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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0051854

Facility Name: Pershing Gardens HC Center

Address: 3900 S Oak Park Ave (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: Larry Templin **Telephone Number:** (630) 361-2868
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 1/1/16 to 12/31/16 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) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	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	11,346	1
2		Skilled Pediatric (SNF/PED)			2
3	20	Intermediate (ICF)	20	7,320	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	51	TOTALS	51	18,666	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			3,607	3,607	8
9	SNF/PED					9
10	ICF	11,152	1,186		12,338	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,152	1,186	3,607	15,945	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.42%

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] Non-allowable costs have been eliminated in Schedule V, Column 7

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 3,408

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: 12/31/16 Fiscal Year: 12/31/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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	101,327	3,266	5,928	110,521		110,521		110,521			1
2	Food Purchase		81,815		81,815		81,815		81,815			2
3	Housekeeping		9,594	48,600	58,194		58,194		58,194			3
4	Laundry		3,007	36,232	39,239		39,239		39,239			4
5	Heat and Other Utilities			46,741	46,741		46,741	171	46,912			5
6	Maintenance	33,220		33,679	66,899		66,899	61	66,960			6
7	Other (specify):* Waste Removal			10,997	10,997		10,997		10,997			7
8	TOTAL General Services	134,547	97,682	182,177	414,406		414,406	232	414,638			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	992,868	131,539	8,714	1,133,121		1,133,121	23,819	1,156,940			10
10a	Therapy		3,489	19,292	22,781		22,781	(6,727)	16,054			10a
11	Activities	22,291		402	22,693		22,693		22,693			11
12	Social Services	49,498		992	50,490		50,490		50,490			12
13	CNA Training											13
14	Program Transportation			1,699	1,699		1,699		1,699			14
15	Other (specify):*							4,426	4,426			15
16	TOTAL Health Care and Programs	1,064,657	135,028	43,099	1,242,784		1,242,784	21,518	1,264,302			16
	C. General Administration											
17	Administrative	81,927		198,301	280,228		280,228	(166,919)	113,309			17
18	Directors Fees											18
19	Professional Services			113,769	113,769		113,769	(750)	113,019			19
20	Dues, Fees, Subscriptions & Promotions			26,819	26,819		26,819	(46)	26,773			20
21	Clerical & General Office Expenses	30,356	18,059	35,345	83,760		83,760	40,750	124,510			21
22	Employee Benefits & Payroll Taxes			210,804	210,804		210,804		210,804			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,210	10,210		10,210	200	10,410			24
25	Other Admin. Staff Transportation			8,338	8,338		8,338	878	9,216			25
26	Insurance-Prop.Liab.Malpractice			48,756	48,756		48,756	901	49,657			26
27	Other (specify):*							11,015	11,015			27
28	TOTAL General Administration	112,283	18,059	652,342	782,684		782,684	(113,971)	668,713			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,311,487	250,769	877,618	2,439,874		2,439,874	(92,221)	2,347,653			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Pershing Gardens HC Center #0051854 Report Period Beginning: 1/1/16 Ending: 12/31/16

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							112,631	112,631			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			25,655	25,655		25,655	236,260	261,915			32
33	Real Estate Taxes			72,000	72,000		72,000		72,000			33
34	Rent-Facility & Grounds			287,084	287,084		287,084	(281,113)	5,971			34
35	Rent-Equipment & Vehicles			21,929	21,929		21,929		21,929			35
36	Other (specify):*											36
37	**TOTAL Ownership**			406,668	406,668		406,668	67,778	474,446			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		128,528	416,300	544,828		544,828	(41,540)	503,288			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			104,876	104,876		104,876		104,876			42
43	Other (specify):* Nonallowable Exp	51,289	1,021	102,698	155,008		155,008	(155,008)				43
44	**TOTAL Special Cost Centers**	51,289	129,549	623,874	804,712		804,712	(196,548)	608,164			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,362,776	380,318	1,908,160	3,651,254		3,651,254	(220,991)	3,430,263			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	(1,293)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	112,631	30		9
10	Interest and Other Investment Income	(35)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(5,911)	43		18
19	Entertainment				19
20	Contributions	(25,200)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,483)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(48,000)	43		24
25	Fund Raising, Advertising and Promotional	(891)	43		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 See Page 5A	(59,314)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (34,496)		$	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)	(186,495)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (186,495)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (220,991)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' PREPARATION REPORT

Pershing Gardens HC Center

ID# 0051854

Report Period Beginning: 1/1/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salary	(51,289)	43	1
2	Marketing Expense	(7,186)	43	2
3	Theft & Damage Loss	(238)	43	3
4	PAC Dues	(601)	20	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				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**	(59,314)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pershing Gardens HC Center # 0051854 **Report Period Beginning:** 1/1/16 **Ending:** 12/31/16

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	171	0	0	0	0	0	0	0	0	171	5
6	Maintenance	0	0	61	0	0	0	0	0	0	0	0	61	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	232	0	0	0	0	0	0	0	0	232	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	27,066	(3,247)	0	0	0	0	0	0	0	23,819	10
10a	Therapy	0	0	0	0	(6,727)	0	0	0	0	0	0	(6,727)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	4,426	0	0	0	0	0	0	0	0	4,426	15
16	**TOTAL Health Care and Programs**	0	0	31,492	(3,247)	(6,727)	0	0	0	0	0	0	21,518	16
	C. General Administration													
17	Administrative	0	0	(166,919)	0	0	0	0	0	0	0	0	(166,919)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,483)	0	3,329	0	2,404	0	0	0	0	0	0	(750)	19
20	Fees, Subscriptions & Promotions	(601)	0	414	0	141	0	0	0	0	0	0	(46)	20
21	Clerical & General Office Expenses	0	964	39,158	0	628	0	0	0	0	0	0	40,750	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	200	0	0	0	0	0	0	0	0	200	24
25	Other Admin. Staff Transportation	0	0	290	0	588	0	0	0	0	0	0	878	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	901	0	0	0	0	0	0	901	26
27	Other (specify):*	0	0	11,015	0	0	0	0	0	0	0	0	11,015	27
28	**TOTAL General Administration**	(7,084)	964	(112,513)	0	4,662	0	0	0	0	0	0	(113,971)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(7,084)	964	(80,789)	(3,247)	(2,065)	0	0	0	0	0	0	(92,221)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Pershing Gardens HC Center # 0051854 **Report Period Beginning:** 1/1/16 **Ending:** 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	112,631	0	0	0	0	0	0	0	0	0	0	112,631	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(35)	233,531	0	0	2,764	0	0	0	0	0	0	236,260	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(287,084)	5,971	0	0	0	0	0	0	0	0	(281,113)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	112,596	(53,553)	5,971	0	2,764	0	0	0	0	0	0	67,778	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	(41,540)	0	0	0	0	0	0	(41,540)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(140,008)	0	(15,000)	0	0	0	0	0	0	0	0	(155,008)	43
44	**TOTAL Special Cost Centers**	(140,008)	0	(15,000)	0	(41,540)	0	0	0	0	0	0	(196,548)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(34,496)	(52,589)	(89,818)	(3,247)	(40,841)	0	0	0	0	0	0	(220,991)	45

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	21	Clerical & Gen Office Expenses		Pershing Gardens Realty, LLC	100.00%	$ 964	$ 964	1
2	V	32	Interest		Pershing Gardens Realty, LLC	100.00%	162,571	162,571	2
3	V	32	Amortization of loan fees		Pershing Gardens Realty, LLC	100.00%	70,960	70,960	3
4	V	34	Rent-Facility & Grounds	287,084	Pershing Gardens Realty, LLC	100.00%		(287,084)	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			$ 287,084			$ 234,495	$ * (52,589)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	Heat and Other Utilities	$	Premier Healthcare Management, LLC	100.00%	$ 171	$ 171	15
16	V	6	Maintenance		Premier Healthcare Management, LLC	100.00%	61	61	16
17	V	10	Nursing and Medical Records		Premier Healthcare Management, LLC	100.00%	27,066	27,066	17
18	V	15	Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	100.00%	4,426	4,426	18
19	V	17	Administrative	198,301	Premier Healthcare Management, LLC	100.00%	31,382	(166,919)	19
20	V	19	Professional Services		Premier Healthcare Management, LLC	100.00%	3,329	3,329	20
21	V	20	Dues, Fees, Subs & Promo		Premier Healthcare Management, LLC	100.00%	414	414	21
22	V	21	Clerical & Gen Office Expenses		Premier Healthcare Management, LLC	100.00%	39,158	39,158	22
23	V	24	Travel and Seminar		Premier Healthcare Management, LLC	100.00%	200	200	23
24	V	25	Other Admin. Staff Trans		Premier Healthcare Management, LLC	100.00%	290	290	24
25	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	11,015	11,015	25
26	V	34	Rent-Facility & Grounds		Premier Healthcare Management, LLC	100.00%	5,971	5,971	26
27	V	43	Marketing Consultant	15,000	Premier Healthcare Management, LLC	100.00%		(15,000)	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			$ 213,301			$ 123,483	$ * (89,818)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	Nursing and Medical Records	$ 5,119	Premier Healthcare Supplies, LLC	100.00%	$ 1,872	$ (3,247)	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			$ 5,119			$ 1,872	$ * (3,247)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	10A	Therapy	$ 6,727	REX Therapeutics	100.00%	$	$ (6,727)	15
16	V	19	Professional Services		REX Therapeutics	100.00%	2,404	2,404	16
17	V	20	Fees and Subscriptions		REX Therapeutics	100.00%	141	141	17
18	V	21	Clerical & General Office Exp		REX Therapeutics	100.00%	628	628	18
19	V	25	Other Admin Staff Transp		REX Therapeutics	100.00%	588	588	19
20	V	26	Insurance-Prop.Liab.Malp		REX Therapeutics	100.00%	901	901	20
21	V	32	Interest Expense		REX Therapeutics	100.00%	2,764	2,764	21
22	V	39	Allocated Employee Benefits		REX Therapeutics	100.00%	30,094	30,094	22
23	V	39	Therapy Consultant		REX Therapeutics	100.00%	2,004	2,004	23
24	V	39	Therapy Management Wages		REX Therapeutics	100.00%	11,275	11,275	24
25	V								25
26	V								26
27	V	39	Therapy Wages		REX Therapeutics	100.00%	224,513	224,513	27
28	V	39	Contract Therapy	328,251	REX Therapeutics	100.00%	18,825	(309,426)	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			$ 334,978			$ 294,137	$ * (40,841)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/16 Ending: 12/31/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Barak Baver	50.00%	Gilman Healthcare Center	Gilman	Premier Healthcare	Skokie	Management Co.	1
2	David Cheplowitz	50.00%	Courtyard Healthcare	Berwyn	Management, LLC			2
3			Winfield Woods Healthcare Center	Winfield	Premier Healthcare	Skokie	Medical Supply	3
4			Norridge Gardens	Norridge	Supplies, LLC			4
5			Gardenview Manor	Danville	Pershing Gardens	Stickney	Lessor	5
6			Champaign Urbana Nursing and Rehab	Savoy	Realty, LLC			6
7			Premier Healthcare of Fort Wayne, LLC	Fort Wayne, IN	REX Therapeutics	Skokie	Therapy	7
8			Premier Healthcare of North Vernon, LLC	North Vernon, IN				8
9			Premier Healthcare of Sheridan, LLC	Sheridan, IN				9
10			Premier Healthcare of Connersville, LLC	Connersville, IN				10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	David Cheplowitz	Shareholder	Administrative	50.00%	See Att Sch 7A	1.83	5%	Alloc Salary	$ 7,128	17-7	1
2	Barak Baver	Shareholder	Administrative	50.00%	See Att Sch 7A	1.83	5%	Alloc Salary	7,128	17-7	2
3	Sara Baver	Relative	Clerical	0	See Att Sch 7A	1.83	5%	Alloc Salary	2,020	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	$ 16,276		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

Name of Related Organization: Premier Healthcare Management, 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	5	Heat and Other Utilities	Census Days	348,950	11	$ 3,732	$	15,945	$ 171	1
2	6	Maintenance	Census Days	348,950	11	1,338		15,945	61	2
3	10	Nursing and Medical Records	Census Days	348,950	11	592,321	592,321	15,945	27,066	3
4	15	Emp Benefit Alloc-Healthcare	Census Days	348,950	11	96,859		15,945	4,426	4
5	17	Administrative	Census Days	348,950	11	686,791	686,791	15,945	31,382	5
6	19	Professional Services	Census Days	348,950	11	72,849		15,945	3,329	6
7	20	Dues, Fees, Subs & Promo	Census Days	348,950	11	9,057		15,945	414	7
8	21	Clerical & Gen Office Expenses	Census Days	348,950	11	856,961	787,295	15,945	39,158	8
9	24	Travel and Seminar	Census Days	348,950	11	4,369		15,945	200	9
10	25	Other Admin. Staff Trans	Census Days	348,950	11	6,355		15,945	290	10
11	27	Emp Benefit Alloc-Gen Admin	Census Days	348,950	11	241,050		15,945	11,015	11
12	34	Rent-Facility & Grounds	Census Days	348,950	11	130,681		15,945	5,971	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					$ 2,702,363	$ 2,066,407		$ 123,483	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] 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	Nursing and Medical Records	Revenue	111,222	11	$ 40,679	$	5,119	$ 1,872	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					$ 40,679	$		$ 1,872	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

Name of Related Organization: REX Therapeutics
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	19	Professional Services	Therapy Revenue	3,342,403	4	$ 23,994	$	334,978	$ 2,404	1
2	20	Fees and Subscriptions	Therapy Revenue	3,342,403	4	1,410		334,978	141	2
3	21	Clerical & General Office Exp	Therapy Revenue	3,342,403	4	6,268		334,978	628	3
4	25	Other Admin Staff Transp	Therapy Revenue	3,342,403	4	5,868		334,978	588	4
5	26	Insurance-Prop.Liab.Malp	Therapy Revenue	3,342,403	4	8,993		334,978	901	5
6	32	Interest Expense	Therapy Revenue	3,342,403	4	27,581		334,978	2,764	6
7	39	Allocated Employee Benefits	Therapy Revenue	3,342,403	4	300,276		334,978	30,094	7
8	39	Therapy Consultant	Therapy Revenue	3,342,403	4	20,000		334,978	2,004	8
9	39	Therapy Management Wages	Therapy Revenue	3,342,403	4	112,504	112,504	334,978	11,275	9
10										10
11										11
12	39	Therapy Wages	Direct Allocation	224,513	1	224,513	224,513	224,513	224,513	12
13	39	Contract Therapy	Direct Allocation	18,825	1	18,825		18,825	18,825	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					$ 750,232	$ 337,017		$ 294,137	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	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	The Private Bank		X	Mortgage			$	$			$ 69,220	1
2	Bank Leumi		X	Mortgage		7/12/2016	5,000,000	4,916,667	7/12/2021	variable	93,351	2
3												3
4												4
5												5
	Working Capital											
6	The Private Bank		X	Note Payable								6
7	Bank Leumi		X	Line of Credit		8/1/2016		569,002	8/1/2017	variable	25,655	7
8												8
9	TOTAL Facility Related						$ 5,000,000	$ 5,485,669			$ 188,226	9
	B. Non-Facility Related*											
10								Allocated from REX Therapeutics			2,764	10
11								Amortization of Loan Costs			70,960	11
12								Offset Interest Income			(35)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 73,689	14
15	TOTALS (line 9+line14)						$ 5,000,000	$ 5,485,669			$ 261,915	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.)

SEE ACCOUNTANTS' PREPARATION 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: 1/1/16 Ending: 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 136,357	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.)	2015	$ 107,279	2
3. Under or (over) accrual (line 2 minus line 1).		$ (29,078)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 104,212	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.)		$ 1,535	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** $ 4,669 **For** 2012 **Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$ (4,669)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 72,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	60,746	8
	2012	72,004	9
	2013	74,020	10
	2014	104,257	11
	2015	107,279	12

Accrual based on prior year tax bill.

Note: Beginning Accrual adjusted to actual

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2015 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 Larry Templin

TELEPHONE (630) 361-2868 FAX #:

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A) 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	$ 77,043.44	$ 77,043.44
2.	19-06-103-034-0000	Long Term Care Property	$ 30,235.39	$ 30,235.39
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 107,278.83	$ 107,278.83

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 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	$ 127,559	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Automatic Wet Pipe Fire Sprinkler System			2012	67,793		20	3,390	3,390	16,949	9
10	Fire Protection Coverage-1St & 2Nd Floor Dining Rooms			2012	4,560		20	228	228	1,140	10
11	Removal Of Underground Storage Tank			2012	4,036		20	202	202	1,009	11
12	Installation Of Wander System And Cables			2012	5,721		20	286	286	1,430	12
13	New Signage			2012	9,858		20	493	493	2,465	13
14	Replace A/C System On Second Floor			2012	3,000		20	150	150	750	14
15	Fire Alarm Installation			2012	3,200		20	160	160	800	15
16	A: 1St Floor Day Room- New Blinds And Custom Fireplace			2012	3,857		20	193	193	964	16
17	B: Porch- Demolish Existing Porches And Build New Stairs Railings And			2012	9,904		20	495	495	2,476	17
18	C: Lobby- New Custom Baseboard Heaters			2012	3,792		20	190	190	948	18
19	D: 1St Floor Day Room-Structural Wood Repair; Replace Ceiling; New D			2012	28,689		20	1,434	1,434	7,172	19
20	E: Lobby-New Flooring;Ceiling; Lighting;Wallcoverings;Window Treatm			2012	19,878		20	994	994	4,970	20
21	F: Basement Corridor-New Flooring; Signage; Lighting			2012	6,453		20	323	323	1,614	21
22	G: Therapy Room-New Flooring;Wall Partitions; Lighting; Electrical; Do			2012	54,039		20	2,702	2,702	13,510	22
23	H: 1St Floor Corridor-Removal Of Old Cove Base; New Flooring;Wall Ba			2012	30,741		20	1,537	1,537	7,685	23
24	I: 2Nd Floor Corridor- New Flooring; Removal Of Old Cove Base; New W			2012	35,164		20	1,758	1,758	8,791	24
25	J: New Elevator			2012	8,123		20	406	406	2,031	25
26	K: 2Nd Floor Day Room- Replace Ceiling; Millwork Base; Window Treat			2012	18,891		20	945	945	4,723	26
27	L: Resident Rooms- New Flooring; Paint Walls; Lighting; Cubicle Curtai			2012	82,484		20	4,294	4,294	21,472	27
28	M: Various Areas-New Wooden Handrails And Bumper Gaurds; Painting			2012	65,457		20	3,273	3,273	16,364	28
29	New Fire Alarm Panel Analog Notifier			2012	4,950		20	248	248	1,238	29
30	Various Bathroom Remodels: Remove & Replace Tub,Toilet,Sink, New Fl			2012	48,310		20	2,416	2,416	7,247	30
31	New Wiring And Motor For Kitchen Exhaust Fan			2013	2,837		20	142	142	568	31
32	New Outlets For Window A/C Units			2013	2,900		20	145	145	520	32
33	New Generator, New 400 Amp Main Service			2013	141,085		20	7,054	7,054	24,102	33
34	Additional Work On Exterior Remodel: Demo Existing, New Concrete, De			2013	16,903		20	845	845	2,817	34
35	Fire Alarm Installation Charge			2013	9,423		20	471	471	1,413	35
36	Install Door Automator To Front Entry			2013	5,575		20	279			36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 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	Various Areas: Light Fixtures;Floor & Wall Tile;	2013	$ 24,566	$	20	$ 1,228	$ 1,228	$ 3,685	37
38	Main Entrance Exterior Remodel: Demolish Entire Old Exterior-	2013	59,204		20	2,960	2,960	8,880	38
39	Fire System	2014	3,103		20	155	155	465	39
40	Tuckpoint Wall Where Overhang From Roof Was Removed	2014	5,800		20	290	290	870	40
41	Hot Water Tank Wiring	2014	3,125		20	156	156	469	41
42	Champion Roofing	2014	2,850		20	143	143	428	42
43	Install Wire Panelboard In Boiler Room	2014	7,000		20	350	350	1,050	43
44	Elevator Wiring & Shunt Trip Breaker	2014	19,000		20	950	950	2,850	44
45	Champion Roofing	2014	3,248		20	162	162	487	45
46	New Elevator	2014	2,500		20	125	125	375	46
47	Elevator Modernization	2014	125,000		20	6,250	6,250	18,750	47
48	Install Fire Alarm System In Basement Elevator Room	2014	10,548		20	527	527	527	48
49	Repaired 2 Lower Level Circuits, 1 Battery Pack, And 2 Fluoresce	2015	7,675		20	384	384	768	49
50	Rewired Kitchen With Two 20 Amp 120 Volt Circuits	2015	4,750		20	238	238	476	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	Allocated from Premier Healthcare Management LLC.	2013	1,138		20	57	57	182	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,197,945	$		$ 83,908	$ 83,629	$ 322,989	70

SEE ACCOUNTANTS' PREPARATION REPORT

**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: 1/1/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 283,358	$	$ 28,336	$ 28,336	10	$ 128,620	71
72	Current Year Purchases	7,737		387	387	10	387	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 291,095	$	$ 28,723	$ 28,723		$ 129,007	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)	$ 2,503,826	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 112,631	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 112,631	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 451,996	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	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	Allocated from Management Co.				5,971			5
6								6
7	TOTAL				$ 5,971 **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 6,966 Description: See Attached Schedule 14A
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19	Facility	2014 Land Rover	1,662.53	14,963	19
20					20
21	TOTAL		$ 1,662.53	$ 14,963	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Pershing Gardens HC Center**
IDPH License ID Number: **0051854**
Fiscal Year End: **12/31/16**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Nursing Equipment	3,295
Dietary Equipment	3,671
Total - Line 16	**6,966**

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/16 Ending: 12/31/16

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(1), 39(3)	2691	hrs	$ 99,401		$ 39,169	$	2,691	$ 138,570	1
2	Licensed Speech and Language Development Therapist	39(1), 39(3)	1050	hrs	38,781		15,282		1,050	54,063	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	39(1), 39(3)	2338	hrs	86,331		34,018		2,338	120,349	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39(2)		# of prescrpts				126,975		126,975	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): Therapy Manager	39(1)	145		11,275				145	11,275	12
13	Other (specify): See Attached Scheule 16A						50,503	1,553		52,056	13
14	TOTAL				$ 235,788		$ 138,972	$ 128,528	6,224	$ 503,288	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Pershing Gardens HC Center**
IDPH License ID Number: **0051854**
Fiscal Year End: **12/31/16**

Schedule 16A

XIV. Special Services
Line 13 Other Services

Description	Schedule V Line & Column Reference	Amount
Lab & Xray	39(3)	13,288
Outside MD Service-MCA	39(3)	562
Rentals-MCA	39(3)	4,555
Medical Supplies - MCA	39(2)	1,553
Therapy Consultant	39(3)	2,004
Employee Benefits Allocated f	39(3)	30,094
Total - Line 13		**52,056**

Facility Name & ID Number Pershing Gardens HC Center **#** 0051854 **Report Period Beginning:** 1/1/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 4,540	$ 4,540	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 278,000)	859,180	859,180	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	7,090	7,090	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 870,810	$ 870,810	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		14,786	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,104,752	2,197,945	15
16	Equipment, at Historical Cost	217,068	291,095	16
17	Accumulated Depreciation (book methods)	(317,997)	(451,996)	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): See Attached Schedule 17A	4,900	648,389	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,008,723	$ 2,700,219	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,879,533	$ 3,571,029	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 743,045	$ 793,035	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	569,002	569,002	29
30	Accrued Salaries Payable	103,609	103,609	30
31	Accrued Taxes Payable (excluding real estate taxes)	273,349	273,349	31
32	Accrued Real Estate Taxes(Sch.IX-B)	(14,789)	104,212	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 17A	1,964,297	6,030	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,638,513	$ 1,849,237	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,916,667	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,916,667	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,638,513	$ 6,765,904	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,758,980)	$ (3,194,875)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,879,533	$ 3,571,029	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name: **Pershing Gardens HC Center**
IDPH License ID Number: **0051854**
Fiscal Year End: **12/31/16**

Schedule 17A

XV. Balance Sheet

Line 23 Other Assets (specify):

Description	Operating	After Consolidation
Loan Costs	4,900	104,953
Intangibles		543,436
Total - Line 23	**4,900**	**648,389**

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Accrued MDS Tax	32,918	32,918
Accrued Expenses	62,987	62,987
Accrued Bed Tax	14,092	14,092
Payroll Withholdings	392,470	392,470
Due to Related Parties	1,430,330	(527,937)
Security Deposits	31,500	31,500
Total - Line 36	**1,964,297**	**6,030**

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 376,530	1
2	Restatements (describe): Bad Debt Expense		2
3	**Prior Period Adjustments - Bad Debt Expense**	(2,276,297)	3
4	**Prior Period Adjustments - Other Expenses**	(174,010)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,073,777)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	314,797	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	( )	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)**	$ 314,797	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,758,980)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/16 Ending: 12/31/16

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,299,416	1
2	Discounts and Allowances for all Levels	567,192	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,866,608	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	99,408	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 99,408	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	35	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 35	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,966,051	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	414,406	31
32	Health Care	1,242,784	32
33	General Administration	782,684	33
	B. Capital Expense		
34	Ownership	406,668	34
	C. Ancillary Expense		
35	Special Cost Centers	699,836	35
36	Provider Participation Fee	104,876	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,651,254	40
41	**Income before Income Taxes (line 30 minus line 40)****	314,797	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 314,797	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,716,551	44
45	Private Pay - Net Inpatient Revenue	209,555	45
46	Medicare - Net Inpatient Revenue	1,916,611	46
47	Other-(specify) Insurance	23,891	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,866,608	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,980	2,164	$ 70,131	$ 32.41	1
2	Assistant Director of Nursing	1,224	1,360	38,376	28.22	2
3	Registered Nurses	6,944	7,384	195,562	26.48	3
4	Licensed Practical Nurses	12,004	12,148	288,829	23.78	4
5	CNAs & Orderlies	30,624	31,626	329,218	10.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,727	1,871	22,291	11.91	10
11	Social Service Workers	2,577	2,825	49,498	17.52	11
12	Dietician					12
13	Food Service Supervisor	3,666	3,962	52,173	13.17	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,304	5,496	49,154	8.94	15
16	Dishwashers					16
17	Maintenance Workers	2,358	2,406	33,220	13.81	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,048	2,096	81,927	39.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,472	2,568	30,356	11.82	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) See Sch 20A	3,419	3,556	122,041	34.32	33
34	TOTAL (lines 1 - 33)	76,347	79,462	$ 1,362,776 *	$ 17.15	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 5,928	L1, C3	35
36	Medical Director	Monthly	12,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,714	L10, C3	39
40	Physical Therapy Consultant	Monthly	12,000	L10a, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	16	992	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	16	$ 39,634		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Pershing Gardens HC Center

Period Beginning **1/1/16**
Period End **12/31/16**

Schedule 20A

XVIII. Staffing and Salary Costs

		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator		2,115	2,220	70,752	31.87
Marketing		1,304	1,336	51,289	38.39
	TOTAL	3,419	3,556	122,041	

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Richard Taylor	Administrator	0	$ 36,427
Brian Gallagher	Administrator	0	45,500
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 81,927

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 198,301
TOTAL (agree to Schedule V, line 17, col. 3)	$ 198,301
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal Fees	$ 29,035
Marcum LLP	Accounting Services	14,370
Richard Peelo & Associates	Accounting Services	4,200
Ability Network Inc	Data Processing	1,464
ADP	Data Processing	6,843
Change Healthcare	Data Processing	679
eSolutions Inc	Data Processing	2,054
HDSI	Data Processing	5,260
MDI Achieve	Data Processing	1,004
Matrixcare	Data Processing	17,566
Singer Networks, LLC	Data Processing	6,475
See Attached Schedule 21A		24,819
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 113,769

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 24,776
Unemployment Compensation Insurance	57,620
FICA Taxes	102,606
Employee Health Insurance	18,063
Employee Meals	100
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physical Exam	221
Other Employee Benefits	7,418
TOTAL (agree to Schedule V, line 22, col.8)	$ 210,804

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	14,544
Health Care Worker Background Check	
(Indicate # of checks performed 50)	1,654
Patient Background Checks 11	110
Dues & Subscriptions	7,627
Licenses & Permits	1,063
IL Council on LTC	1,220
Allocated from Premier Mgmt & REX Ther.	555
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,773

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	10,210
Allocated from Management Co.	200
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,410

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Pershing Gardens HC Center**
IDPH License ID Number: **0051854**
Fiscal Year End: **12/31/16**

Schedule 21A

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
Terrill Consulting Services, Inc.	Billing Consultant	13,859
Sharon Lofgren	Medicare Billing	3,600
M & M Financial	Financial Consultant	6,660
Personnel Planners	UC Consultant	700
Total		**24,819**

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/16 Ending: 12/31/16

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. **1,220 IL Council on LTC**

(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. $ **12,756** 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. $ **104,876**
This amount is to be recorded on line 42 of Schedule V.

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **N/A** 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? **No**
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 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