FOR BHF USE

LL1

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

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0052092

Facility Name: Park View Rehab Center

Address: 5888 North Ridge (Number) Chicago (City) 60660 (Zip Code)

County: Cook

Telephone Number: (773) 769-2626 **Fax #** (773) 769-2650

HFS ID Number:

Date of Initial License for Current Owners: 11/1/1992

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: 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 01/01/17 to 12/31/17 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) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	128	Skilled (SNF)	128	46,720	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	128	TOTALS	128	46,720	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,009	157	3,985	11,151	8
9	SNF/PED					9
10	ICF	32,348	117	433	32,898	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,357	274	4,418	44,049	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.28%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

I. On what date did you start providing long term care at this location?
Date started 07/01/2002

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/2002 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 128 and days of care provided 3,985

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	208,676	38,596	8,563	255,835		255,835		255,835			1
2	Food Purchase		230,299		230,299		230,299	2,114	232,413			2
3	Housekeeping	132,487	20,558		153,045		153,045	3,428	156,473			3
4	Laundry	54,164	11,063		65,227		65,227		65,227			4
5	Heat and Other Utilities			132,290	132,290		132,290	(54)	132,236			5
6	Maintenance	62,122		97,093	159,215		159,215	(1,896)	157,319			6
7	Other (specify):*											7
8	TOTAL General Services	457,449	300,516	237,946	995,911		995,911	3,592	999,503			8
	B. Health Care and Programs											
9	Medical Director			15,000	15,000		15,000		15,000			9
10	Nursing and Medical Records	1,918,625	90,946	123,060	2,132,631		2,132,631	(54,211)	2,078,420			10
10a	Therapy	32,882			32,882		32,882		32,882			10a
11	Activities	112,771	10,235	2,448	125,454		125,454		125,454			11
12	Social Services	156,363	203	2,469	159,035		159,035		159,035			12
13	CNA Training											13
14	Program Transportation			4,390	4,390		4,390		4,390			14
15	Other (specify):*							8,817	8,817			15
16	TOTAL Health Care and Programs	2,220,641	101,384	147,367	2,469,392		2,469,392	(45,394)	2,423,998			16
	C. General Administration											
17	Administrative	190,173		476,600	666,773		666,773	(442,819)	223,954			17
18	Directors Fees											18
19	Professional Services			82,326	82,326	(724)	81,602	(12,266)	69,336			19
20	Dues, Fees, Subscriptions & Promotions			48,851	48,851		48,851	(8,588)	40,263			20
21	Clerical & General Office Expenses	85,092		114,053	199,145		199,145	67,825	266,970			21
22	Employee Benefits & Payroll Taxes			554,610	554,610		554,610		554,610			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,979	1,979		1,979	1,569	3,548			24
25	Other Admin. Staff Transportation			9,739	9,739		9,739	3,364	13,103			25
26	Insurance-Prop.Liab.Malpractice			193,784	193,784		193,784	1,404	195,188			26
27	Other (specify):*							28,483	28,483			27
28	TOTAL General Administration	275,265		1,481,942	1,757,207	(724)	1,756,483	(361,027)	1,395,456			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,953,355	401,900	1,867,255	5,222,510	(724)	5,221,786	(402,829)	4,818,957			29

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

Facility Name & ID Number Park View Rehab Center #0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			92,862	92,862		92,862	63,236	156,098			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,056	7,056		7,056	308,400	315,456			32
33	Real Estate Taxes					724	724	158,648	159,372			33
34	Rent-Facility & Grounds			956,949	956,949		956,949	(938,945)	18,004			34
35	Rent-Equipment & Vehicles			1,974	1,974		1,974		1,974			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,058,841	1,058,841	724	1,059,565	(408,662)	650,903			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		123,721	568,190	691,911		691,911		691,911			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			314,591	314,591		314,591		314,591			42
43	Other (specify):*			21,704	21,704		21,704	(21,704)				43
44	**TOTAL Special Cost Centers**		123,721	904,485	1,028,206		1,028,206	(21,704)	1,006,502			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,953,355	525,621	3,830,581	7,309,557		7,309,557	(833,194)	6,476,363			45

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,277)	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	59,939	30		9
10	Interest and Other Investment Income	(7,189)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(15)	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	(1,162)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,422)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,885)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(86,816)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (46,827)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(786,368)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (786,368)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (833,195)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Park View Rehab Center

ID# 0052092

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Medicare Sequestration	$ (31,746)	21	1
2	Marketing Expense	(704)	43	2
3	Bank Charges	(10,921)	21	3
4	PAC Dues	(8,693)	20	4
5	Bldg Co. - Professional Fees	(9,010)	19	5
6	Marketing Expense	(7,500)	43	6
7	Non-Allowable Legal Fees	(6,302)	19	7
8	Medical Records Revenue	(179)	10	8
9	Prior Period Professional Fees	(7,924)	19	9
10	Capitalized R&M	(3,837)	06	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**	(86,816)		49

Park View Rehab Center

ID# 0052092

Report Period Beginning: 01/01/17

Ending: 12/31/17

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park View Rehab Center **#** 0052092 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(15)		1,829		300							2,114	2
3	Housekeeping			3,428									3,428	3
4	Laundry													4
5	Heat and Other Utilities	(2,277)		2,223									(54)	5
6	Maintenance	(3,837)		1,941									(1,896)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(6,129)		9,421		300							3,592	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(179)				(54,032)							(54,211)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					8,817							8,817	15
16	**TOTAL Health Care and Programs**	(179)				(45,215)							(45,394)	16
	C. General Administration													
17	Administrative			(442,819)									(442,819)	17
18	Directors Fees													18
19	Professional Services	(23,236)	9,010	1,506	121	334							(12,266)	19
20	Fees, Subscriptions & Promotions	(10,115)		1,442	30	55							(8,588)	20
21	Clerical & General Office Expenses	(51,714)	(828)	140,773		(20,406)							67,825	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			530		1,039							1,569	24
25	Other Admin. Staff Transportation			8		3,356							3,364	25
26	Insurance-Prop.Liab.Malpractice			869		535							1,404	26
27	Other (specify):*			26,452		2,031							28,483	27
28	**TOTAL General Administration**	(85,065)	8,182	(271,239)	151	(13,056)							(361,027)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(91,373)	8,182	(261,818)	151	(57,971)							(402,829)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park View Rehab Center # 0052092 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	59,939		10	3,287								63,236	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(7,189)	313,455	1	2,134								308,400	32
33	Real Estate Taxes		153,822		4,826								158,648	33
34	Rent-Facility & Grounds		(956,949)	26,329	(8,325)								(938,945)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	52,750	(489,672)	26,339	1,922								(408,662)	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):*	(8,204)				(13,500)							(21,704)	43
44	**TOTAL Special Cost Centers**	(8,204)				(13,500)							(21,704)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(46,827)	(481,490)	(235,479)	2,072	(71,471)							(833,194)	45

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 956,949	Park View Rehab Center Realty	100.00%	$	$ (956,949)	1
2	V	19	Professional Fees		Park View Rehab Center Realty	100.00%	9,010	9,010	2
3	V	32	Interest		Park View Rehab Center Realty	100.00%	313,455	313,455	3
4	V	33	Real Estate Tax		Park View Rehab Center Realty	100.00%	153,822	153,822	4
5	V	21	State Replacement Tax	828	Park View Rehab Center Realty	100.00%		(828)	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			$ 957,777			$ 476,287	$ * (481,490)	14

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	DIETARY	$	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	$ 1,829	$ 1,829	15
16	V	3	HOUSEKEEPING		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	3,428	3,428	16
17	V	5	UTILITIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	2,223	2,223	17
18	V	6	REPAIRS AND MAINTENANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,941	1,941	18
19	V	17	S WEBSTER SALARY		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	18,070	18,070	19
20	V	17	Y LEVOVITZ-SALARY		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	15,711	15,711	20
21	V	19	PROFESSIONAL FEES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,506	1,506	21
22	V	20	DUES FEES SUBSCRIPTIONS		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,442	1,442	22
23	V	21	CLERICAL AND GENERAL		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	6,605	6,605	23
24	V	21	CLERICAL & GENERAL SALARIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	134,169	134,169	24
25	V	24	SEMINARS & EDUCATION		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	530	530	25
26	V	25	AUTO EXPENSE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	8	8	26
27	V	26	INSURANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	869	869	27
28	V	27	EMPLOYEE BEN. GEN ADMIN.		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	26,452	26,452	28
29	V	30	DEPRECIATION		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	10	10	29
30	V	32	INTEREST		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1	1	30
31	V	34	RENT		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	26,329	26,329	31
32	V								32
33	V	17	MANAGEMENT FEES	476,600	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%		(476,600)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 476,600			$ 241,121	$ * (235,479)	39

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES		PREMIER HC REAL ESTATE, LLC	100.00%	121	$ 121	15
16	V	20	LICENSES & PERMITS		PREMIER HC REAL ESTATE, LLC	100.00%	30	30	16
17	V	30	DEPRECIATION		PREMIER HC REAL ESTATE, LLC	100.00%	3,287	3,287	17
18	V	32	INTEREST EXPENSE		PREMIER HC REAL ESTATE, LLC	100.00%	2,134	2,134	18
19	V	33	REAL ESTATE TAXES		PREMIER HC REAL ESTATE, LLC	100.00%	4,826	4,826	19
20	V								20
21	V	34	RENT	8,325	PREMIER HC REAL ESTATE, LLC	100.00%		(8,325)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 8,325			$ 10,397	$ * 2,072	39

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	DIETARY	$	iCare Consulting Services LLC	100.00%	$ 300	$ 300	15
16	V	10	NURSING SALARIES	114,200	iCare Consulting Services LLC	100.00%	60,168	(54,032)	16
17	V	15	EMPLOYEE BEN. HC PROGRAMS		iCare Consulting Services LLC	100.00%	8,817	8,817	17
18	V	19	PROFESSIONAL FEES		iCare Consulting Services LLC	100.00%	334	334	18
19	V	20	DUES FEES SUBSCRIPTIONS		iCare Consulting Services LLC	100.00%	55	55	19
20	V	21	CLERICAL AND GENERAL	38,600	iCare Consulting Services LLC	100.00%	3,129	(35,471)	20
21	V	21	CLERICAL & GENERAL SALARIES		iCare Consulting Services LLC	100.00%	15,065	15,065	21
22	V	24	SEMINARS & EDUCATION		iCare Consulting Services LLC	100.00%	1,039	1,039	22
23	V	25	AUTO EXPENSE		iCare Consulting Services LLC	100.00%	3,356	3,356	23
24	V	26	INSURANCE		iCare Consulting Services LLC	100.00%	535	535	24
25	V	27	EMPLOYEE BEN. GEN ADMIN.		iCare Consulting Services LLC	100.00%	2,031	2,031	25
26	V								26
27	V	43	MARKETING	13,500	iCare Consulting Services LLC			(13,500)	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			$ 166,300			$ 94,829	$ * (71,471)	39

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Yeruchom Levovitz	15.92%	CENTER HOME HISPANIC ELDERLY	CHICAGO	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		MANAGEMENT CO.	1
2	Shimon Webster	19.84%	PINE CREST HEALTH CARE	HAZEL CREST	PREMIER HEALTHCARE REALTY, LLC		BUILDING CO.	2
3	Chaim O Levovitz	3.91%	RIVER VIEW REHAB CENTER	ELGIN	PARK VIEW REHAB CENTER REALTY		BUILDING CO.	3
4	Jeffrey Webster	4.84%	FOREST CITY REHAB & NURSING	ROCKFORD	ICARE CONSULTING		CONSULTING	4
5	Mikel Children 2012 Trust	6.25%	ROCK RIVER HEALTH CARE	ROCKFORD	LIFELINE LAB		LAB	5
6	Howard Wengrow	4.05%	PEARL PAVILION	FREEPORT	PHARMORE DRUGS		PHARMACY	6
7	Jay Wengrow	2.34%						7
8	David Wengrow	2.34%						8
9	Dina Braunstein	2.34%						9
10	GPN Family Trust	14.25%						10
11	Menachem Shabat	3.56%						11
12	Ahuva Shabat	3.56%						12
13	Eliana Shabat	3.56%						13
14	Ayelet Shabat	3.56%						14
15	Moshe Levovitz	1.56%						15
16	Yakov Kohen	1.56%						16
17	Sharon Hinkle	1.56%						17
18	Ari Shabat	2.50%						18
19	Shoshana R. Shabat	2.50%						19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Shimon Webster	Owner	Administrative	19.84%	See Attachment	4.83	12.08%	Alloc Salary	$ 18,070	17-7	1
2	Yeruchom Levovitz	Owner	Administrative	15.92%	See Attachment	4.83	12.08%	Alloc Salary	15,711	17-7	2
3											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	$ 33,781		13

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

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	DIETARY	PATIENT DAYS	365,085	10	$ 15,162	$	44,049	$ 1,829	1
2	3	HOUSEKEEPING	PATIENT DAYS	365,085	10	28,415		44,049	3,428	2
3	5	UTILITIES	PATIENT DAYS	365,085	10	18,421		44,049	2,223	3
4	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	365,085	10	16,085		44,049	1,941	4
5	17	S WEBSTER SALARY	PATIENT DAYS	365,085	10	149,768	149,768	44,049	18,070	5
6	17	Y LEVOVITZ-SALARY	PATIENT DAYS	365,085	10	130,217	130,217	44,049	15,711	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	365,085	10	12,478		44,049	1,506	7
8	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	365,085	10	11,953		44,049	1,442	8
9	21	CLERICAL AND GENERAL	PATIENT DAYS	365,085	10	54,741		44,049	6,605	9
10	21	CLERICAL & GENERAL SALA	PATIENT DAYS	365,085	10	1,112,012	1,112,012	44,049	134,169	10
11	24	SEMINARS & EDUCATION	PATIENT DAYS	365,085	10	4,389		44,049	530	11
12	25	AUTO EXPENSE	PATIENT DAYS	365,085	10	69		44,049	8	12
13	26	INSURANCE	PATIENT DAYS	365,085	10	7,200		44,049	869	13
14	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	365,085	10	219,241		44,049	26,452	14
15	30	DEPRECIATION	PATIENT DAYS	365,085	10	79		44,049	10	15
16	32	INTEREST	PATIENT DAYS	365,085	10	4		44,049	1	16
17	34	RENT	PATIENT DAYS	365,085	10	218,217		44,049	26,329	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,998,451	$ 1,391,997		$ 241,121	25

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	365,085	10	1,000		44,049	121	1
2	20	LICENSES & PERMITS	PATIENT DAYS	365,085	10	250		44,049	30	2
3	30	DEPRECIATION	PATIENT DAYS	365,085	10	27,243		44,049	3,287	3
4	32	INTEREST EXPENSE	PATIENT DAYS	365,085	10	17,683		44,049	2,134	4
5	33	REAL ESTATE TAXES	PATIENT DAYS	365,085	10	40,000		44,049	4,826	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					$ 86,176	$		$ 10,397	25

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	DIETARY	PATIENT DAYS	365,085	10	$ 2,486	$	44,049	$ 300	1
2	10	NURSING SALARIES	PATIENT DAYS	365,085	10	498,679	498,679	44,049	60,168	2
3	15	EMPLOYEE BEN. HC PROGRA	PATIENT DAYS	365,085	10	73,073		44,049	8,817	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	365,085	10	2,768		44,049	334	4
5	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	365,085	10	459		44,049	55	5
6	21	CLERICAL AND GENERAL	PATIENT DAYS	365,085	10	25,935		44,049	3,129	6
7	21	CLERICAL & GENERAL SALA	PATIENT DAYS	365,085	10	124,859	124,859	44,049	15,065	7
8	24	SEMINARS & EDUCATION	PATIENT DAYS	365,085	10	8,610		44,049	1,039	8
9	25	AUTO EXPENSE	PATIENT DAYS	365,085	10	27,819		44,049	3,356	9
10	26	INSURANCE	PATIENT DAYS	365,085	10	4,434		44,049	535	10
11	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	365,085	10	16,833		44,049	2,031	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					$ 785,955	$ 623,538		$ 94,829	25

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		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	MB Financial		X	Mortgage			$	$ 5,666,502			$ 313,455	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB Financial		X	Line of Credit				2,818,846			7,056	6
7	Alloc Premier HC Realty	X									2,134	7
8	See Supplemental Schedule										1	8
9	TOTAL Facility Related						$	$ 8,485,348			$ 322,646	9
	B. Non-Facility Related*											
10	Interest Income		X								(7,189)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (7,189)	14
15	TOTALS (line 9+line14)						$	$ 8,485,348			$ 315,457	15

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

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

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

Facility Name & ID Number Park View Rehab Center # 0052092 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	133,637	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.)	$	158,648	2
3. Under or (over) accrual (line 2 minus line 1).	$	25,011	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	133,637	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	724	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.	$	159,372	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	126,715	8
	2013	128,430	9
	2014	131,017	10
	2015	140,733	11
	2016	153,822	12

2017 Accrual = $153,822 x .87 = $133,637

Allocated from Premier HC Realty - $4,827

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park View Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0052092

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-05-306-016-0000	Long Term Care Facility	$ 153,821.70	$ 153,821.70
2.	10-23-324-047-0000	Allocated from Home Office	$ 34,107.75	$ 4,115.24
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 187,929.45	$ 157,936.94

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 2016 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 2016 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2016.

Please complete the Real Estate Tax Statement below and include it in the 2017 cost report along with a copy of your 2016 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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park View Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0052092

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 84,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1991	$ 105,600	1
2	Allocated From Premier HC Realty			2,292	2
3	TOTALS			$ 107,892	3

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	128		1991	1971	$ 1,878,400	$	39	$ 48,164	$ 48,164	$ 1,421,535	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	22,988		20			22,988	9
10	Various			1994	38,610		20			38,610	10
11	Various			1995	68,517		20			68,517	11
12	Various			1996	107,653		20			107,653	12
13	Various			1997	32,071		20	4	4	32,071	13
14	Various			1998	19,271		20	958	958	19,269	14
15	Various			1999	16,863		20	844	844	16,026	15
16	Various			2000	50,104		20	2,506	2,506	45,097	16
17	Various			2001	9,165		20	458	458	7,789	17
18	Various			2002	38,362		20	1,919	1,919	30,694	18
19	Various			2003	20,009		20	1,000	1,000	15,008	19
20	Various			2004	38,100		20	1,906	1,906	26,676	20
21	Various			2005	127,366		20	6,369	6,369	82,792	21
22	Various			2006	2,900		20	145	145	1,740	22
23	Various			2007	3,348		20	167	167	1,839	23
24	Various			2008	32,480		20	1,624	1,624	16,240	24
25	Various			2009	33,390		20	2,417	2,417	21,749	25
26	Various			2010	17,840		20	892	892	7,136	26
27	Various			2012	32,072		20	1,604	1,604	9,624	27
28	Various			2013	417,287		20	21,314	21,314	95,531	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		318,938			3,338	3,338	287,895	67
68	Related Party Allocations (Pages 12H & 12I)		136,295	3,272		5,729	2,457	34,337	68
69	Financial Statement Depreciation			92,862			(92,862)		69
70	TOTAL (lines 4 thru 69)		$ 3,462,029	$ 96,134		$ 101,358	$ 5,224	$ 2,410,816	70

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,462,029	$ 96,134		$ 101,358	$ 5,224	$ 2,410,816	1
2	Fire Sprinkler-Piping, Reducer, Extender, Heat Detector, Pump C	2014	6,588		20	329	329	1,098	2
3	Therapy Room - Install Ceiling Tile & Paint Ceiling	2014	5,111		20	256	256	916	3
4	Bathroom Wall / Supply Line / Shower Valve	2014	4,600		20	230	230	805	4
5	Paint Walls In Basement Corridor, 1St Flr Rms, Bathrooms, Ther	2014	9,852		20	493	493	1,519	5
6	Security Camera	2015	8,313		20	416	416	1,178	6
7	Install New Maxton Valve For Passenger Elevator	2016	3,900		20	195	195	309	7
8	Install New 2 Zone Fujitsu Btgu System	2016	5,450		20	1,090	1,090	1,726	8
9	Replace Supply Line Including 2 3 Bulb Valve	2016	3,440		20	172	172	229	9
10	Install Flooring,Carpet,Corner Guards,2Nd/3Rd Floor Corner Ro	2016	261,797		20	13,090	13,090	15,271	10
11	Doors/Locks/Contacts/Eletrical Install 8 Door Key Pads	2017	7,164		20	1,433	1,433	1,433	11
12	2Nd Floor Dining Room -Upholster Cornice/Sheers/Led Lighting	2017			20	4,492	4,492	4,492	12
13	-2Nd & 3Rd Floor Corridor Signage,Led Lights/Cove Bases	2017			20				13
14	-1St/2Nd/3Rd Floor Resid. Rooms-Roller Shades/Cubicle Curtains	2017			20				14
15	-Repair Shower Room Floors In 6 Rooms/Mens Room	2017			20				15
16	-Plumbing In Utility Room, Cubicle Curtains/Replace Leaking Pip	2017			20				16
17	-Prep & Paint Walls And Trims On 3Rd Floor. Acrovyn Sheets	2017			20				17
18	-Kickplates, Chair Rails, Corner Guards/Vanity Lights	2017	155,124		20	7,756	7,756	7,756	18
19	Pump Repair - Water Feeder Replacement	2017	3,837		20	192	192	192	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,937,205	$ 96,134		$ 131,501	$ 35,367	$ 2,447,740	34

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,937,205	$ 96,134		$ 131,501	$ 35,367	$ 2,447,740	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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,937,205	$ 96,134		$ 131,501	$ 35,367	$ 2,447,740	34

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,937,205	$ 96,134		$ 131,501	$ 35,367	$ 2,447,740	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,937,205	$ 96,134		$ 131,501	$ 35,367	$ 2,447,740	34

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,937,205	$ 96,134		$ 131,501	$ 35,367	$ 2,447,740	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,937,205	$ 96,134		$ 131,501	$ 35,367	$ 2,447,740	34

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Heritage Nursing Center, Inc	1978	4,510		20			4,510	9
10	Heritage Nursing Center, Inc	1981	78,925		20			78,925	10
11	Heritage Nursing Center, Inc	1983	6,069		20			6,069	11
12	Heritage Nursing Center, Inc	1985	8,483		20			8,483	12
13	Heritage Nursing Center, Inc	1986	5,000		20			5,000	13
14	Heritage Nursing Center, Inc	1987	2,250		20			2,250	14
15	Heritage Nursing Center, Inc	1990	4,919		20			4,919	15
16	Heritage Nursing Center, Inc	1991	118,564		20			118,564	16
17	Heritage Nursing Center, Inc	1992	23,467		20			23,467	17
18	Heritage Nursing Center, Inc	2007	58,551		20	2,928	2,928	32,203	18
19	Heritage Nursing Center, Inc	2009	4,500		20	225	225	2,025	19
20	Heritage Nursing Center, Inc	2010	3,700		20	185	185	1,480	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 318,938	$		$ 3,338	$ 3,338	$ 287,895	34

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 318,938	$		$ 3,338	$	$ 287,895	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 318,938	$		$ 3,338	$	$ 287,895	34

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated From Premier Realty	2011	44,933	1,152	39	1,284	132	7,808	3
4	Allocated From Premier Realty	2012	5,721	147	39	163	16	981	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From Premier Realty	2011	79,915	1,904	20	3,996	2,092	24,308	9
10	Allocated From Premier Realty	2012	2,317	59	20	116	57	695	10
11									11
12	Allocated From Premier HC & Financial Services	2012	1,020	10	20	51	41	306	12
13	Allocated From Premier HC & Financial Services	2016	2,389		20	119	119	239	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)		$ 136,295	$ 3,272		$ 5,729	$ 2,457	$ 34,337	34

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 136,295	$ 3,272		$ 5,729	$ 2,457	$ 34,337	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 136,295	$ 3,272		$ 5,729	$ 2,457	$ 34,337	34

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 154,879	$ 24	$ 23,934	$ 23,910	10	$ 114,602	71
72	Current Year Purchases	3,308		662	662	10	662	72
73	Fully Depreciated Assets	286,062				10	286,062	73
74								74
75	TOTALS	$ 444,248	$ 24	$ 24,596	$ 24,572		$ 401,325	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,489,345	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 96,158	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 156,097	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 59,939	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,849,065	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from Premier				18,004			6
7	TOTAL				$ 18,004 **			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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 1,974 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 215,912	$		$ 215,912	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			113,638			113,638	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			238,640			238,640	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				116,580		116,580	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):						7,141		7,141	13
14	TOTAL			$		$ 568,190	$ 123,721		$ 691,911	14

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

STATE OF ILLINOIS

Facility Name & ID Number Park View Rehab Center **#** 0052092 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 76,962	$ 133,514	1
2	Cash-Patient Deposits	100	100	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,800,618	1,800,618	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	357,790	357,790	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule		66,033	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,235,470	$ 2,358,055	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		292,400	13
14	Buildings, at Historical Cost		5,107,548	14
15	Leasehold Improvements, at Historical Cost	989,282	989,282	15
16	Equipment, at Historical Cost	45,326	493,326	16
17	Accumulated Depreciation (book methods)	(284,057)	(482,815)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	3,646	595,907	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 754,197	$ 6,995,648	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,989,667	$ 9,353,703	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 591,267	$ 591,267	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	276,368	276,368	30
31	Accrued Taxes Payable (excluding real estate taxes)	19,104	19,104	31
32	Accrued Real Estate Taxes(Sch.IX-B)		133,637	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	45,046	45,046	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 931,785	$ 1,065,422	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		2,818,846	39
40	Mortgage Payable		5,666,502	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)**	$	$ 8,485,348	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 931,785	$ 9,550,770	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,057,882	$ (197,067)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,989,667	$ 9,353,703	48

***(See instructions.)**

Facility Name & ID Number Park View Rehab Center **#** 0052092 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,387,325	1
2	Restatements (describe):		2
3	**Equity Restatement**	77,090	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,464,415	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	988,027	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	(394,560)	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)**	$ 593,467	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)**	$ 2,057,882	24 *

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

Facility Name & ID Number Park View Rehab Center **#** 0052092 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,437,664	1
2	Discounts and Allowances for all Levels	(492,923)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,944,741	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	3,903	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)**	$ 3,903	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,189	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,189	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	341,751	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 341,751	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,297,584	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	995,911	31
32	Health Care	2,469,392	32
33	General Administration	1,757,207	33
	B. Capital Expense		
34	Ownership	1,058,841	34
	C. Ancillary Expense		
35	Special Cost Centers	713,615	35
36	Provider Participation Fee	314,591	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,309,557	40
41	**Income before Income Taxes (line 30 minus line 40)****	988,027	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 988,027	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,760,512	44
45	Private Pay - Net Inpatient Revenue	80,071	45
46	Medicare - Net Inpatient Revenue	1,913,898	46
47	Other-(specify) Hospice	55,111	47
48	Other-(specify) Commercial	135,149	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,944,741	49

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,091	2,154	$ 92,611	$ 42.99	1
2	Assistant Director of Nursing	2,021	2,064	81,601	39.54	2
3	Registered Nurses	6,288	6,820	228,232	33.47	3
4	Licensed Practical Nurses	25,899	27,763	748,334	26.95	4
5	CNAs & Orderlies	54,347	57,370	743,709	12.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,789	2,000	32,882	16.44	8
9	Activity Director	1,816	2,032	36,714	18.07	9
10	Activity Assistants	5,957	6,574	76,057	11.57	10
11	Social Service Workers	7,916	8,236	156,363	18.99	11
12	Dietician					12
13	Food Service Supervisor	1,944	2,080	38,798	18.65	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,709	15,051	169,878	11.29	15
16	Dishwashers					16
17	Maintenance Workers	3,249	3,462	62,122	17.94	17
18	Housekeepers	9,957	11,197	132,487	11.83	18
19	Laundry	4,307	4,510	54,164	12.01	19
20	Administrator	1,750	2,107	100,828	47.85	20
21	Assistant Administrator	2,008	2,214	89,345	40.35	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,621	7,190	85,092	11.83	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,593	1,719	24,138	14.04	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	153,262	164,543	$ 2,953,355 *	$ 17.95	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	156	$ 8,563	01-03	35
36	Medical Director	Monthly	15,000	09-03	36
37	Medical Records Consultant	Monthly	1,600	10-03	37
38	Nurse Consultant	Monthly	114,200	10-03	38
39	Pharmacist Consultant	Monthly	7,260	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	49	2,448	11-03	44
45	Social Service Consultant	42	2,469	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	247	$ 151,540		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sue Bohne	Administrator	0	$ 55,804
David Zaruba	Administrator	0	45,024
Carey Olivia	Assistant Admin	0	89,345
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 190,173

B. Administrative - Other

Description	Amount
Management Fees - Premier Healthcare & Financial	$ 476,600
TOTAL (agree to Schedule V, line 17, col. 3)	$ 476,600
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal Fees	$ 13,475
Marcum LLP	Accounting Fees	15,863
MTS Consulting	Tax Consulting	5,289
Skidelsky & Associates	RE Tax Appeal	250
Prospect Resources	Energy Procurement	1,300
Mowery & Schoenfeld	Accounting Fees	1,643
Madison Specs	Cost Segregation	1,440
Onshift, Inc	Computer Services	1,750
Creative Technology	Computer Services	10,391
Reliable Healthy Systems	Computer Services	12,540
Point Click Care	Computer Services	17,566
See Supplemental Schedule		819
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 82,326

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 94,599
Unemployment Compensation Insurance	24,801
FICA Taxes	219,517
Employee Health Insurance	175,122
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Pension	26,268
Employee Expense	11,797
Christmas Expense	2,506
TOTAL (agree to Schedule V, line 22, col.8)	$ 554,610

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	24,741
Health Care Worker Background Check	
(Indicate # of checks performed 170)	1,695
Patient Background Checks	
Dues & Subcriptions	8,693
Licenses & Permits	3,607
Allocated from Premier Financial	1,442
Allocated from Premier HC Realty	30
See Supplemental Schedule	55
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 40,263

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,979
Allocated from Premier Financial	530
Allocated from iCare Consulting	1,039
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,548

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/17 Ending: 12/31/17

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. **ICLTC - $17,386**

(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. $ **8,416** Line **10-02**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **314,591**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

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

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

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

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