable Marketing Prof Fee	(4,952)	19	10
11	Building Company Professional Fees	(309)	19	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(92,344)		49

Park View Rehab Center

ID# 0052092

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park View Rehab Center # 0052092 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(121)		1,536		132							1,547	2
3	Housekeeping			902									902	3
4	Laundry													4
5	Heat and Other Utilities	(2,161)		755									(1,406)	5
6	Maintenance	(12,528)		1,604		37							(10,887)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(14,810)		4,797		169							(9,844)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,065)				(33,555)							(34,620)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					9,246							9,246	15
16	**TOTAL Health Care and Programs**	(1,065)				(24,309)							(25,374)	16
	C. General Administration													
17	Administrative			(427,267)		3,805							(423,462)	17
18	Directors Fees													18
19	Professional Services	(17,954)	309	769	113	1,681							(15,081)	19
20	Fees, Subscriptions & Promotions	(11,586)		3,502	24	24							(8,036)	20
21	Clerical & General Office Expenses	(33,534)		83,199		(12,709)							36,956	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			340		560							900	24
25	Other Admin. Staff Transportation			742		4,591							5,333	25
26	Insurance-Prop.Liab.Malpractice			737									737	26
27	Other (specify):*			17,795		1,762							19,557	27
28	**TOTAL General Administration**	(63,073)	309	(320,183)	137	(286)							(383,097)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(78,948)	309	(315,386)	137	(24,426)							(418,314)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park View Rehab Center **#** 0052092 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	(95,406)	198,758	957	2,605								106,914	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(223)	186,880		1,839								188,496	32
33	Real Estate Taxes				3,797								3,797	33
34	Rent-Facility & Grounds		(721,589)	8,756	(8,756)								(721,589)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(14,194)	14,194											36
37	**TOTAL Ownership**	(109,823)	(321,757)	9,713	(515)								(422,382)	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):*	(6,462)				(17,887)							(24,349)	43
44	**TOTAL Special Cost Centers**	(6,462)				(17,887)							(24,349)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(195,232)	(321,448)	(305,673)	(378)	(42,313)							(865,045)	45

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 721,589	Park View Rehab Center Realty	100.00%	$	$ (721,589)	1
2	V	19	Professional Fees		Park View Rehab Center Realty	100.00%	309	309	2
3	V	32	Interest Expense		Park View Rehab Center Realty	100.00%	186,880	186,880	3
4	V	30	Depreciation		Park View Rehab Center Realty	100.00%	198,758	198,758	4
5	V	36	Amortization		Park View Rehab Center Realty	100.00%	14,194	14,194	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 721,589			$ 400,141	$ * (321,448)	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: 01/01/15 Ending: 12/31/15

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%	$ 1,536	$ 1,536	15
16	V	3	HOUSEKEEPING		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	902	902	16
17	V	5	UTILITIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	755	755	17
18	V	6	REPAIRS AND MAINTENANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,604	1,604	18
19	V	17	S WEBSTER SALARY		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	13,142	13,142	19
20	V	17	Y LEVOVITZ-SALARY		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	12,469	12,469	20
21	V	19	PROFESSIONAL FEES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	769	769	21
22	V	20	DUES FEES SUBSCRIPTIONS		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	3,502	3,502	22
23	V	21	CLERICAL AND GENERAL		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	8,700	8,700	23
24	V	21	CLERICAL & GENERAL SALARIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	74,499	74,499	24
25	V	24	SEMINARS & EDUCATION		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	340	340	25
26	V	25	AUTO EXPENSE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	742	742	26
27	V	26	INSURANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	737	737	27
28	V	27	EMPLOYEE BEN. GEN ADMIN.		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	17,795	17,795	28
29	V	30	DEPRECIATION		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	957	957	29
30	V	34	RENT		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	8,756	8,756	30
31	V								31
32	V	17	MANAGEMENT FEES	452,878				(452,878)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 452,878			$ 147,205	$ * (305,673)	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: 01/01/15 Ending: 12/31/15

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	19	PROFESSIONAL FEES		PREMIER HC REAL ESTATE, LLC	100.00%	113	$ 113	15
16	V	20	LICENSES & PERMITS		PREMIER HC REAL ESTATE, LLC	100.00%	24	24	16
17	V	30	DEPRECIATION		PREMIER HC REAL ESTATE, LLC	100.00%	2,605	2,605	17
18	V	32	INTEREST EXPENSE		PREMIER HC REAL ESTATE, LLC	100.00%	1,839	1,839	18
19	V	33	REAL ESTATE TAXES		PREMIER HC REAL ESTATE, LLC	100.00%	3,797	3,797	19
20	V								20
21	V	34	RENT	8,756				(8,756)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 8,756			$ 8,378	$ * (378)	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: 01/01/15 Ending: 12/31/15

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%	$ 132	$ 132	15
16	V	3	HOUSEKEEPING		iCare Consulting Services LLC	100.00%			16
17	V	5	UTILITIES		iCare Consulting Services LLC	100.00%			17
18	V	6	REPAIRS AND MAINTENANCE		iCare Consulting Services LLC	100.00%	37	37	18
19	V	10	NURSING SALARIES	110,931	iCare Consulting Services LLC	100.00%	77,376	(33,555)	19
20	V	15	EMPLOYEE BEN. HC PROGRAMS		iCare Consulting Services LLC	100.00%	9,246	9,246	20
21	V	17	ADMIN SALARY NON-RELATED		iCare Consulting Services LLC	100.00%			21
22	V	17	M LEVOVITZ-SALARY		iCare Consulting Services LLC	100.00%	3,805	3,805	22
23	V	19	PROFESSIONAL FEES		iCare Consulting Services LLC	100.00%	1,681	1,681	23
24	V	20	DUES FEES SUBSCRIPTIONS		iCare Consulting Services LLC	100.00%	24	24	24
25	V	21	CLERICAL AND GENERAL	27,748	iCare Consulting Services LLC	100.00%	4,102	(23,646)	25
26	V	21	CLERICAL & GENERAL SALARIES		iCare Consulting Services LLC	100.00%	10,937	10,937	26
27	V	24	SEMINARS & EDUCATION		iCare Consulting Services LLC	100.00%	560	560	27
28	V	25	AUTO EXPENSE		iCare Consulting Services LLC	100.00%	4,591	4,591	28
29	V	26	INSURANCE		iCare Consulting Services LLC	100.00%			29
30	V	27	EMPLOYEE BEN. GEN ADMIN.		iCare Consulting Services LLC	100.00%	1,762	1,762	30
31	V	30	DEPRECIATION		iCare Consulting Services LLC	100.00%			31
32	V	43	MARKETING	17,887				(17,887)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 156,566			$ 114,253	$ * (42,313)	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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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	CHICAGO	PREMIER HEALTHC	SKOKIE, IL	MANAGEMENT C	1
2	YERUCHOM LEVOVITZ	15.92%	PINE CREST HEALTH CARE	HAZEL CREST	PREMIER HEALTHC	SKOKIE, IL	BUILDING CO.	2
3	CHAIM O. LEVOVITZ	3.91%	RIVER VIEW REHAB CENTER	ELGIN	PARK VIEW REHAB	CHICAGO, IL	BUILDING CO.	3
4	JEFFREY WEBSTER	4.84%	FOREST CITY REHAB & NURSING	ROCKFORD	ICARE CONSULTIN(	SKOKIE, IL	CONSULTING	4
5	MIKEL CHILDREN 2012 TRUST	6.25%	ROCK RIVER HEALTH CARE	ROCKFORD	LIFELINE LAB	SKOKIE, IL	LAB	5
6	HOWARD WENGROW	4.05%	BROOK CHATEAU	KANSAS CITY, MO	PHARMORE DRUGS	SKOKIE, IL	PHARMACY	6
7	JAY WENGROW	2.34%	LEISURE TERRACE	OVERLAND PARK,KS				7
8	DAVID WENGROW	2.34%	BREEZY MEADOWS	BUTLER, MO				8
9	DINA BRAUNSTEIN	2.34%	PEARL PAVILION	FREEPORT				9
10	GPN FAMILY TRUST	14.25%						10
11	MENACHEM SHABAT	3.56%						11
12	AHUVA SHABAT	3.56%						12
13	ELIANA SHABAT	3.56%						13
14	AYELET SHABAT	3.56%						14
15	MOSHE LEVOVITZ	1.56%						15
16	YAKOV KOHEN	1.56%						16
17	SHARON HINKLE	1.56%						17
18	ARI SHABAT	2.5%						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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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	3.80	9.50%	Alloc Sal	$ 13,142	17-7	1
2	Yeruchom Levovitz	Owner	Administrative	15.92%	See Attached	3.80	9.50%	Alloc Sal	12,469	17-7	2
3	Yakov Kohen	Owner	Clerical	1.56%	See Attached	3.80	9.50%	Alloc Sal	7,683	21-7	3
4	Moshe Levovitz	Owner	Administrative	1.56%	See Attached	0.95	2.38%	Alloc Sal	951	17-7	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	$ 34,245		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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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	461,493	11	$ 16,187	$	43,804	$ 1,536	1
2	3	HOUSEKEEPING	PATIENT DAYS	461,493	11	9,503		43,804	902	2
3	5	UTILITIES	PATIENT DAYS	461,493	11	7,957		43,804	755	3
4	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	461,493	11	16,899		43,804	1,604	4
5	17	S WEBSTER SALARY	PATIENT DAYS	461,493	11	138,451	138,451	43,804	13,142	5
6	17	Y LEVOVITZ-SALARY	PATIENT DAYS	461,493	11	131,370	131,370	43,804	12,469	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	461,493	11	8,102		43,804	769	7
8	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	461,493	11	36,899		43,804	3,502	8
9	21	CLERICAL AND GENERAL	PATIENT DAYS	461,493	11	91,659		43,804	8,700	9
10	21	CLERICAL & GENERAL SALA	PATIENT DAYS	461,493	11	784,868	784,868	43,804	74,499	10
11	24	SEMINARS & EDUCATION	PATIENT DAYS	461,493	11	3,583		43,804	340	11
12	25	AUTO EXPENSE	PATIENT DAYS	461,493	11	7,819		43,804	742	12
13	26	INSURANCE	PATIENT DAYS	461,493	11	7,768		43,804	737	13
14	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	461,493	11	187,476		43,804	17,795	14
15	30	DEPRECIATION	PATIENT DAYS	461,493	11	10,078		43,804	957	15
16	34	RENT	PATIENT DAYS	461,493	11	92,250		43,804	8,756	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,550,868	$ 1,054,689		$ 147,205	25

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	19	PROFESSIONAL FEES	PATIENT DAYS	461,493	11	1,195		43,804	113	1
2	20	LICENSES & PERMITS	PATIENT DAYS	461,493	11	250		43,804	24	2
3	30	DEPRECIATION	PATIENT DAYS	461,493	11	27,440		43,804	2,605	3
4	32	INTEREST EXPENSE	PATIENT DAYS	461,493	11	19,378		43,804	1,839	4
5	33	REAL ESTATE TAXES	PATIENT DAYS	461,493	11	40,000		43,804	3,797	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					$ 88,263	$		$ 8,378	25

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	461,493	11	$ 1,393	$	43,804	$ 132	1
2	3	HOUSEKEEPING	PATIENT DAYS	461,493	11			43,804		2
3	5	UTILITIES	PATIENT DAYS	461,493	11			43,804		3
4	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	461,493	11	391		43,804	37	4
5	10	NURSING SALARIES	PATIENT DAYS	461,493	11	815,183	815,183	43,804	77,376	5
6	15	EMPLOYEE BEN. HC PROGRA	PATIENT DAYS	461,493	11	97,410		43,804	9,246	6
7	17	ADMIN SALARY NON-RELATI	PATIENT DAYS	461,493	11			43,804		7
8	17	M LEVOVITZ-SALARY	PATIENT DAYS	461,493	11	40,090	40,090	43,804	3,805	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	461,493	11	17,714		43,804	1,681	9
10	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	461,493	11	250		43,804	24	10
11	21	CLERICAL AND GENERAL	PATIENT DAYS	461,493	11	43,215		43,804	4,102	11
12	21	CLERICAL & GENERAL SALA	PATIENT DAYS	461,493	11	115,221	115,221	43,804	10,937	12
13	24	SEMINARS & EDUCATION	PATIENT DAYS	461,493	11	5,896		43,804	560	13
14	25	AUTO EXPENSE	PATIENT DAYS	461,493	11	48,366		43,804	4,591	14
15	26	INSURANCE	PATIENT DAYS	461,493	11			43,804		15
16	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	461,493	11	18,559		43,804	1,762	16
17	30	DEPRECIATION	PATIENT DAYS	461,493	11			43,804		17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,203,688	$ 970,494		$ 114,253	25

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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	MB Financial		X	Mortgage			$	$ 5,927,833			$ 141,998	1
2	Heritage		X	Note Payable				3,125,809			44,882	2
3												3
4												4
5												5
	Working Capital											
6	MB Financial		X	Line of Credit							689	6
7	Allocated From Premier HC	X									1,839	7
8												8
9	TOTAL Facility Related						$	$ 9,053,642			$ 189,408	9
	B. Non-Facility Related*											
10	Interest Income		X								(223)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (223)	14
15	TOTALS (line 9+line14)						$	$ 9,053,642			$ 189,185	15

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

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

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/15 Ending: 12/31/15

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							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Park View Rehab Center **#** 0052092 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 130,560	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.)		$ 134,814	2
3. Under or (over) accrual (line 2 minus line 1).		$ 4,254	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 133,637	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$ 2,970	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.		$ 140,861	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	110,253	8
	2011	109,794	9
	2012	126,715	10
	2013	128,430	11
	2014	131,017	12

2015 Accrual: $131,017 X 1.02 = $133,637

Allocated From Premier: $3,797

Beginning Accrual Adjusted

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 2014 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 2014.

	(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	$ 131,017.04	$ 131,017.04
2.	10-23-324-047-0000	Home Office Allocation	$ 37,388.39	$ 3,548.83
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 168,405.43	$ 134,565.87

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 01/01/15 Ending: 12/31/15

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			1,803	2
3	TOTALS			$ 107,403	3

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 198,758	39	$ 48,164	$ (150,594)	$ 1,325,207	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	1	1	68,517	11
12	Various			1996	107,653		20	5,381	5,381	107,650	12
13	Various			1997	32,071		20	1,604	1,604	30,469	13
14	Various			1998	19,271		20	964	964	17,347	14
15	Various			1999	16,863		20	844	844	14,338	15
16	Various			2000	50,104		20	2,506	2,506	40,085	16
17	Various			2001	9,165		20	458	458	6,873	17
18	Various			2002	38,362		20	1,919	1,919	26,856	18
19	Various			2003	20,009		20	1,000	1,000	13,008	19
20	Various			2004	38,100		20	1,906	1,906	22,864	20
21	Various			2005	127,366		20	6,369	6,369	70,054	21
22	Various			2006	2,900		20	145	145	1,450	22
23	Various			2007	3,348		20	167	167	1,505	23
24	Various			2008	32,480		20	1,624	1,624	12,992	24
25	Various			2009	33,390		20	2,417	2,417	16,915	25
26	Various			2010	17,840		20	892	892	5,352	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: 01/01/15 Ending: 12/31/15

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			6,303	6,303	295,859	67
68	Related Party Allocations (Pages 12H & 12I)		105,341	2,573		4,413	1,840	17,998	68
69	Financial Statement Depreciation			27,859			(27,859)		69
70	TOTAL (lines 4 thru 69)		$ 2,981,716	$ 229,190		$ 87,077	$ (142,113)	$ 2,156,937	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: 01/01/15 Ending: 12/31/15

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		$ 2,981,716	$ 229,190		$ 87,077	$ (142,113)	$ 2,156,937	1
2	Fusible Links- Fire Dampers	2012	13,680		20	684	684	2,736	2
3	Plumbing/Hot Water Tanks	2012	15,500		20	775	775	3,100	3
4	Elevator Door Edge	2012	2,892		20	145	145	580	4
5	Brickwork And Exterior Work	2013	150,000		20	7,500	7,500	20,000	5
6	Corridors - Doors	2013	7,715		20	386	386	996	6
7	Decorative Lighting	2013	3,000		20	600	600	1,550	7
8	Sliding Doors	2013	10,932		20	547	547	1,412	8
9	Lighting And Electrical	2013	2,908		20	145	145	376	9
10	B&G Pump	2013	3,400		20	170	170	383	10
11	Heating And Boiler Work	2013	7,964		20	398	398	863	11
12	Dig Up Floor, Add Drain	2013	2,800		20	140	140	292	12
13	Lobby & Vestibule: New Ceiling & Lighting,Ceramic Tile Installa	2013	11,537		20	577	577	1,250	13
14	Conference & Reception:New Flooring, Wallcovering, Window Tr	2013	5,536		20	277	277	600	14
15	1St Floor Corridor:New Flooring, Wallcovering, Handrails, Bump	2013	27,899		20	1,395	1,395	3,022	15
16	1St Floor Dining Room: New Flooring, Wallcovering,Chair Rails,	2013	14,425		20	721	721	1,563	16
17	1St Floor Resident Rooms: Window Treatments, Cubicle Curtains	2013	21,825		20	1,091	1,091	2,364	17
18	Elevator: Replace Ceilings, Handrails, New Wall Panel System, Fl	2013	8,273		20	414	414	896	18
19	Basement Corridor:New Flooring, Handrails, Bumper Guards, Sir	2013	17,767		20	888	888	1,925	19
20	Various Areas: Remove Old Wallcovering, Install New, & Paint V	2013	29,506		20	1,475	1,475	3,196	20
21	Elevator Repair- Cylinder And Piston Replacement	2013	32,400		20	1,620	1,620	4,185	21
22	Elevator Modernization-Car Operating Panel, Ball Fixtures, & So	2013	16,500		20	825	825	2,131	22
23	New Hardscaping And Softscaping	2013	42,900		20	2,145	2,145	5,899	23
24	Fire Sprinkler-Piping, Reducer, Extender, Heat Detector, Pump C	2014	6,588		20	329	329	439	24
25	Therapy Room - Install Ceiling Tile & Paint Ceiling	2014	5,111		20	256	256	405	25
26	Bathroom Wall / Supply Line / Shower Valve	2014	4,600		20	230	230	345	26
27	Paint Walls In Basement Corridor, 1St Flr Rms, Bathrooms, Ther	2014	9,852		20	493	493	534	27
28	Security Camera	2015	8,313		20	416	416	416	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,465,539	$ 229,190		$ 111,719	$ (117,471)	$ 2,218,394	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: 01/01/15 Ending: 12/31/15

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		$ 3,465,539	$ 229,190		$ 111,719	$ (117,471)	$ 2,218,394	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,465,539	$ 229,190		$ 111,719	$ (117,471)	$ 2,218,394	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: 01/01/15 Ending: 12/31/15

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		$ 3,465,539	$ 229,190		$ 111,719	$ (117,471)	$ 2,218,394	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,465,539	$ 229,190		$ 111,719	$ (117,471)	$ 2,218,394	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: 01/01/15 Ending: 12/31/15

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		$ 3,465,539	$ 229,190		$ 111,719	$ (117,471)	$ 2,218,394	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,465,539	$ 229,190		$ 111,719	$ (117,471)	$ 2,218,394	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: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	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	35,916	18
19	Heritage Nursing Center, Inc	2009	4,500		20	1,769	1,769	4,500	19
20	Heritage Nursing Center, Inc	2010	3,700		20	543	543	3,256	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 318,938	$		$ 6,303	$ 6,303	$ 295,859	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: 01/01/15 Ending: 12/31/15

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	$		$ 6,303	$ 6,303	$ 295,859	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 318,938	$		$ 6,303	$ 6,303	$ 295,859	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: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated From Premier Realty	2011	35,348	906	35	1,010	104	4,123	3
4	Allocated From Premier Realty	2012	4,500	115	35	129	14	514	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From Premier Realty	2011	62,869	1,498	20	3,143	1,645	12,836	9
10	Allocated From Premier Realty	2012	1,822	47	20	91	44	364	10
11									11
12	Allocated From Premier HC & Financial Services	2012	802	7	20	40	33	161	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 105,341	$ 2,573		$ 4,413	$ 1,840	$ 17,998	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: 01/01/15 Ending: 12/31/15

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		$ 105,341	$ 2,573		$ 4,413	$ 1,840	$ 17,998	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 105,341	$ 2,573		$ 4,413	$ 1,840	$ 17,998	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: 01/01/15 Ending: 12/31/15

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	$ 136,189	$ 38	$ 22,187	$ 22,149	10	$ 72,893	71
72	Current Year Purchases	8,160	949	866	(83)	10	866	72
73	Fully Depreciated Assets	276,805				10	276,805	73
74								74
75	TOTALS	$ 421,154	$ 987	$ 23,053	$ 22,066		$ 350,564	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)	$ 3,994,095	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 230,177	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 134,771	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (95,406)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,568,958	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: 01/01/15 Ending: 12/31/15

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 2,017 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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 211,495	$		$ 211,495	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			105,748			105,748	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			239,323			239,323	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				119,505		119,505	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						5,154		5,154	13
14	TOTAL			$		$ 556,566	$ 124,659		$ 681,225	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:** 01/01/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/15 **(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	$ 784,221	$ 967,498	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,170,115	1,170,115	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	145,987	145,987	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	2,636	71,817	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,102,959	$ 2,355,417	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		292,400	13
14	Buildings, at Historical Cost		5,107,548	14
15	Leasehold Improvements, at Historical Cost	458,461	458,461	15
16	Equipment, at Historical Cost	54,547	502,547	16
17	Accumulated Depreciation (book methods)	(256,330)	(455,088)	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):		614,761	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 256,678	$ 6,520,629	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,359,637	$ 8,876,046	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 564,630	$ 564,631	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,556	9,556	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	211,525	211,525	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,859	20,859	31
32	Accrued Real Estate Taxes(Sch.IX-B)		133,637	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	38,582	38,582	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 845,152	$ 978,790	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		3,125,809	39
40	Mortgage Payable		5,927,833	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43			7,039	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 9,060,681	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 845,152	$ 10,039,471	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,514,485	$ (1,163,425)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,359,637	$ 8,876,046	48

***(See instructions.)**

Facility Name & ID Number Park View Rehab Center **#** 0052092 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,183,672	1
2	Restatements (describe):		2
3	PY Depreciation	(8,067)	3
4	Rounding	4	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,175,609	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,032,236	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	(1,193,360)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Additional Paid In Capital	500,000	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 338,876	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)**	$ 1,514,485	24 *

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

Facility Name & ID Number Park View Rehab Center **#** 0052092 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	$ 7,338,153	1
2	Discounts and Allowances for all Levels	(361,391)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,976,762	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	246,648	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 246,648	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,867	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,867	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	223	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 223	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	261,452	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 261,452	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,486,952	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	890,837	31
32	Health Care	2,110,649	32
33	General Administration	1,547,995	33
	B. Capital Expense		
34	Ownership	886,248	34
	C. Ancillary Expense		
35	Special Cost Centers	705,574	35
36	Provider Participation Fee	313,413	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,454,716	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,032,236	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,032,236	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,436,697	44
45	Private Pay - Net Inpatient Revenue	46,650	45
46	Medicare - Net Inpatient Revenue	1,366,641	46
47	Other-(specify) Hospice	25,659	47
48	Other-(specify) Insurance	101,115	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,976,762	49

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

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

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

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,725	1,894	$ 74,243	$ 39.20	1
2	Assistant Director of Nursing	1,899	2,059	75,066	36.46	2
3	Registered Nurses	7,276	8,063	227,716	28.24	3
4	Licensed Practical Nurses	22,189	24,160	561,088	23.22	4
5	CNAs & Orderlies	56,455	61,290	642,900	10.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,749	1,956	30,207	15.44	8
9	Activity Director	1,780	1,907	31,103	16.31	9
10	Activity Assistants	5,872	6,418	74,952	11.68	10
11	Social Service Workers	7,213	8,708	132,928	15.27	11
12	Dietician					12
13	Food Service Supervisor	1,942	2,074	34,030	16.41	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,562	16,429	169,662	10.33	15
16	Dishwashers					16
17	Maintenance Workers	2,261	2,465	41,022	16.64	17
18	Housekeepers	10,107	11,567	114,455	9.89	18
19	Laundry	4,372	4,866	47,704	9.80	19
20	Administrator	2,040	2,162	96,576	44.67	20
21	Assistant Administrator	2,000	2,174	79,588	36.61	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,812	3,996	68,048	17.03	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	1,732	1,814	20,604	11.36	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	148,986	164,002	$ 2,521,892 *	$ 15.38	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	142	$ 7,837	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant	Monthly	800	10-03	37
38	Nurse Consultant	Monthly	110,931	10-03	38
39	Pharmacist Consultant	Monthly	5,504	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	50	2,500	11-03	44
45	Social Service Consultant	48	2,830	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	240	$ 148,402		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: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sue Bohne	Administrator	0.00%	$ 96,576
Olivia Carey	Asst. Admin	0.00%	79,588
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 176,164

B. Administrative - Other

Description	Amount
Premier Healthcare & Financial Services, Inc- Mgmt Fees	$ 452,878
TOTAL (agree to Schedule V, line 17, col. 3)	$ 452,878
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting Fees	$ 15,760
See Attached	Legal Fees	35,908
Reliable Health Systems	Computer Systems- Charts	12,420
Prospect Resources	Energy Consulting	1,300
Point Click Care	Software	9,338
Legat Architects	Architecture	1,831
Murphy Consulting	Health Consulting	500
Creative Technology	Computer Fees	5,679
Ardent Communications	Marketing - ADJ	4,952
First Real Estate Services	R/E Appraisal	2,750
Skideslky & Associates	R/E Objection Fees	220
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 90,658

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 76,233
Unemployment Compensation Insurance	31,388
FICA Taxes	180,236
Employee Health Insurance	181,804
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	20,580
Other Employee Benefits	7,571
Holiday Expense	4,637
TOTAL (agree to Schedule V, line 22, col.8)	$ 502,449

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	3,667
Health Care Worker Background Check	2,910
(Indicate # of checks performed 291)	
Patient Background Checks	
Advertising & Promotions	4,225
Dues & Subscriptions	14,945
Licenses & Fees	6,439
Allocated From Premier HC & Financial	3,502
See Supplemental Schedule	48
Less: Public Relations Expense	( )
Non-allowable advertising	(4,225)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,511

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,262
Allocated From Premier HC & Financial	340
Allocated From iCare	560
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,162

**See instructions.

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

Facility Name & ID Number Park View Rehab Center **#** 0052092 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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. **ILCLTC $22,306**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,762** 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. $ **313,413**
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 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.