

		FOR BHF USE					

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

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

I. IDPH License ID Number: 0051318

Facility Name: Pine Crest Health Care

Address: 3300 West 175th St Hazel Crest 60429
 Number City Zip Code

County: Cook

Telephone Number: (708)335-2400 **Fax #** (708)335-1825

HFS ID Number: _____

Date of Initial License for Current Owners: 3/1/2011

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Steven N. 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 01/01/16 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) _____	* _____ (Date) _____
	* Subject to the attached Accountants Consulting Report	
	(Print Name and Title) _____	
	(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	
	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>	

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 Pine Crest Health Care

0051318 Report Period Beginning: 01/01/16 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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>199</u>	Skilled (SNF)	<u>199</u>	<u>72,834</u>	<u>1</u>
2		Skilled Pediatric (SNF/PED)			<u>2</u>
3		Intermediate (ICF)			<u>3</u>
4		Intermediate/DD			<u>4</u>
5		Sheltered Care (SC)			<u>5</u>
6		ICF/DD 16 or Less			<u>6</u>
7	<u>199</u>	TOTALS	<u>199</u>	<u>72,834</u>	<u>7</u>

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	<u>58,168</u>	<u>212</u>	<u>6,258</u>	<u>64,638</u>	<u>8</u>
9	SNF/PED					<u>9</u>
10	ICF					<u>10</u>
11	ICF/DD					<u>11</u>
12	SC					<u>12</u>
13	DD 16 OR LESS					<u>13</u>
14	TOTALS	<u>58,168</u>	<u>212</u>	<u>6,258</u>	<u>64,638</u>	<u>14</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.75%

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

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

I. On what date did you start providing long term care at this location?
Date started 03/01/2011

J. Was the facility purchased or leased after January 1, 1978?
YES Date 03/01/2011 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 199 and days of care provided 2,840

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/16 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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	280,116	56,414	12,050	348,580		348,580		348,580		1
2	Food Purchase		337,996		337,996		337,996	(5,078)	332,918		2
3	Housekeeping	219,595	36,545		256,140		256,140	2,214	258,354		3
4	Laundry	91,902	25,484		117,386		117,386		117,386		4
5	Heat and Other Utilities			229,870	229,870		229,870	(18,551)	211,319		5
6	Maintenance	65,854	285	209,900	276,039		276,039	(2,245)	273,794		6
7	Other (specify):*										7
8	TOTAL General Services	657,467	456,724	451,820	1,566,011		1,566,011	(23,660)	1,542,351		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	2,291,576	97,484	199,124	2,588,184		2,588,184	(64,584)	2,523,600		10
10a	Therapy	65,350			65,350		65,350		65,350		10a
11	Activities	127,898	9,304		137,202		137,202		137,202		11
12	Social Services	292,647		1,406	294,053		294,053		294,053		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							16,144	16,144		15
16	TOTAL Health Care and Programs	2,777,471	106,788	218,530	3,102,789		3,102,789	(48,440)	3,054,349		16
	C. General Administration										
17	Administrative	115,972		640,600	756,572		756,572	(605,470)	151,102		17
18	Directors Fees										18
19	Professional Services			72,825	72,825	(176)	72,649	10,005	82,655		19
20	Dues, Fees, Subscriptions & Promotions			42,505	42,505		42,505	(6,813)	35,692		20
21	Clerical & General Office Expenses	161,140		102,625	263,765		263,765	78,548	342,313		21
22	Employee Benefits & Payroll Taxes			601,614	601,614		601,614		601,614		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,694	1,694		1,694	1,874	3,568		24
25	Other Admin. Staff Transportation			650	650		650	6,768	7,418		25
26	Insurance-Prop.Liab.Malpractice			310,213	310,213		310,213	1,376	311,589		26
27	Other (specify):*							40,037	40,037		27
28	TOTAL General Administration	277,112		1,772,726	2,049,838	(176)	2,049,662	(473,675)	1,575,987		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,712,050	563,512	2,443,076	6,718,638	(176)	6,718,462	(545,775)	6,172,688		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

Pine Crest Health Care

#0051318

Report Period Beginning:

01/01/16

Ending:

12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			32,724	32,724		32,724	103,722	136,446			30
31	Amortization of Pre-Op. & Org.			220	220		220		220			31
32	Interest			6,520	6,520		6,520	142	6,662			32
33	Real Estate Taxes			636,000	636,000	176	636,176	5,850	642,026			33
34	Rent-Facility & Grounds			1,182,053	1,182,053		1,182,053	9,847	1,191,900			34
35	Rent-Equipment & Vehicles			5,151	5,151		5,151		5,151			35
36	Other (specify):*											36
37	TOTAL Ownership			1,862,668	1,862,668	176	1,862,844	119,561	1,982,404			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		135,572	515,703	651,275		651,275		651,275			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			486,664	486,664		486,664		486,664			42
43	Other (specify):*			38,209	38,209		38,209	(38,209)				43
44	TOTAL Special Cost Centers		135,572	1,040,576	1,176,148		1,176,148	(38,209)	1,137,939			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,712,050	699,084	5,346,320	9,757,454		9,757,454	(464,423)	9,293,031			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 Pine Crest Health Care

0051318

Report Period Beginning:

01/01/16

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	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	(20,091)	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	96,721	30		9
10	Interest and Other Investment Income	(2,577)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(11)	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	(10)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(48,476)	21		24
25	Fund Raising, Advertising and Promotional	(3,305)	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	(91,624)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (69,373)		\$	30

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	2	
		Amount	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)	(395,050)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (395,050)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (464,423)		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	2	3	4
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	52

Pine Crest Health Care

ID# 0051318

Report Period Beginning: 01/01/16

Ending: 12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Medicare Sequestration	\$ (16,586)	21	1
2	Vending Income	(5,830)	02	2
3	VA Drugs	(39,814)	10	3
4	Marketing	(2,572)	43	4
5	Bank Charges	(7,123)	21	5
6	Cloverleaf Farm	(2,090)	02	6
7	Capitalized R&M	(9,275)	06	7
8	Non-allowable legal	(727)	19	8
9	PAC Dues	(6,363)	20	9
10	Misc. Income	(1,244)	21	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	(91,624)		49

Pine Crest Health Care

ID# 0051318

Report Period Beginning: 01/01/16

Ending: 12/31/16

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 Pine Crest Health Care# 0051318

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	(7,931)		2,589		264							(5,078)	2
3	Housekeeping			2,214									2,214	3
4	Laundry													4
5	Heat and Other Utilities	(20,091)		1,540									(18,551)	5
6	Maintenance	(9,275)		6,961		69							(2,245)	6
7	Other (specify):*													7
8	TOTAL General Services	(37,297)		13,304		333							(23,660)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(39,814)				(24,770)							(64,584)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					16,144							16,144	15
16	TOTAL Health Care and Programs	(39,814)				(8,626)							(48,440)	16
	C. General Administration													
17	Administrative			(605,470)									(605,470)	17
18	Directors Fees													18
19	Professional Services	(727)		1,795	474	8,463							10,005	19
20	Fees, Subscriptions & Promotions	(9,668)		2,764	37	54							(6,813)	20
21	Clerical & General Office Expenses	(73,439)		182,259		(30,271)							78,548	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			842		1,032							1,874	24
25	Other Admin. Staff Transportation					6,768							6,768	25
26	Insurance-Prop.Liab.Malpractice			1,376									1,376	26
27	Other (specify):*			37,957		2,080							40,037	27
28	TOTAL General Administration	(83,834)		(378,477)	511	(11,874)							(473,675)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(160,945)		(365,173)	511	(20,167)							(545,775)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Pine Crest Health Care # 0051318 Report Period Beginning: 01/01/16 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 (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	96,721		2,995	4,006								103,722	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,577)			2,719								142	32
33	Real Estate Taxes				5,850								5,850	33
34	Rent-Facility & Grounds			21,548	(11,701)								9,847	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	94,144		24,543	874								119,561	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):*	(2,572)				(35,637)							(38,209)	43
44	TOTAL Special Cost Centers	(2,572)				(35,637)							(38,209)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(69,373)		(340,630)	1,384	(55,804)							(464,423)	45

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. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							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		\$			\$	\$ *	14

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	2 DIETARY	\$	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	\$ 2,589	\$ 2,589
16	V	3 HOUSEKEEPING		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	2,214	2,214
17	V	5 UTILITIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,540	1,540
18	V	6 REPAIRS AND MAINTENANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	6,961	6,961
19	V	17 S WEBSTER SALARY		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	17,697	17,697
20	V	17 Y LEVOVITZ-SALARY		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	17,433	17,433
21	V	19 PROFESSIONAL FEES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,795	1,795
22	V	20 DUES FEES SUBSCRIPTIONS		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	2,764	2,764
23	V	21 CLERICAL AND GENERAL		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	10,100	10,100
24	V	21 CLERICAL & GENERAL SALARIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	172,159	172,159
25	V	24 SEMINARS & EDUCATION		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	842	842
26	V	26 INSURANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,376	1,376
27	V	27 EMPLOYEE BEN. GEN ADMIN.		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	37,957	37,957
28	V	30 DEPRECIATION		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	2,995	2,995
29	V	34 RENT		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	21,548	21,548
30	V						
31	V						
32	V	17 Management Fees	640,600				(640,600)
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 640,600			\$ 299,970	\$ * (340,630)

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	19 PROFESSIONAL FEES		PREMIER HC REAL ESTATE, LLC	100.00%	474	\$	474	15
16	V	20 LICENSES & PERMITS		PREMIER HC REAL ESTATE, LLC	100.00%	37		37	16
17	V	30 DEPRECIATION		PREMIER HC REAL ESTATE, LLC	100.00%	4,006		4,006	17
18	V	32 INTEREST EXPENSE		PREMIER HC REAL ESTATE, LLC	100.00%	2,719		2,719	18
19	V	33 REAL ESTATE TAXES		PREMIER HC REAL ESTATE, LLC	100.00%	5,850		5,850	19
20	V								20
21	V	34 RENT	11,701	PREMIER HC REAL ESTATE, LLC	100.00%			(11,701)	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		\$ 11,701			\$ 13,085	\$ *	1,384	39

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	2 <u>DIETARY</u>	\$	<u>iCare Consulting Services LLC</u>	100.00%	\$ 264	\$	264	15
16	V	6 <u>REPAIRS AND MAINTENANCE</u>		<u>iCare Consulting Services LLC</u>	100.00%	69		69	16
17	V	10 <u>NURSING SALARIES</u>	179,149	<u>iCare Consulting Services LLC</u>	100.00%	154,379		(24,770)	17
18	V	15 <u>EMPLOYEE BEN. HC PROGRAMS</u>		<u>iCare Consulting Services LLC</u>	100.00%	16,144		16,144	18
19	V	19 <u>PROFESSIONAL FEES</u>		<u>iCare Consulting Services LLC</u>	100.00%	8,463		8,463	19
20	V	20 <u>DUES FEES SUBSCRIPTIONS</u>		<u>iCare Consulting Services LLC</u>	100.00%	54		54	20
21	V	21 <u>CLERICAL AND GENERAL</u>		<u>iCare Consulting Services LLC</u>	100.00%	6,689		6,689	21
22	V	21 <u>CLERICAL & GENERAL SALARIES</u>	56,204	<u>iCare Consulting Services LLC</u>	100.00%	19,244		(36,960)	22
23	V	24 <u>SEMINARS & EDUCATION</u>		<u>iCare Consulting Services LLC</u>	100.00%	1,032		1,032	23
24	V	27 <u>EMPLOYEE BEN. GEN ADMIN.</u>		<u>iCare Consulting Services LLC</u>	100.00%	2,080		2,080	24
25	V	25 <u>AUTO & TRAVEL</u>		<u>iCare Consulting Services LLC</u>	100.00%	6,768		6,768	25
26	V	43 <u>MARKETING</u>	35,637	<u>iCare Consulting Services LLC</u>	100.00%			(35,637)	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		\$ 270,990			\$ 215,186	\$ *	(55,804)	39

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

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

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

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

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

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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

Pine Crest Health Care

0051318

Report Period Beginning:

01/01/16

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	Atied Associates	40.000%	CENTER HOME HISPANIC ELDERLY,LLC	CHICAGO	PREMIER HEALTHCARE & FIN	SKOKIE, IL	MANAGEMENT CO.	1
2	EZ&A	0.980%	PARK VIEW REHAB CENTER	CHICAGO	PREMIER HEALTHCARE REAL	SKOKIE, IL	BUILDING CO.	2
3	Yaffa Kohen	2.451%	FOREST CITY REHAB & NURSING CENTE	ROCKFORD	ICARE CONSULTING SERVICES	SKOKIE, IL	CONSULTING	3
4	Moshe Levovitz	0.980%	RIVER VIEW REHAB CENTER	ELGIN				4
5	Nachman Levovitz	0.980%	ROCK RIVER HEALTH CARE	ROCKFORD				5
6	Yeruchom Levovitz	14.853%	BROOK CHATEAU	KANSAS CITY, MO				6
7	Jeffrey Sax	2.206%	LEISURE TERRACE	OVERLAND PARK, KS				7
8	Eli Webster	0.980%	BREEZY MEADOWS	BUTLER, MO				8
9	Jeffrey Webster	7.672%	PEARL PAVILION	FREEPORT				9
10	Shimon Webster	16.814%						10
11	Howard Wengrow	9.632%						11
12	Marc Works	2.451%						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

Pine Crest Health Care

0051318

Report Period Beginning:

01/01/16

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								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

Pine Crest Health Care

0051318

Report Period Beginning:

01/01/16

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	9	
					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								\$		1	
2	Shimon Webster	Owner	Administrative	16.81%	See Attached	5.85	14.63%	Alloc. Salary	17,697	17-7	2
3	Yeruchom Levovitz	Owner	Administrative	14.85%	See Attached	5.85	14.63%	Alloc. Salary	17,433	17-7	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	\$ 35,130		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 Pine Crest Health Care

0051318

Report Period Beginning:

01/01/16

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

0051318

Report Period Beginning:

01/01/16

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 NO

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

Name of Related Organization PREMIER HEALTHCARE & FINANCIAL SER
 Street Address 8131 MONTICELLO
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (773) 945-1000
 Fax Number (773) 751-2027

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	2	DIETARY	PATIENT DAYS	441,943	10	\$ 17,705	\$ 64,638	\$ 2,589	1	
2	3	HOUSEKEEPING	PATIENT DAYS	441,943	10	15,135	64,638	2,214	2	
3	5	UTILITIES	PATIENT DAYS	441,943	10	10,527	64,638	1,540	3	
4	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	441,943	10	47,591	64,638	6,961	4	
5	17	S WEBSTER SALARY	PATIENT DAYS	441,943	10	120,995	120,995	64,638	17,697	5
6	17	Y LEVOVITZ-SALARY	PATIENT DAYS	441,943	10	119,190	119,190	64,638	17,433	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	441,943	10	12,272	64,638	1,795	7	
8	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	441,943	10	18,896	64,638	2,764	8	
9	21	CLERICAL AND GENERAL	PATIENT DAYS	441,943	10	69,058	64,638	10,100	9	
10	21	CLERICAL & GENERAL SALA	PATIENT DAYS	441,943	10	1,177,077	1,177,077	64,638	172,159	10
11	24	SEMINARS & EDUCATION	PATIENT DAYS	441,943	10	5,755	64,638	842	11	
12	26	INSURANCE	PATIENT DAYS	441,943	10	9,405	64,638	1,376	12	
13	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	441,943	10	259,519	64,638	37,957	13	
14	30	DEPRECIATION	PATIENT DAYS	441,943	10	20,479	64,638	2,995	14	
15	34	RENT	PATIENT DAYS	441,943	10	147,325	64,638	21,548	15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 2,050,929	\$ 1,417,262	\$ 299,970	25	

Facility Name & ID Number Pine Crest Health Care

0051318

Report Period Beginning:

01/01/16

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 NO

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

Name of Related Organization PREMIER HC REAL ESTATE, LLC
 Street Address 8131 MONTICELLO
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (773) 945-1000
 Fax Number (773) 751-2027

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	441,943	10	3,241	64,638	474	1
2	20	LICENSES & PERMITS	PATIENT DAYS	441,943	10	250	64,638	37	2
3	30	DEPRECIATION	PATIENT DAYS	441,943	10	27,389	64,638	4,006	3
4	32	INTEREST EXPENSE	PATIENT DAYS	441,943	10	18,587	64,638	2,719	4
5	33	REAL ESTATE TAXES	PATIENT DAYS	441,943	10	40,000	64,638	5,850	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					\$ 89,467	\$	\$ 13,085	25

Facility Name & ID Number Pine Crest Health Care

0051318

Report Period Beginning:

01/01/16

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 NO

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

Name of Related Organization iCare Consulting Services LLC
 Street Address 8131 Monticello
 City / State / Zip Code Skokie, IL 60076
 Phone Number (773) 945-1000
 Fax Number (773) 751-2027

1	2	3	4	5	6	7	8	9	
Schedule V	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
Line Reference									
1	2	DIETARY	PATIENT DAYS	441,943	10	\$ 1,804	\$ 64,638	\$ 264	1
2	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	441,943	10	472	64,638	69	2
3	10	NURSING SALARIES	PATIENT DAYS	441,943	10	1,055,519	1,084,019	154,379	3
4	15	EMPLOYEE BEN. HC PROGRA	PATIENT DAYS	441,943	10	110,378	64,638	16,144	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	441,943	10	57,864	64,638	8,463	5
6	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	441,943	10	369	64,638	54	6
7	21	CLERICAL AND GENERAL	PATIENT DAYS	441,943	10	45,733	64,638	6,689	7
8	21	CLERICAL & GENERAL SALA	PATIENT DAYS	441,943	10	131,573	131,573	19,244	8
9	24	SEMINARS & EDUCATION	PATIENT DAYS	441,943	10	7,055	64,638	1,032	9
10	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	441,943	10	14,224	64,638	2,080	10
11	25	AUTO & TRAVEL	PATIENT DAYS	345,177	7	36,142	64,638	6,768	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					\$ 1,461,133	\$ 1,215,592	\$ 215,186	25

Facility Name & ID Number Pine Crest Health Care

0051318

Report Period Beginning:

01/01/16

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

0051318

Report Period Beginning:

01/01/16

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

0051318

Report Period Beginning:

01/01/16

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

0051318

Report Period Beginning:

01/01/16

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

0051318

Report Period Beginning:

01/01/16

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

0051318

Report Period Beginning:

01/01/16

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

Pine Crest Health Care

0051318

Report Period Beginning:

01/01/16

Ending:

12/31/16

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																				
2																				
3																				
4																				
5																				
6																				
7	TOTAL Long-Term																			
Working Capital																				
8	Allocated from Premier RE																			
9																				
10																				
11																				
12																				
13																				
14	TOTAL Working Capital																			
B. Non-Facility Related*																				
15																				
16																				
17																				
18																				
19																				
20	TOTAL Non-Facility Related																			

* 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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2015 report.		\$	(28,554)	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.)		\$	613,296	2
3. Under or (over) accrual (line 2 minus line 1).		\$	641,850	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		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.)		\$	176	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.		\$	642,026	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2011	404,181	8	
	2012	437,685	9	
	2013	455,257	10	
	2014	592,503	11	
	2015	607,446	12	
Beginning accrual adjusted because the facility does not accrue for real estate taxes as they do not own the building.				
Allocated from Premier: \$5,850				
				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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Pine Crest Health Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051318

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>28-26-402-004-0000</u>	<u>Long Term Care Property</u>	\$ <u>607,446.01</u>	\$ <u>607,446.01</u>
2. <u>10-23-324-047-0000</u>	<u>Home Office Allocation</u>	\$ <u>38,132.87</u>	\$ <u>5,577.26</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>645,578.88</u></u>	\$ <u><u>613,023.27</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

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 Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Pine Crest Health Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051318

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
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 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 Pine Crest Health Care

0051318 Report Period Beginning:

01/01/16 Ending:

12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 80,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? (a) Own the Facility (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (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 NO
If so, please complete the following:

1. Total Amount Incurred: 8,299 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: 220 4. Dates Incurred: 03/1/2011

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Allocated From Premier Realty</u>			<u>\$ 2,779</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 2,779	3

Facility Name & ID Number Pine Crest Health Care

0051318

Report Period Beginning:

01/01/16

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	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		2011	212,146		20	17,568	17,568	93,121	9
10	Various		2012	222,435		20	23,906	23,906	108,037	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 Pine Crest Health Care

0051318

Report Period Beginning:

01/01/16

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	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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								67	
68			165,217	6,864	6,945	81	34,679	68	
69				32,724		(32,724)		69	
70		\$	599,798	\$ 39,588		\$ 48,419	\$ 8,831	\$ 235,837	70

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

Facility Name & ID Number Pine Crest Health Care

0051318

Report Period Beginning:

01/01/16

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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 599,798	\$ 39,588		\$ 48,419	\$ 8,831	\$ 235,837	1
2	Three Hvac Rooftop Unit Replacements	2013	27,000		20	2,700	2,700	10,350	2
3	Compressor	2013	3,498		20	175	175	598	3
4	Repair Ducting On Roof	2013	7,000		20	350	350	1,254	4
5	Boiler Repair	2013	8,500		20	425	425	1,523	5
6	Sprinkler System Repair	2013	19,989		20	999	999	3,665	6
7	Installed 2 Door Restrictors On Elevator	2013	7,900		20	395	395	1,448	7
8	Roofing	2013	108,621		20	5,431	5,431	19,461	8
9	Toilets	2013	18,228		20	911	911	3,418	9
10	Fire Alarm Repair	2013	2,568		20	128	128	449	10
11	Custom Build In Nursing Station	2013	20,000		20	4,000	4,000	13,000	11
12	Ceiling Tiles	2013	2,563		20	513	513	1,752	12
13	Vinyl Flooring-2200 Wing Corridor, 2300,2400,2500 Wings, Rotun	2013	73,684		20	14,737	14,737	52,807	13
14	Freight Elevator - Door Header, Safety Edge, Hanger Rollers	2014	4,000		20	200	200	600	14
15	Two Shunt Trip Breakers For Each Elevator	2014	14,000		20	700	700	1,750	15
16	Fire Alarm Control Panel	2014	14,815		20	741	741	1,852	16
17	Patch & Paints Walls In 4 Corridors, Rotunda, Day Room & Din	2014	13,875		20	694	694	1,445	17
18	N & S Dining, Rotunda, Corridor: Ceiling Fixtures, Chair Rails, V	2014	96,135		20	4,807	4,807	10,014	18
19	Elevator Door Modernization	2015	17,000		20	850	850	1,700	19
20	Dvr And Camera	2015	2,911		20	582	582	1,116	20
21	Laundry Room Roof Replacement & Entire Roof Coating	2015	30,937		20	1,547	1,547	2,191	21
22	Control System - Elevator #1	2016	12,463		20	467	467	467	22
23	Control System - Elevator #1	2016	24,924		20	623	623	623	23
24	Control System - Elevator #2	2016	53,442		20	1,781	1,781	1,781	24
25	Control System - Elevator #2	2016	3,875		20	65	65	65	25
26	Asphalt Work	2016	13,954		20	233	233	233	26
27	Fire Alarm System	2016	8,972		20	112	112	112	27
28	Water Heater	2016	6,545		20	327	327	327	28
29	Replace Dgc-Remote Annunciator	2016	2,606		20	130	130	130	29
30	Installed 2 Exhaust Fans	2016	3,850		20	193	193	193	30
31	Rplaced Exf Motors For Heating/Cooling System	2016	2,819		20	141	141	141	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,226,472	\$ 39,588		\$ 93,376	\$ 53,788	\$ 370,302	34

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

Facility Name & ID Number Pine Crest Health Care

0051318

Report Period Beginning:

01/01/16

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	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$ 1,226,472	\$ 39,588		\$ 93,376	\$ 53,788	\$ 370,302
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34		\$ 1,226,472	\$ 39,588		\$ 93,376	\$ 53,788	\$ 370,302

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

Facility Name & ID Number Pine Crest Health Care

0051318

Report Period Beginning:

01/01/16

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,226,472	\$ 39,588		\$ 93,376	\$ 53,788	\$ 370,302	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		\$ 1,226,472	\$ 39,588		\$ 93,376	\$ 53,788	\$ 370,302	34

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

Facility Name & ID Number Pine Crest Health Care

0051318

Report Period Beginning:

01/01/16

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,226,472	\$ 39,588		\$ 93,376	\$ 53,788	\$ 370,302	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		\$ 1,226,472	\$ 39,588		\$ 93,376	\$ 53,788	\$ 370,302	34

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

Facility Name & ID Number Pine Crest Health Care

0051318

Report Period Beginning:

01/01/16

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	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1 Building Company		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8 Leasehold Improvements:							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34 TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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
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.

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Premier HC Realty, LLC	2011	54,468	1,397	35	1,556	159	7,909	3
4	Allocated from Premier HC Realty, LLC	2012	6,935	178	35	198	20	991	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Premier Healthcare & Financial Services	2012	1,236	12	20	62	50	309	9
10	Allocated from Premier Healthcare & Financial Services	2016	2,896	2,896	20	145	(2,751)	145	10
11									11
12	Allocated from Premier Healthcare Realty	2011	96,874	2,309	20	4,844	2,535	24,623	12
13	Allocated from Premier Healthcare Realty	2012	2,808	72	20	140	68	702	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)		\$ 165,217	\$ 6,864		\$ 6,945	\$ 81	\$ 34,679	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$ 165,217	\$ 6,864		\$ 6,945	\$ 81	\$ 34,679
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 165,217	\$ 6,864		\$ 6,945	\$ 81	\$ 34,679

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

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	\$ 184,656	\$ 51	\$ 25,963	\$ 25,912	10	\$ 126,372	71
72	Current Year Purchases	97,737	88	15,951	15,863	10	15,951	72
73	Fully Depreciated Assets	2,881				10	2,881	73
74								74
75	TOTALS	\$ 285,274	\$ 139	\$ 41,914	\$ 41,775		\$ 145,203	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		McCormick Auto - transportation	2012	\$ 9,504	\$	\$ 1,158	\$ 1,158	5	\$ 6,175	76
77										77
78										78
79										79
80	TOTALS			\$ 9,504	\$	\$ 1,158	\$ 1,158		\$ 6,175	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)	\$ 1,524,028	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 39,727	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 136,448	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 96,721	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 521,681	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Imperial Real Estate, LLC

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:		199		\$ 1,182,052			3
4	Additions							4
5								5
6	Allocated from Premier				9,847			6
7	TOTAL		199		\$ 1,191,899			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: \$ 5,151 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			\$ _____	\$ _____	18
19			\$ _____	\$ _____	19
20			\$ _____	\$ _____	20
21	TOTAL		\$ -	\$ _____	21

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

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

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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.

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

	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	\$		\$ 224,312	\$		\$ 224,312	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			71,372			71,372	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			214,116			214,116	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 prescripts				60,111		60,111	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>See Supplemental</u>					5,903	75,461		81,364	13
14	TOTAL			\$		\$ 515,703	\$ 135,572		\$ 651,275	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.

Facility Name & ID Number Pine Crest Health Care

0051318

Report Period Beginning: 01/01/16

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	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 14,702	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,655,799		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	99,271		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	2,165		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,771,937	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	966,236		15
16	Equipment, at Historical Cost	153,767		16
17	Accumulated Depreciation (book methods)	(734,628)		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): <u>See Attached Schedule</u>	1,026,556		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,411,931	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,183,868	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 515,996	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,261		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	371,425		30
31	Accrued Taxes Payable (excluding real estate taxes)	22,980		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	63,051		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 979,713	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 979,713	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,204,155	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,183,868	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,559,749	1
2	Restatements (describe):		2
3	Adjusting JE from 2015	(121,249)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,438,500	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,173,655	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	(408,000)	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)	\$ 765,655	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)	\$ 3,204,155	24 *

* This must agree with page 17, line 47.

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,752,333	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,752,333	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,577	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,577	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	176,199	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 176,199	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,931,109	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,566,011	31
32	Health Care	3,102,789	32
33	General Administration	2,049,838	33
B. Capital Expense			
34	Ownership	1,862,668	34
C. Ancillary Expense			
35	Special Cost Centers	689,484	35
36	Provider Participation Fee	486,664	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,757,454	40
41	Income before Income Taxes (line 30 minus line 40)**	1,173,655	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,173,655	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 8,523,190	44
45	Private Pay - Net Inpatient Revenue	94,627	45
46	Medicare - Net Inpatient Revenue	1,519,829	46
47	Other-(specify) Hospice	21,429	47
48	Other-(specify) Com. Ins./ VA	593,258	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,752,333	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 Pine Crest Health Care

0051318

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,032	2,073	\$ 94,528	\$ 45.60	1
2	Assistant Director of Nursing	1,881	1,941	81,148	41.81	2
3	Registered Nurses	12,691	14,195	441,364	31.09	3
4	Licensed Practical Nurses	28,831	34,938	892,715	25.55	4
5	CNAs & Orderlies	60,697	68,784	754,546	10.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,697	6,385	65,350	10.23	8
9	Activity Director	1,832	2,070	39,831	19.24	9
10	Activity Assistants	8,676	9,456	88,067	9.31	10
11	Social Service Workers	14,503	15,757	292,647	18.57	11
12	Dietician					12
13	Food Service Supervisor	3,671	4,181	70,155	16.78	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,191	20,849	209,961	10.07	15
16	Dishwashers					16
17	Maintenance Workers	3,542	3,782	65,854	17.41	17
18	Housekeepers	19,857	22,264	219,595	9.86	18
19	Laundry	8,436	9,455	91,902	9.72	19
20	Administrator	1,944	2,082	115,972	55.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,996	5,542	161,140	29.08	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	2,111	2,518	27,275	10.83	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	200,588	226,272	\$ 3,712,050 *	\$ 16.41	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	256	\$ 12,050	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant	Monthly	1,600	10-03	37
38	Nurse Consultant	3,583	179,150	10-03	38
39	Pharmacist Consultant	Monthly	18,374	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	23	1,406	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,862	\$ 230,580		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	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 Pine Crest Health Care

0051318

Report Period Beginning: 01/01/16

Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Zina Ward	Administrator	0%	\$ 115,972	Workers' Compensation Insurance	\$ 118,681	IDPH License Fee	\$		
				Unemployment Compensation Insurance	32,080	Advertising: Employee Recruitment	6,102		
				FICA Taxes	272,505	Health Care Worker Background Check	5,376		
				Employee Health Insurance	146,316	(Indicate # of checks performed)			
				Employee Meals		Patient Background Checks	538		
				Illinois Municipal Retirement Fund (IMRF)*		Advertising & Promotional			
				Pension Expense	19,628	Dues & Subscriptions	12,920		
				Other Employee Benefits	8,474	Licenses & Fees	8,439		
				Holiday Expense	3,933	Premier HC & Financial	2,764		
						See Supplemental Schedule	91		
						Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 115,972	TOTAL (agree to Schedule V, line 22, col.8)		\$ 601,617	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 35,692
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Premier Healthcare & Financial Services, Inc- Mgmt Fees			\$ 640,600				Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 640,600				Seminar Expense	1,694	
							Allocated from iCare Consulting	1,032	
							Allocated from Premier HC & Financial	842	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 72,825	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 3,568

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Pine Crest Health Care

0051318

Report Period Beginning:

01/01/16

Ending:

12/31/16

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ILCLTC \$19,283
- (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. \$ 20,897 Line 10-02
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES 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. \$ 486,664
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. \$ No 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. 4
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees