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: 0051854

Facility Name: Pershing Gardens Hc Center

Address: 3900 South Oak Park Avenue (Number) Stickney (City) 60402 (Zip Code)

County: Cook

Telephone Number: (708)484-7543 **Fax #** (708)484-1412

HFS ID Number:

Date of Initial License for Current Owners: 1/1/2012

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 Pershing Gardens Hc Center # 0051854 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	31	Skilled (SNF)	31	11,315	1
2		Skilled Pediatric (SNF/PED)			2
3	20	Intermediate (ICF)	20	7,300	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	51	TOTALS	51	18,615	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			3,226	3,226	8
9	SNF/PED					9
10	ICF	11,237	488		11,725	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,237	488	3,226	14,951	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.32%

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 01/01/2012

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/2012 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 31 and days of care provided 3,060

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: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number Pershing Gardens Hc Center # 0051854 **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	100,142	5,266	5,566	110,974		110,974		110,974			1
2	Food Purchase		69,753		69,753		69,753	(23)	69,730			2
3	Housekeeping		2,437	52,650	55,087		55,087		55,087			3
4	Laundry		1,417	36,000	37,417		37,417		37,417			4
5	Heat and Other Utilities			53,325	53,325		53,325	(1,324)	52,001			5
6	Maintenance	34,005		59,204	93,209		93,209	28,523	121,732			6
7	Other (specify):*											7
8	**TOTAL General Services**	134,147	78,873	206,745	419,765		419,765	27,176	446,941			8
	B. Health Care and Programs											
9	Medical Director			3,350	3,350		3,350		3,350			9
10	Nursing and Medical Records	949,091	80,180	16,669	1,045,940		1,045,940	15,067	1,061,007			10
10a	Therapy			19,111	19,111		19,111		19,111			10a
11	Activities	24,138	1,648		25,786		25,786		25,786			11
12	Social Services	22,220		1,982	24,202		24,202		24,202			12
13	CNA Training											13
14	Program Transportation			4,277	4,277		4,277		4,277			14
15	Other (specify):*							2,906	2,906			15
16	**TOTAL Health Care and Programs**	995,449	81,828	45,389	1,122,666		1,122,666	17,973	1,140,639			16
	C. General Administration											
17	Administrative	80,160		174,160	254,320		254,320	(124,562)	129,758			17
18	Directors Fees											18
19	Professional Services			91,728	91,728		91,728	(10,812)	80,916			19
20	Dues, Fees, Subscriptions & Promotions			43,005	43,005		43,005	(26,120)	16,885			20
21	Clerical & General Office Expenses	38,679	14,054	88,996	141,729		141,729	(56,125)	85,604			21
22	Employee Benefits & Payroll Taxes			201,909	201,909		201,909		201,909			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,079	3,079		3,079	24	3,103			24
25	Other Admin. Staff Transportation			5,792	5,792		5,792		5,792			25
26	Insurance-Prop.Liab.Malpractice			46,884	46,884		46,884	227	47,111			26
27	Other (specify):*							12,731	12,731			27
28	**TOTAL General Administration**	118,839	14,054	655,553	788,446		788,446	(204,637)	583,809			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,248,435	174,755	907,687	2,330,877		2,330,877	(159,488)	2,171,389			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 Pershing Gardens Hc Center #0051854 **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							113,267	113,267			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,189	21,189		21,189	154,136	175,325			32
33	Real Estate Taxes			72,000	72,000		72,000		72,000			33
34	Rent-Facility & Grounds			257,700	257,700		257,700	(251,808)	5,892			34
35	Rent-Equipment & Vehicles			13,175	13,175		13,175		13,175			35
36	Other (specify):*											36
37	**TOTAL Ownership**			364,064	364,064		364,064	15,595	379,659			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		108,730	322,940	431,670		431,670		431,670			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			101,109	101,109		101,109		101,109			42
43	Other (specify):*		1,277	26,554	27,831		27,831	(322,939)	(295,108)			43
44	**TOTAL Special Cost Centers**		110,007	450,603	560,610		560,610	(322,939)	237,671			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,248,435	284,762	1,722,354	3,255,551		3,255,551	(466,833)	2,788,718			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 Pershing Gardens Hc Center # 0051854 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	(1,571)	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	113,032	30		9
10	Interest and Other Investment Income	(17)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(23)	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	(6,705)	21		18
19	Entertainment				19
20	Contributions	(23,400)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(48,000)	21		24
25	Fund Raising, Advertising and Promotional	(2,525)	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	(324,293)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (293,503)		$	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)	(173,330)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (173,330)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (466,833)		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

Pershing Gardens Hc Center

ID# 0051854

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Expenses	$ (322,939)	43	1
2	Late Fees	(5,292)	21	2
3	Bank Charges	(17,678)	21	3
4	Additional R&M	28,355	06	4
5				5
6	Miscellaneous Income	(300)	21	6
7	PAC Dues	(602)	20	7
8	Non Allowable Expense	(5,837)	21	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(324,293)		49

Pershing Gardens Hc Center

ID# 0051854

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 Pershing Gardens Hc Center # 0051854 **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	(23)											(23)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(1,571)		247									(1,324)	5
6	Maintenance	28,355		168									28,523	6
7	Other (specify):*													7
8	**TOTAL General Services**	26,761		415									27,176	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			16,802	(1,735)								15,067	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			2,906									2,906	15
16	**TOTAL Health Care and Programs**			19,708	(1,735)								17,973	16
	C. General Administration													
17	Administrative			(124,562)									(124,562)	17
18	Directors Fees													18
19	Professional Services			(10,812)									(10,812)	19
20	Fees, Subscriptions & Promotions	(26,527)		407									(26,120)	20
21	Clerical & General Office Expenses	(83,812)		27,687									(56,125)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			24									24	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			227									227	26
27	Other (specify):*			12,731									12,731	27
28	**TOTAL General Administration**	(110,339)		(94,298)									(204,637)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(83,578)		(74,175)	(1,735)								(159,488)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Pershing Gardens Hc Center** **# 0051854** **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	113,032		235									113,267	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(17)	154,153										154,136	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(257,700)	5,892									(251,808)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	113,015	(103,547)	6,127									15,595	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):*	(322,939)											(322,939)	43
44	**TOTAL Special Cost Centers**	(322,939)											(322,939)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(293,503)	(103,547)	(68,048)	(1,735)								(466,833)	45

Facility Name & ID Number Pershing Gardens Hc Center # 0051854 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 Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	$ 257,700		100.00%	$	$ (257,700)	1
2	V	32	Interest Expense			100.00%	154,153	154,153	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 257,700			$ 154,153	$ * (103,547)	14

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

Facility Name & ID Number Pershing Gardens Hc Center # 0051854 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	5	UTILITIES	$	PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	$ 247	$ 247	15
16	V	6	REPAIRS AND MAINTENANCE		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	168	168	16
17	V	10	NURSING SALARY		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	16,802	16,802	17
18	V	15	EMPLOYEE BEN. HEALTH CARE.		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	2,906	2,906	18
19	V	17	NON-OWNER ADMIN. COMP.		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	33,680	33,680	19
20	V	17	SALARY - DAVID CHEPLOWITZ		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	7,959	7,959	20
21	V	17	SALARY - BARAK BAVER		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	7,959	7,959	21
22	V	19	PROFESSIONAL FEES		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	1,188	1,188	22
23	V	20	LICENSES		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	407	407	23
24	V	21	OFFICE EXPENSE		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	25,621	25,621	24
25	V	24	SEMINARS		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	24	24	25
26	V	26	AUTO EXPENSE		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	227	227	26
27	V	27	EMPLOYEE BEN. GEN ADMIN.		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	12,372	12,372	27
28	V	30	DEPRECIATION		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	235	235	28
29	V	34	RENT		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	5,892	5,892	29
30	V								30
31	V								31
32	V								32
33	V	21	CLERICAL SALARY		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	2,066	2,066	33
34	V	27	EMPLOYEE BEN. GEN ADMIN.		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	359	359	34
35	V								35
36	V	17	MANAGEMENT FEES	174,160	PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%		(174,160)	36
37	V	19	MEDICAID CONSULTANT	12,000	PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%		(12,000)	37
38	V								38
39	Total			$ 186,160			$ 118,112	$ * (68,048)	39

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

Facility Name & ID Number Pershing Gardens Hc Center # 0051854 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	10	MEDICAL SUPPLIES	$ 3,290	PREMIER HEALTHCARE SUPPLIES, LLC	100.00%	$ 1,555	$ (1,735)	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			$ 3,290			$ 1,555	$ * (1,735)	39

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

Facility Name & ID Number Pershing Gardens Hc Center # 0051854 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 Pershing Gardens Hc Center # 0051854 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 Pershing Gardens Hc Center # 0051854 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 Pershing Gardens Hc Center # 0051854 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 Pershing Gardens Hc Center # 0051854 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 Pershing Gardens Hc Center # 0051854 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 Pershing Gardens Hc Center # 0051854 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 Pershing Gardens Hc Center # 0051854 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	BARAK BAVER	50.00%	GILMAN HEALTHCARE CENTER,LLC	GILMAN	PREMIER HEALTHCARE MANA	SKOKIE	MANAGEMENT CO.	1
2	DAVID CHEPLOWITZ	50.00%	COURTYARD HEALTHCARE	BERWYN	PREMIER HEALTHCARE SUPPI	SKOKIE	MEDICAL SUPPLY	2
3			WINFIELD WOODS HEALTHCARE CENTER, LLC	WINFIELD	PERSHING GARDENS REALTY,	STICKNEY	BUILDING COMPANY	3
4			CHAMPAIGN URBANA NURSING & REHAB	SAVOY				4
5			GARDENVIEW MANOR	DANVILLE				5
6			NORRIDGE GARDENS	NORRIDGE				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 Pershing Gardens Hc Center # 0051854 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 Pershing Gardens Hc Center # 0051854 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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	David Cheplowitz	Shareholder	Administrative	50.00%	See Attached	2.00	5.00%	Alloc Fees	$ 7,959	17-7	1
2	Barak Baver	Shareholder	Administrative	50.00%	See Attached	2.00	5.00%	Alloc Fees	7,959	17-7	2
3	Sarah Baver	Relative	Clerical	0.00%	See Attached	2.00	5.00%	Alloc Salary	2,066	21-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 17,984		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 Pershing Gardens Hc Center # 0051854 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 Pershing Gardens Hc Center # 0051854 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 MANAGEMENT, L
Street Address: 8170 N. MCCORMICK BLVD. SUITE 137
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-2800
Fax Number: (847) 674-4133

	1 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	5	UTILITIES	PATIENT DAYS	307,887	7	$ 5,092	$	14,951	$ 247	1
2	6	REPAIRS AND MAINTENANC	PATIENT DAYS	307,887	7	3,468		14,951	168	2
3	10	NURSING SALARY	PATIENT DAYS	307,887	7	346,005	346,005	14,951	16,802	3
4	15	EMPLOYEE BEN. HEALTH CA	PATIENT DAYS	307,887	7	59,847		14,951	2,906	4
5	17	NON-OWNER ADMIN. COMI	PATIENT DAYS	307,887	7	693,582	693,582	14,951	33,680	5
6	17	SALARY - DAVID CHEPLOWI	PATIENT DAYS	307,887	7	163,907	163,907	14,951	7,959	6
7	17	SALARY - BARAK BAVER	PATIENT DAYS	307,887	7	163,907	163,907	14,951	7,959	7
8	19	PROFESSIONAL FEES	PATIENT DAYS	307,887	7	24,461		14,951	1,188	8
9	20	LICENSES	PATIENT DAYS	307,887	7	8,375		14,951	407	9
10	21	OFFICE EXPENSE	PATIENT DAYS	307,887	7	527,609	459,690	14,951	25,621	10
11	24	SEMINARS	PATIENT DAYS	307,887	7	501		14,951	24	11
12	26	AUTO EXPENSE	PATIENT DAYS	307,887	7	4,685		14,951	227	12
13	27	EMPLOYEE BEN. GEN ADMIN	PATIENT DAYS	307,887	7	254,783		14,951	12,372	13
14	30	DEPRECIATION	PATIENT DAYS	307,887	7	4,840		14,951	235	14
15	34	RENT	PATIENT DAYS	307,887	7	121,336		14,951	5,892	15
16										16
17										17
18										18
19	21	CLERICAL SALARY	PATIENT DAYS	40	6	41,318	41,318	2	2,066	19
20	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	40	6	7,190		2	359	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,430,906	$ 1,868,409		$ 118,112	25

Facility Name & ID Number Pershing Gardens Hc Center # 0051854 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: PREMIER HEALTHCARE SUPPLIES, LLC
Street Address: 8170 N. MCCORMICK BLVD. SUITE 137
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-2800
Fax Number: (847) 674-4133

	1 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	10	MEDICAL SUPPLIES	REVENUE	113,303	7	$ 53,554	$	12,454	$ 1,555	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					$ 53,554	$		$ 1,555	25

Facility Name & ID Number Pershing Gardens Hc Center # 0051854 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 Pershing Gardens Hc Center # 0051854 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 Pershing Gardens Hc Center # 0051854 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 Pershing Gardens Hc Center # 0051854 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 Pershing Gardens Hc Center # 0051854 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 Pershing Gardens Hc Center # 0051854 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 Pershing Gardens Hc Center # 0051854 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 Pershing Gardens Hc Center # 0051854 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	Private Bank		X	Mortgage			$	$ 3,300,000			$ 154,154	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Private Bank		X	Note Payable				1,440,704			20,665	6
7												7
8												8
9	TOTAL Facility Related						$	$ 4,740,704			$ 174,819	9
	B. Non-Facility Related*											
10	Interest Income		X								(17)	10
11	Interest Other		X								524	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 507	14
15	TOTALS (line 9+line14)						$	$ 4,740,704			$ 175,326	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 Pershing Gardens Hc Center # 0051854 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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Pershing Gardens Hc Center **#** 0051854 **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.**	$ 97,205	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.)		$ 104,257	2
3. Under or (over) accrual (line 2 minus line 1).		$ 7,052	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 145,924	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 152,976	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	55,939	8
	2011	60,746	9
	2012	72,004	10
	2013	74,020	11
	2014	104,257	12

2015 Accrual = $104,257 x 1.4 = $145,924

	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 Pershing Gardens Hc Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051854

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.	19-06-103-035-0000	Long Term Care Property	$ 74,873.46	$ 74,873.46
2.	19-06-103-034-0000	Long Term Care Property	$ 29,383.82	$ 29,383.82
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 104,257.28	$ 104,257.28

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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 Pershing Gardens Hc Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051854

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 Pershing Gardens Hc Center # 0051854 Report Period Beginning: 01/01/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,845 B. General Construction Type: Exterior Brick Frame _____ 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		2012	$ 14,786	1
2					2
3	TOTALS			$ 14,786	3

Facility Name & ID Number Pershing Gardens Hc Center # 0051854 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	51		2012	1964	$ 1,220,815	$	35	$ 34,880	$ 34,880	$ 92,679	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*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 Pershing Gardens Hc Center # 0051854 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)								67
68	Related Party Allocations (Pages 12H & 12I)		1,209	11		60	49		68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 1,222,024	$ 11		$ 34,940	$ 34,929	$ 92,679	70

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

Facility Name & ID Number Pershing Gardens Hc Center # 0051854 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		$ 1,222,024	$ 11		$ 34,940	$ 34,929	$ 92,679	1
2	Automatic Wet Pipe Fire Sprinkler System	2012	67,793		20	3,390	3,390	13,559	2
3	Fire Protection Coverage-1St & 2Nd Floor Dining Rooms	2012	4,560		20	228	228	912	3
4	Removal Of Underground Storage Tank	2012	4,036		20	202	202	807	4
5	Installation Of Wander System And Cables	2012	5,721		20	286	286	1,144	5
6	New Signage	2012	9,858		20	493	493	1,972	6
7	Replace A/C System On Second Floor	2012	3,000		20	150	150	600	7
8	Fire Alarm Installation	2012	3,200		20	160	160	640	8
9	A: 1St Floor Day Room- New Blinds And Custom Fireplace	2012	3,857		20	193	193	771	9
10	B: Porch- Demolish Existing Porches And Build New Stairs Railin	2012	9,904		20	495	495	1,981	10
11	C: Lobby- New Custom Baseboard Heaters	2012	3,792		20	190	190	758	11
12	D: 1St Floor Day Room-Structural Wood Repair; Replace Ceiling;	2012	28,689		20	1,434	1,434	5,738	12
13	E: Lobby-New Flooring;Ceiling; Lighting;Wallcoverings;Window	2012	19,878		20	994	994	3,976	13
14	F: Basement Corridor-New Flooring; Signage; Lighting	2012	6,453		20	323	323	1,291	14
15	G: Therapy Room-New Flooring;Wall Partitions; Lighting; Electr	2012	54,039		20	2,702	2,702	10,808	15
16	H: 1St Floor Corridor-Removal Of Old Cove Base; New Flooring;	2012	30,741		20	1,537	1,537	6,148	16
17	I: 2Nd Floor Corridor- New Flooring; Removal Of Old Cove Base	2012	35,164		20	1,758	1,758	7,033	17
18	J: New Elevator	2012	8,123		20	406	406	1,625	18
19	K: 2Nd Floor Day Room- Replace Ceiling; Millwork Base; Windo	2012	18,891		20	945	945	3,778	19
20	L: Resident Rooms- New Flooring; Paint Walls; Lighting; Cubicle	2012	82,484		20	4,294	4,294	17,178	20
21	M: Various Areas-New Wooden Handrails And Bumper Gaurds;	2012	65,457		20	3,273	3,273	13,091	21
22	New Fire Alarm Panel Analog Notifier	2012	4,950		20	248	248	990	22
23	Various Bathroom Remodels: Remove & Replace Tub,Toilet,Sink,	2012	48,310		20	2,416	2,416	4,831	23
24	New Wiring And Motor For Kitchen Exhaust Fan	2013	2,837		20	142	142	426	24
25	New Outlets For Window A/C Units	2013	2,900		20	145	145	375	25
26	New Generator, New 400 Amp Main Service	2013	141,085		20	7,054	7,054	17,048	26
27	Additional Work On Exterior Remodel: Demo Existing, New Conc	2013	16,903		20	845	845	1,972	27
28	Fire Alarm Installation Charge	2013	9,423		20	471	471	942	28
29	Install Door Automator To Front Entry	2013	5,575		20	279	279	557	29
30	Various Areas: Light Fixtures;Floor & Wall Tile;	2013	24,566		20	1,228	1,228	2,457	30
31	Main Entrance Exterior Remodel: Demolish Entire Old Exterior-	2013	59,204		20	2,960	2,960	5,920	31
32	Fire System	2014	3,103		20	155	155	310	32
33	Tuckpoint Wall Where Overhang From Roof Was Removed	2014	5,800		20	290	290	580	33
34	TOTAL (lines 1 thru 33)		$ 2,012,321	$ 11		$ 74,626	$ 74,615	$ 222,896	34

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

Facility Name & ID Number Pershing Gardens Hc Center # 0051854 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		$ 2,012,321	$ 11		$ 74,626	$ 74,615	$ 222,896	1
2	Hot Water Tank Wiring	2014	3,125		20	156	156	313	2
3	Champion Roofing	2014	2,850		20	143	143	285	3
4	Install Wire Panelboard In Boiler Room	2014	7,000		20	350	350	700	4
5	Elevator Wiring & Shunt Trip Breaker	2014	19,000		20	950	950	1,900	5
6	Champion Roofing	2014	3,248		20	162	162	325	6
7	New Elevator	2014	2,500		20	125	125	250	7
8	Elevator Modernization	2014	125,000		20	6,250	6,250	12,500	8
9	Install Fire Alarm System In Basement Elevator Room	2014	10,548		20				9
10	Repaired 2 Lower Level Circuits, 1 Battery Pack, And 2 Fluoresce	2015	7,675		20	384	384	384	10
11	Rewired Kitchen With Two 20 Amp 120 Volt Circuits	2015	4,750		20	238	238	238	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)		$ 2,198,017	$ 11		$ 83,383	$ 83,372	$ 239,790	34

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

Facility Name & ID Number Pershing Gardens Hc Center # 0051854 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		$ 2,198,017	$ 11		$ 83,383	$ 83,372	$ 239,790	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)		$ 2,198,017	$ 11		$ 83,383	$ 83,372	$ 239,790	34

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

Facility Name & ID Number Pershing Gardens Hc Center # 0051854 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		$ 2,198,017	$ 11		$ 83,383	$ 83,372	$ 239,790	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)		$ 2,198,017	$ 11		$ 83,383	$ 83,372	$ 239,790	34

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

Facility Name & ID Number Pershing Gardens Hc Center # 0051854 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									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)		$	$		$	$	$	34

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

Facility Name & ID Number Pershing Gardens Hc Center # 0051854 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		$	$		$	$	$	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)		$	$		$	$	$	34

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

Facility Name & ID Number Pershing Gardens Hc Center # 0051854 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									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Premier Healthcare Management	2013	1,209	11	20	60	49		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)		$ 1,209	$ 11		$ 60	$ 49	$	34

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

Facility Name & ID Number Pershing Gardens Hc Center # 0051854 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		$ 1,209	$ 11		$ 60	$ 49	$	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)		$ 1,209	$ 11		$ 60	$ 49	$	34

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

Facility Name & ID Number Pershing Gardens Hc Center # 0051854 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	$ 272,447	$ 90	$ 28,805	$ 28,715	10	$ 99,206	71
72	Current Year Purchases	10,911	134	1,079	945	10	1,079	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 283,358	$ 224	$ 29,884	$ 29,660		$ 100,284	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)	$ 2,496,161	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 235	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 113,267	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 113,032	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 340,074	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 Pershing Gardens Hc Center # 0051854 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	Allocated from Premier HC Management				5,892			6
7	TOTAL				$ 5,892 **			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: $ 4,220 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	Facility	Lexus	$ 995.00	$ 8,955	17
18					18
19					19
20					20
21	TOTAL		$ 995.00	$ 8,955	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 Pershing Gardens Hc Center # 0051854 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 Pershing Gardens Hc Center # 0051854 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		$		$ 105,907	$		$ 105,907	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				45,519			45,519	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39 - 03	hrs				171,514			171,514	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					95,343		95,343	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							13,387		13,387	13
14	TOTAL				$		$ 322,940	$ 108,730		$ 431,670	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 Pershing Gardens Hc Center **#** 0051854 **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	$ 142,595	$ 910,460	1
2	Cash-Patient Deposits	401,629	401,629	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,214,763	2,214,763	3
4	Supply Inventory (priced at)	1,250	1,250	4
5	Short-Term Investments			5
6	Prepaid Insurance	7,553	7,553	6
7	Other Prepaid Expenses	5,661	5,644	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	768	10,768	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,774,219	$ 3,552,067	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,527	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,104,752	1,506,861	15
16	Equipment, at Historical Cost	209,331	360,122	16
17	Accumulated Depreciation (book methods)	(317,997)	(406,647)	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):	1,210,551	1,553,827	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,206,637	$ 3,114,690	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,980,856	$ 6,666,757	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 600,720	$ 600,720	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,440,704	1,440,704	29
30	Accrued Salaries Payable	21,149	21,149	30
31	Accrued Taxes Payable (excluding real estate taxes)	173,532	173,532	31
32	Accrued Real Estate Taxes(Sch.IX-B)		145,924	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	950,712	950,712	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,186,817	$ 3,332,741	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,300,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	1,417,509	1,034,228	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,417,509	$ 4,334,228	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,604,326	$ 7,666,969	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 376,530	$ (1,000,212)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,980,856	$ 6,666,757	48

***(See instructions.)**

Facility Name & ID Number Pershing Gardens Hc Center **#** 0051854 **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**	$ 331,035	1
2	Restatements (describe):		2
3	Equity Restatement	(243,037)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 87,998	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	232,532	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	56,000	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 288,532	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)**	$ 376,530	24 *

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

Facility Name & ID Number Pershing Gardens Hc Center # 0051854 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	$ 2,864,171	1
2	Discounts and Allowances for all Levels	540,003	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,404,174	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	79,020	6
7	Oxygen	533	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 79,553	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	4,039	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,039	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	17	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 17	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	300	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 300	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,488,083	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	419,765	31
32	Health Care	1,122,666	32
33	General Administration	788,446	33
	B. Capital Expense		
34	Ownership	364,064	34
	C. Ancillary Expense		
35	Special Cost Centers	459,501	35
36	Provider Participation Fee	101,109	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,255,551	40
41	**Income before Income Taxes (line 30 minus line 40)****	232,532	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 232,532	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,699,138	44
45	Private Pay - Net Inpatient Revenue	60,563	45
46	Medicare - Net Inpatient Revenue	1,600,570	46
47	Other-(specify) Insurance	43,903	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,404,174	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 Pershing Gardens Hc Center # 0051854 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	2,076	2,118	$ 77,315	$ 36.50	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,281	11,064	309,464	27.97	3
4	Licensed Practical Nurses	9,911	10,102	243,873	24.14	4
5	CNAs & Orderlies	29,612	30,797	318,439	10.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,876	1,985	24,138	12.16	9
10	Activity Assistants					10
11	Social Service Workers	1,455	1,511	22,220	14.71	11
12	Dietician					12
13	Food Service Supervisor	2,887	3,171	54,154	17.08	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,989	5,191	45,988	8.86	15
16	Dishwashers					16
17	Maintenance Workers	2,147	2,393	34,005	14.21	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,600	1,667	80,160	48.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,223	4,232	38,679	9.14	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	71,057	74,231	$ 1,248,435 *	$ 16.82	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	Monthly	$ 5,566	01-03	35
36	Medical Director	Monthly	3,350	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	7,797	10-03	38
39	Pharmacist Consultant	Monthly	8,872	10-03	39
40	Physical Therapy Consultant	Monthly	19,111	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	1,982	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 46,678		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 Pershing Gardens Hc Center # 0051854 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Richard Taylor	Administrator	0	$ 80,160
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 80,160

B. Administrative - Other

Description	Amount
Premier Healthcare Management, LLC	$ 174,160
TOTAL (agree to Schedule V, line 17, col. 3)	$ 174,160
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Ability Network Inc	Data Processing	$ 1,281
ADP	Data Processing	2,027
eHealth Data Solutions	Data Processing	2,100
eSolutions Inc	Data Processing	977
HDSI	Data Processing	5,673
MDI Achieve	Data Processing	3,468
Matrixcare	Data Processing	4,476
Bylmas, Inc.	Tax Credit Consulting	720
LTC Consulting Services	Medical Billing Solutions	2,620
Sharon Lofgren	Medicare Billing	3,600
See Supplemental Schedule		64,787
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 91,729

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 28,950
Unemployment Compensation Insurance	58,903
FICA Taxes	90,291
Employee Health Insurance	7,755
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	16,010
TOTAL (agree to Schedule V, line 22, col.8)	$ 201,909

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	5,550
Health Care Worker Background Check	
(Indicate # of checks performed 1065)	1,065
Patient Background Checks	
Dues & Subscriptions	5,189
Licenses & Permits	694
Allocated from Premier HC Management	407
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,885

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,079
Allocated from Premier HC Management	24
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,103

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Pershing Gardens Hc Center # 0051854 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 Pershing Gardens Hc Center # 0051854 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC: $1,221**

(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. $ **10,258** Line **10**

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

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

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

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **101,109**
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. $ **N/A** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.