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: 0051854

Facility Name: Pershing Gardens HC Center

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

County: Cook

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** (630) 361-2868
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2017 to 12/31/2017 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	31	Skilled (SNF)	31	11,315	1
2		Skilled Pediatric (SNF/PED)			2
3	20	Intermediate (ICF)	20	7,300	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	51	TOTALS	51	18,615	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			3,588	3,588	8
9	SNF/PED					9
10	ICF	10,812	1,685		12,497	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,812	1,685	3,588	16,085	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.41%

D. How many bed reserve days during this year were paid by the Department?
0 (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] Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location?
Date started 01/01/2012

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 31 and days of care provided 3,056

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: 12/31/17 Fiscal Year: 12/31/17

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	113,834	615	6,019	120,468		120,468		120,468			1
2	Food Purchase		93,599		93,599		93,599		93,599			2
3	Housekeeping	2,525	9,155	44,550	56,230		56,230		56,230			3
4	Laundry	1,266	7,007	33,000	41,273		41,273		41,273			4
5	Heat and Other Utilities			58,278	58,278		58,278	243	58,521			5
6	Maintenance	36,069		32,946	69,015		69,015	6,561	75,576			6
7	Other (specify):* Waste Removal			8,577	8,577		8,577		8,577			7
8	TOTAL General Services	153,694	110,376	183,370	447,440		447,440	6,804	454,244			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,120,613	126,058	7,903	1,254,574		1,254,574	26,803	1,281,377			10
10a	Therapy		876	20,826	21,702		21,702	(5,226)	16,476			10a
11	Activities	18,837		928	19,765		19,765		19,765			11
12	Social Services	49,630		4,731	54,361		54,361		54,361			12
13	CNA Training											13
14	Program Transportation			2,050	2,050		2,050		2,050			14
15	Other (specify):* Mgmt Co Benefits Alloc							5,185	5,185			15
16	TOTAL Health Care and Programs	1,189,080	126,934	48,438	1,364,452		1,364,452	26,762	1,391,214			16
	C. General Administration											
17	Administrative	95,508		214,421	309,929		309,929	(175,180)	134,749			17
18	Directors Fees											18
19	Professional Services			113,642	113,642		113,642	5,475	119,117			19
20	Dues, Fees, Subscriptions & Promotions			18,251	18,251		18,251	(53)	18,198			20
21	Clerical & General Office Expenses	46,000	7,261	56,248	109,509		109,509	46,609	156,118			21
22	Employee Benefits & Payroll Taxes			215,824	215,824		215,824		215,824			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,813	2,813		2,813	68	2,881			24
25	Other Admin. Staff Transportation			8,548	8,548		8,548	1,103	9,651			25
26	Insurance-Prop.Liab.Malpractice			58,119	58,119		58,119	968	59,087			26
27	Other (specify):* Mgmt Co Benefits Alloc							13,380	13,380			27
28	TOTAL General Administration	141,508	7,261	687,866	836,635		836,635	(107,630)	729,005			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,484,282	244,571	919,674	2,648,527		2,648,527	(74,064)	2,574,463			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Pershing Gardens HC Center #0051854 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							116,381	116,381			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,378	53,378		53,378	320,809	374,187			32
33	Real Estate Taxes			68,849	68,849		68,849		68,849			33
34	Rent-Facility & Grounds			460,417	460,417		460,417	(455,611)	4,806			34
35	Rent-Equipment & Vehicles			31,263	31,263		31,263	545	31,808			35
36	Other (specify):*											36
37	**TOTAL Ownership**			613,907	613,907		613,907	(17,876)	596,031			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		107,923	415,324	523,247		523,247	(92,785)	430,462			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			107,197	107,197		107,197		107,197			42
43	Other (specify):* **Disallowed Costs**	4,653	4,994	114,782	124,429		124,429	(124,429)				43
44	**TOTAL Special Cost Centers**	4,653	112,917	637,303	754,873		754,873	(217,214)	537,659			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,488,935	357,488	2,170,884	4,017,307		4,017,307	(309,154)	3,708,153			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,677)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	115,118	30		9
10	Interest and Other Investment Income	(1,279)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(312)	43		17
18	Fines and Penalties	(5,949)	43		18
19	Entertainment				19
20	Contributions	(21,300)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,229)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(64,326)	43		24
25	Fund Raising, Advertising and Promotional	(301)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(24,413)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (5,668)		$	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)	(303,486)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (303,486)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (309,154)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Pershing Gardens HC Center

ID# 0051854

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salary	$ (4,653)	43	1
2	Marketing Expense	(25,911)	43	2
3	PAC Dues	(364)	20	3
4	Miscellaneous Income Offset	(14)	21	4
5	Expense Repairs under $2,500	6,529	6	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(24,413)		49

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	19	Professional Fees		Pershing Gardens Realty, LLC	100.00%	$ 292	$ 292	1
2	V	21	Clerical & Gen Office Expenses		Pershing Gardens Realty, LLC	100.00%	354	354	2
3	V	32	Interest	536	Pershing Gardens Realty, LLC	100.00%	317,772	317,236	3
4	V	34	Rent-Facility & Grounds	460,417	Pershing Gardens Realty, LLC	100.00%		(460,417)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 460,953			$ 318,418	$ * (142,535)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Heat and Other Utilities	$	Premier Healthcare Management, LLC	100.00%	$ 243	$ 243	15
16	V	6	Maintenance		Premier Healthcare Management, LLC	100.00%	32	32	16
17	V	10	Nursing and Medical Records		Premier Healthcare Management, LLC	100.00%	31,014	31,014	17
18	V	10	Nursing and Medical Records		Premier Healthcare Management, LLC	100.00%	0		18
19	V	15	Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	100.00%	5,185	5,185	19
20	V	15	Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	100.00%	0		20
21	V	17	Administrative	214,421	Premier Healthcare Management, LLC	100.00%	31,519	(182,902)	21
22	V	17	Administrative		Premier Healthcare Management, LLC	100.00%	7,722	7,722	22
23	V	17	Administrative		Premier Healthcare Management, LLC	100.00%	0		23
24	V	19	Professional Services		Premier Healthcare Management, LLC	100.00%	1,854	1,854	24
25	V	20	Dues, Fees, Subs & Promo		Premier Healthcare Management, LLC	100.00%	182	182	25
26	V	21	Clerical & Gen Office Expenses		Premier Healthcare Management, LLC	100.00%	43,459	43,459	26
27	V	24	Travel and Seminar		Premier Healthcare Management, LLC	100.00%	68	68	27
28	V	25	Other Admin. Staff Trans		Premier Healthcare Management, LLC	100.00%	567	567	28
29	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	12,089	12,089	29
30	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	1,291	1,291	30
31	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	0		31
32	V	34	Rent-Facility & Grounds		Premier Healthcare Management, LLC	100.00%	4,806	4,806	32
33	V	35	Equipment Rental		Premier Healthcare Management, LLC	100.00%	545	545	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 214,421			$ 140,576	$ * (73,845)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	$ 6,790	Premier Healthcare Supplies, LLC	100.00%	$ 2,579	$ (4,211)	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			$ 6,790			$ 2,579	$ * (4,211)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	Therapy	$ 5,226	REX Therapeutics	100.00%	$	$ (5,226)	15
16	V	19	Professional Services		REX Therapeutics	100.00%	4,558	4,558	16
17	V	20	Fees and Subscriptions		REX Therapeutics	100.00%	129	129	17
18	V	21	Clerical & General Office Exp		REX Therapeutics	100.00%	2,810	2,810	18
19	V	25	Other Admin Staff Transp		REX Therapeutics	100.00%	536	536	19
20	V	26	Insurance-Prop.Liab.Malp		REX Therapeutics	100.00%	968	968	20
21	V	30	Depreciation		REX Therapeutics	100.00%	1,263	1,263	21
22	V	32	Interest Expense		REX Therapeutics	100.00%	4,852	4,852	22
23	V	39	Therapy Consultant		REX Therapeutics	100.00%	3,610	3,610	23
24	V	39	Therapy Management Wages		REX Therapeutics	100.00%	11,075	11,075	24
25	V	39	Allocated Employee Benefits		REX Therapeutics	100.00%	34,568	34,568	25
26	V								26
27	V	39	Therapy Wages		REX Therapeutics	100.00%	237,498	237,498	27
28	V	39	Contract Therapy	410,912	REX Therapeutics	100.00%	31,376	(379,536)	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			$ 416,138			$ 333,243	$ * (82,895)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES

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

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

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	David Cheplowitz	Shareholder	Administrative	50.00%	See Att Sch 7A	1.5	4%	Alloc Salary	$ 6,603	17-7	1
2	Barak Baver	Shareholder	Administrative	50.00%	See Att Sch 7A	1.5	4%	Alloc Salary	6,603	17-7	2
3	Sara Baver	Relative	Clerical	0	See Att Sch 7A	1.5	4%	Alloc Salary	1,658	21-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 14,864		13

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

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

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2017 Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Premier Healthcare Management, LLC
Street Address: 8170 N. McCormick Blvd. Suite 137
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 674-2800
Fax Number: (847) 674-4133

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	Census Days	428,856	12	$ 6,472	$	16,085	$ 243	1
2	6	Maintenance	Census Days	428,856	12	843		16,085	32	2
3	10	Nursing and Medical Records	Illinois Census Days	307,749	7	593,374	593,374	16,085	31,014	3
4	10	Nursing and Medical Records	Indiana Census Days	121,107	5	239,535	239,535		0	4
5	15	Emp Benefit Alloc-Healthcare	Illinois Census Days	307,749	7	99,203		16,085	5,185	5
6	15	Emp Benefit Alloc-Healthcare	Indiana Census Days	121,107	5	40,047			0	6
7	17	Administrative	Census Days	428,856	12	840,373	840,373	16,085	31,519	7
8	17	Administrative	Illinois Census Days	307,749	7	147,750	147,750	16,085	7,722	8
9	17	Administrative	Indiana Census Days	121,107	5	133,577	133,577		0	9
10	19	Professional Services	Census Days	428,856	12	49,430		16,085	1,854	10
11	20	Dues, Fees, Subs & Promo	Census Days	428,856	12	4,850		16,085	182	11
12	21	Clerical & Gen Office Expenses	Census Days	428,856	12	1,158,702	1,087,471	16,085	43,459	12
13	24	Travel and Seminar	Census Days	428,856	12	1,803		16,085	68	13
14	25	Other Admin. Staff Trans	Census Days	428,856	12	15,107		16,085	567	14
15	27	Emp Benefit Alloc-Gen Admin	Census Days	428,856	12	322,307		16,085	12,089	15
16	27	Emp Benefit Alloc-Gen Admin	Illinois Census Days	307,749	7	24,702		16,085	1,291	16
17	27	Emp Benefit Alloc-Gen Admin	Indiana Census Days	121,107	5	22,332			0	17
18	34	Rent-Facility & Grounds	Census Days	428,856	12	128,146		16,085	4,806	18
19	35	Equipment Rental	Census Days	428,856	12	14,538		16,085	545	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,843,091	$ 3,042,080		$ 140,576	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2017 Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Premier Healthcare Supplies, LLC
Street Address: 8170 N. McCormick Blvd. Suite 137
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 674-2800
Fax Number: (847) 674-4133

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing and Medical Records	Revenue	161,406	12	$ 65,860	$	6,320	$ 2,579	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					$ 65,860	$		$ 2,579	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2017 Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: REX Therapeutics
Street Address: 8170 N. McCormick Blvd. Suite 137
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 674-2800
Fax Number: (847) 674-4133

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Services	Therapy Revenue	5,071,121	7	$ 55,562	$	416,032	$ 4,558	1
2	20	Fees and Subscriptions	Therapy Revenue	5,071,121	7	1,569		416,032	129	2
3	21	Clerical & General Office Exp	Therapy Revenue	5,071,121	7	34,248		416,032	2,810	3
4	25	Other Admin Staff Transp	Therapy Revenue	5,071,121	7	6,528		416,032	536	4
5	26	Insurance-Prop.Liab.Malp	Therapy Revenue	5,071,121	7	11,796		416,032	968	5
6	30	Depreciation	Therapy Revenue	5,071,121	7	15,390		416,032	1,263	6
7	32	Interest Expense	Therapy Revenue	5,071,121	7	59,135		416,032	4,852	7
8	39	Therapy Consultant	Therapy Revenue	5,071,121	7	44,000		416,032	3,610	8
9	39	Therapy Management Wages	Therapy Revenue	5,071,121	7	135,002	135,002	416,032	11,075	9
10	39	Allocated Employee Benefits	Therapy Revenue	5,071,121	7	421,361		416,032	34,568	10
11										11
12	39	Therapy Wages	Direct Allocation	3,215,952	4	3,215,952	3,215,952	237,498	237,498	12
13	39	Contract Therapy	Direct Allocation	396,932	4	396,932		31,376	31,376	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					$ 4,397,475	$ 3,350,954		$ 333,243	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	Bank Leumi		X	Mortgage		7/12/2016	5,000,000	4,716,667	7/12/2021	variable	317,772	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank Leumi		X	Line of Credit		8/1/2016		823,575	8/1/2017	variable	53,122	6
7												7
8												8
9	TOTAL Facility Related						$ 5,000,000	$ 5,540,242			$ 370,894	9
	B. Non-Facility Related*											
10												10
11								Allocated from REX Therapeutics			4,852	11
12								Offset Interest Income			(1,815)	12
13								Other Interest Expense			256	13
14	TOTAL Non-Facility Related						$	$			$ 3,293	14
15	TOTALS (line 9+line14)						$ 5,000,000	$ 5,540,242			$ 374,187	15

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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.**		$ 119,001	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.)	2016	$	2
3. Under or (over) accrual (line 2 minus line 1).		$ (119,001)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 191,001	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND** $ 5,025 **For** 2013 **Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$ (3,151)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 68,849	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	72,004	8
	2013	74,020	9
	2014	104,257	10
	2015	107,279	11
	2016	110,790	12

Accrual based on prior year tax bill.

Note: Adjusted beginning accrual to actual balance.

	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 Pershing Gardens HC Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051854

CONTACT PERSON REGARDING THIS REPORT Larry Templin

TELEPHONE (630) 361-2868 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 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.	19-06-103-035-0000	Long Term Care Property	$ 79,565.06	$ 79,565.06
2.	19-06-103-034-0000	Long Term Care Property	$ 31,225.03	$ 31,225.03
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 110,790.09	$ 110,790.09

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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 Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,845 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

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

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

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

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

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

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2012	$ 14,786	1
2					2
3	TOTALS			$ 14,786	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	51		2012	1964	$ 1,220,815	$	35	$ 34,880	$ 34,880	$ 162,439	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Automatic Wet Pipe Fire Sprinkler System			2012	67,793		20	3,390	3,390	20,339	9
10	Fire Protection Coverage-1St & 2Nd Floor Dining Rooms			2012	4,560		20	228	228	1,368	10
11	Removal Of Underground Storage Tank			2012	4,036		20	202	202	1,211	11
12	Installation Of Wander System And Cables			2012	5,721		20	286	286	1,716	12
13	New Signage			2012	9,858		20	493	493	2,958	13
14	Replace A/C System On Second Floor			2012	3,000		20	150	150	900	14
15	Fire Alarm Installation			2012	3,200		20	160	160	960	15
16	A: 1St Floor Day Room- New Blinds And Custom Fireplace			2012	3,857		20	193	193	1,157	16
17	B: Porch- Demolish Existing Porches And Build New Stairs Railings And			2012	9,904		20	495	495	2,971	17
18	C: Lobby- New Custom Baseboard Heaters			2012	3,792		20	190	190	1,138	18
19	D: 1St Floor Day Room-Structural Wood Repair; Replace Ceiling; New D			2012	28,689		20	1,434	1,434	8,606	19
20	E: Lobby-New Flooring;Ceiling; Lighting;Wallcoverings;Window Treatm			2012	19,878		20	994	994	5,964	20
21	F: Basement Corridor-New Flooring; Signage; Lighting			2012	6,453		20	323	323	1,937	21
22	G: Therapy Room-New Flooring;Wall Partitions; Lighting; Electrical; Do			2012	54,039		20	2,702	2,702	16,212	22
23	H: 1St Floor Corridor-Removal Of Old Cove Base; New Flooring;Wall Ba			2012	30,741		20	1,537	1,537	9,222	23
24	I: 2Nd Floor Corridor- New Flooring; Removal Of Old Cove Base; New W			2012	35,164		20	1,758	1,758	10,549	24
25	J: New Elevator			2012	8,123		20	406	406	2,437	25
26	K: 2Nd Floor Day Room- Replace Ceiling; Millwork Base; Window Treat			2012	18,891		20	945	945	5,668	26
27	L: Resident Rooms- New Flooring; Paint Walls; Lighting; Cubicle Curtai			2012	82,484		20	4,124	4,124	25,596	27
28	M: Various Areas-New Wooden Handrails And Bumper Gaurds; Painting			2012	65,457		20	3,273	3,273	19,637	28
29	New Fire Alarm Panel Analog Notifier			2012	4,950		20	248	248	1,486	29
30	Various Bathroom Remodels: Remove & Replace Tub,Toilet,Sink, New Fl			2012	48,310		20	2,416	2,416	9,663	30
31	New Wiring And Motor For Kitchen Exhaust Fan			2013	2,837		20	142	142	710	31
32	New Outlets For Window A/C Units			2013	2,900		20	145	145	665	32
33	New Generator, New 400 Amp Main Service			2013	141,085		20	7,054	7,054	31,156	33
34	Additional Work On Exterior Remodel: Demo Existing, New Concrete, De			2013	16,903		20	845	845	3,662	34
35	Fire Alarm Installation Charge			2013	9,423		20	471	471	1,884	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	Install Door Automator To Front Entry	2013	5,575		20	279	$ 279	$ 1,115	37
38	Various Areas: Light Fixtures;Floor & Wall Tile;	2013	$ 24,566	$	20	$ 1,228	1,228	4,913	38
39	Main Entrance Exterior Remodel: Demolish Entire Old Exterior-	2013	59,204		20	2,960	2,960	11,840	39
40	Fire System	2014	3,103		20	155	155	620	40
41	Tuckpoint Wall Where Overhang From Roof Was Removed	2014	5,800		20	290	290	1,160	41
42	Hot Water Tank Wiring	2014	3,125		20	156	156	625	42
43	Champion Roofing	2014	2,850		20	143	143	571	43
44	Install Wire Panelboard In Boiler Room	2014	7,000		20	350	350	1,400	44
45	Elevator Wiring & Shunt Trip Breaker	2014	19,000		20	950	950	3,800	45
46	Champion Roofing	2014	3,248		20	162	162	649	46
47	New Elevator	2014	2,500		20	125	125	500	47
48	Elevator Modernization	2014	125,000		20	6,250	6,250	25,000	48
49	Install Fire Alarm System In Basement Elevator Room	2014	10,548		20	527	527	1,054	49
50	Repaired 2 Lower Level Circuits, 1 Battery Pack, And 2 Fluoresce	2015	7,675		20	384	384	1,152	50
51	Rewired Kitchen With Two 20 Amp 120 Volt Circuits	2015	4,750		20	238	238	714	51
52	Replace Kitchen Door and Drywall in Dining Rm Ceiling	2017	4,125		20	103	103	103	52
53	Install New Circuit and Feeder in Laundry Room	2017	4,215		20	105	105	105	53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64	Allocated from Premier Healthcare Management LLC.	2013	933		20	47	47	196	64
65									65
66	Allocated from REX Therapeutics					1,263	1,263		66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,206,080	$		$ 85,199	$ 85,199	$ 407,728	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	$ 291,095	$	$ 29,101	$ 29,101	10	$ 158,108	71
72	Current Year Purchases	41,613		2,081	2,081	10	2,081	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 332,708	$	$ 31,182	$ 31,182		$ 160,189	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	N/A									77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,553,574	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 116,381	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 116,381	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 567,917	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		93
94			94
95		$	95

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

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

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Management Co.				4,806			5
6								6
7	TOTAL				$ 4,806 **			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: $ 11,313 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17				$	17
18	Facility	2014 Land Rover	1,662.53	19,950	18
19	Allocated from Management Co.			545	19
20					20
21	TOTAL		$ 1,662.53	$ 20,495	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Pershing Gardens HC Center**
IDPH License ID Number: **0051854**
Fiscal Year End: **12/31/2017**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Nursing Equipment	11,246
Dietary Equipment	67
Total - Line 16	**11,313**

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(7)	1947	hrs	$ 72,485		$ 9,150	$	1,947	$ 81,635	1
3	Licensed Speech and Language Licensed Recreational Therapist			hrs							3
5	Physician Care			visits							5
6	Dental Care			visits							6
8	Habilitation			hrs							8
9	Pharmacy	39(2)		# of prescrpts				107,923		107,923	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify):										12
13	Other (specify): See Attached Scheule 16A						42,590			42,590	13
14	TOTAL				$ 248,573		$ 73,966	$ 108,799	6,676	$ 431,338	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Pershing Gardens HC Center**
IDPH License ID Number: **0051854**
Fiscal Year End: **12/31/2017**

Schedule 16A

XIV. Special Services
Line 13 Other Services

Description	Schedule V Line & Column Reference	Amount
Lab & Xray	39(3)	4,352
Outside MD Service-MCA	39(3)	60
Therapy Consultant	39(7)	3,610
Employee Benefits Allocated fro	39(7)	34,568
Total - Line 13		**42,590**

STATE OF ILLINOIS

Facility Name & ID Number Pershing Gardens HC Center # 0051854 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2017 (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	$ 18,519	$ 18,519	1
2	Cash-Patient Deposits	1,912	1,912	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 411,474)	1,630,953	1,630,953	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	41,585	7,193	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,692,969	$ 1,658,577	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		14,786	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,114,551	2,206,080	15
16	Equipment, at Historical Cost	263,751	332,708	16
17	Accumulated Depreciation (book methods)	(686,581)	(567,917)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule 17A		519,299	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 691,721	$ 2,504,956	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,384,690	$ 4,163,533	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 956,712	$ 1,061,001	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	689	689	28
29	Short-Term Notes Payable	823,575	823,575	29
30	Accrued Salaries Payable	120,825	120,825	30
31	Accrued Taxes Payable (excluding real estate taxes)	222,045	222,045	31
32	Accrued Real Estate Taxes(Sch.IX-B)		191,001	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	542,641	542,641	36
37	Due to Related Parties	1,574,170	154,677	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,240,657	$ 3,116,454	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,716,667	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,716,667	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,240,657	$ 7,833,121	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,855,967)	$ (3,669,588)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,384,690	$ 4,163,533	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name: **Pershing Gardens HC Center**
IDPH License ID Number: **0051854**
Fiscal Year End: **12/31/2017**

Schedule 17A

XV. Balance Sheet

Line 23 Other Assets (specify):

Description	Operating	After Consolidation
Loan Costs		90,048
Intangibles		429,251
Total - Line 23	**-**	**519,299**

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Accrued MDS Tax	34,387	34,387
Accrued Expenses	165,576	165,576
Accrued Bed Tax	16,336	16,336
Payroll Withholdings	294,389	294,389
Due to Prior Owner	153	153
Security Deposits	31,800	31,800
Total - Line 36	**542,641**	**542,641**

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,758,980)	1
2	Restatements (describe):		2
3	**Post closing adjustments - Depreciation Expense**	(334,494)	3
4	**Post closing adjustments - Interest Expense**	(4,899)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,098,373)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	272,406	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	(30,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 242,406	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,855,967)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,570,202	1
2	Discounts and Allowances for all Levels	613,297	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,183,499	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	104,034	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 104,034	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	260	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	627	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 887	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,279	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,279	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	14	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 14	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,289,713	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	447,440	31
32	Health Care	1,364,452	32
33	General Administration	836,635	33
	B. Capital Expense		
34	Ownership	613,907	34
	C. Ancillary Expense		
35	Special Cost Centers	647,676	35
36	Provider Participation Fee	107,197	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,017,307	40
41	**Income before Income Taxes (line 30 minus line 40)****	272,406	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 272,406	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,790,701	44
45	Private Pay - Net Inpatient Revenue	311,863	45
46	Medicare - Net Inpatient Revenue	2,034,097	46
47	Other-(specify) Insurance	17,060	47
48	Other-(specify) Hospice	29,778	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,183,499	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	2,048	2,080	$ 76,950	$ 37.00	1
2	Assistant Director of Nursing	1,800	2,056	58,048	28.23	2
3	Registered Nurses	6,035	6,173	190,575	30.87	3
4	Licensed Practical Nurses	13,494	13,841	353,533	25.54	4
5	CNAs & Orderlies	31,821	32,808	396,176	12.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,353	1,465	18,837	12.86	10
11	Social Service Workers	2,206	2,846	49,630	17.44	11
12	Dietician					12
13	Food Service Supervisor	1,342	1,822	31,678	17.39	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,766	8,022	82,156	10.24	15
16	Dishwashers					16
17	Maintenance Workers	2,466	2,530	36,069	14.26	17
18	Housekeepers	245	245	2,525	10.31	18
19	Laundry	116	116	1,266	10.91	19
20	Administrator	2,032	2,280	95,508	41.89	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,229	3,349	46,000	13.74	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	1,400	1,512	49,984	33.06	33
34	TOTAL (lines 1 - 33)	77,353	81,145	$ 1,488,935 *	$ 18.35	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 6,019	L1, C3	35
36	Medical Director	Monthly	12,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,254	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	1,518	L12, C3	45
46	Other(specify) Rehab Mgmt	Monthly	15,600	L10a, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 41,391		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	31	1,649	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	31	$ 1,649		53

Pershing Gardens HC Center

Period Beginning **1/1/2017**
Period End **12/31/2017**

Schedule 20A

XVIII. Staffing and Salary Costs

		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator		1,272	1,384	45,331	32.75
Marketing		128	128	4,653	36.35
	TOTAL	1,400	1,512	49,984	

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Richard Taylor	Administrator	0	$ 63,538
Michael Jacobson	Administrator	0	31,970
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 95,508

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 214,421
TOTAL (agree to Schedule V, line 17, col. 3)	$ 214,421
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 23,812
Richard Peelo & Associates, Inc	Accounting	2,100
CohnReznick LLP	Accounting	24,674
Plante Moran	Data Processing	4,035
Ability Network Inc	Data Processing	2,184
ADP	Data Processing	730
Change Healthcare	Data Processing	542
eSolutions Inc	Data Processing	4,097
HDSI	Data Processing	1,000
Matrixcare	Data Processing	11,342
Singer Networks, LLC	Data Processing	4,986
See Attached Schedule 21A		34,140
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 113,642

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 33,084
Unemployment Compensation Insurance	28,823
FICA Taxes	112,535
Employee Health Insurance	36,780
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	3,024
Physical Exams	1,578
TOTAL (agree to Schedule V, line 22, col.8)	$ 215,824

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	6,668
Health Care Worker Background Check	
(Indicate # of checks performed 78)	4,033
Patient Background Checks 55	554
Dues & Subscriptions	6,267
Licenses & Permits	
IL Council on LTC	365
Allocated from Management Co.	311
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,198

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,813
Allocated from Management Co.	68
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,881

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Pershing Gardens HC Center**
IDPH License ID Number: **0051854**
Fiscal Year End: **12/31/2017**

Schedule 21A

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
Terrill Consulting Services, Inc.	Billing Consultant	5,330
Sharon Lofgren	Medicare Billing	3,600
M & M Financial	Financial Consultant	5,076
Personnel Planners	UC Consultant	1,225
2401 Incorporated	Survey Compliance	7,860
Paycor	Payroll Processing	10,264
CT Lien Solutions	Risk Management	285
Miscellaneous	Miscellaneous	500
Total		**34,140**

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **365 IL Council on LTC**

(3) Did the nursing home make political contributions or payments to a politica
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?

(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 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **4,696** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **107,197**
This amount is to be recorded on line 42 of Schedule V.

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

SEE ACCOUNTANTS' PREPARATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **None** Has any meal income been offset against
related costs? **N/A** Indicate the amount. $ **N/A**

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

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

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