FOR BHF USE

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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

I. IDPH License ID Number: 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: 11/29/1982

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: Joshua S. Banach **Telephone Number:** (773)945-9528
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 01/01/2018 to 12/31/2018 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) Joshua S. Banach, CPA
(Title) Asst. Controller

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) 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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	6,873	194	4,159	11,226	8
9	SNF/PED					9
10	ICF	31,720	144	543	32,407	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,593	338	4,702	43,633	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.39%

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 7/1/2002

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/1/2002 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 4,159

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: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	226,507	37,592	8,330	272,429		272,429		272,429			1
2	Food Purchase		232,206		232,206		232,206	1,994	234,200			2
3	Housekeeping	142,885	19,849		162,734		162,734	2,918	165,652			3
4	Laundry	58,131	17,739		75,870		75,870		75,870			4
5	Heat and Other Utilities			144,575	144,575		144,575	(482)	144,093			5
6	Maintenance	99,308	50	112,582	211,940		211,940	(7,533)	204,407			6
7	Other (specify):*											7
8	**TOTAL General Services**	526,831	307,436	265,487	1,099,754		1,099,754	(3,103)	1,096,651			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,972,054	14,928	112,180	2,099,162		2,099,162	(72,066)	2,027,096			10
10a	Therapy	32,925			32,925		32,925		32,925			10a
11	Activities	113,606	8,433	2,472	124,511		124,511		124,511			11
12	Social Services	167,674		2,645	170,319		170,319		170,319			12
13	CNA Training											13
14	Program Transportation			4,351	4,351		4,351		4,351			14
15	Other (specify):*							3,928	3,928			15
16	**TOTAL Health Care and Programs**	2,286,259	23,361	139,648	2,449,268		2,449,268	(68,138)	2,381,130			16
	C. General Administration											
17	Administrative	187,812		514,000	701,812		701,812	(434,714)	267,098			17
18	Directors Fees											18
19	Professional Services			103,870	103,870		103,870	191	104,061			19
20	Dues, Fees, Subscriptions & Promotions			56,512	56,512		56,512	(11,576)	44,936			20
21	Clerical & General Office Expenses	57,308		218,896	276,204		276,204	(50,050)	226,154			21
22	Employee Benefits & Payroll Taxes			532,510	532,510		532,510		532,510			22
23	Inservice Training & Education											23
24	Travel and Seminar			487	487		487	1,100	1,587			24
25	Other Admin. Staff Transportation			9,013	9,013		9,013	4,418	13,431			25
26	Insurance-Prop.Liab.Malpractice			316,516	316,516		316,516	1,837	318,353			26
27	Other (specify):*							35,662	35,662			27
28	**TOTAL General Administration**	245,120		1,751,804	1,996,924		1,996,924	(453,132)	1,543,792			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,058,210	330,797	2,156,939	5,545,946		5,545,946	(524,373)	5,021,573			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.

Park View Rehab Center
Travel Detail
12/31/2018

Account Number	Date	Employee	Function	Description	
8600.6	12/31/2018	Olivia Carey	Asst. Administrator	Mileage around Chicago area	8,628.08
8600.6	12/31/2018	Various- Facility Employees	A&G	Mileage within Illinois- Facility Errands	385.30
	12/31/2018	Allocated From iCare Consulting			4418
		Total			13,431.38

Facility Name & ID Number Park View Rehab Center #0052092 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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							160,857	160,857			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,086	1,086		1,086	297,199	298,285			32
33	Real Estate Taxes			163,808	163,808		163,808	4,083	167,891			33
34	Rent-Facility & Grounds			825,263	825,263		825,263	(809,442)	15,821			34
35	Rent-Equipment & Vehicles			1,728	1,728		1,728		1,728			35
36	Other (specify):*											36
37	**TOTAL Ownership**			991,885	991,885		991,885	(347,303)	644,582			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		122,860	699,411	822,271		822,271		822,271			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			311,529	311,529		311,529		311,529			42
43	Other (specify):*			18,513	18,513		18,513	(18,513)				43
44	**TOTAL Special Cost Centers**		122,860	1,029,453	1,152,313		1,152,313	(18,513)	1,133,800			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,058,210	453,657	4,178,277	7,690,144		7,690,144	(890,189)	6,799,955			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: 01/01/2018 Ending: 12/31/2018

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	(2,335)	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	160,857	30		9
10	Interest and Other Investment Income	(6,210)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(18)	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	(2,305)	21		18
19	Entertainment				19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(119,680)	21		24
25	Fund Raising, Advertising and Promotional	(1,134)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(10,026)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(88,867)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (70,218)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (70,218)		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: 01/01/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Medicare Sequestration	$ (47,005)	21	1
2	Additional R&M	1,406	06	2
3	Marketing	(1,113)	43	3
4	Bank Charges	(8,970)	21	4
5	Non-Allowable Legal	(3,986)	19	5
6	PAC Dues	(10,280)	20	6
7	Building Co- Professional Fees	(6,184)	19	7
8	Building Co- Misc Expense	(4,944)	21	8
9	Medical Record Income	(20)	10	9
10	Capitalized R&M	(3,850)	06	10
11	Miscellaneous Income	(3,921)	21	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**	(88,867)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(18)	0	1,480	0	532	0	0	0	0	0	0	1,994	2
3	Housekeeping	0	0	2,918	0	0	0	0	0	0	0	0	2,918	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(2,335)	0	1,853	0	0	0	0	0	0	0	0	(482)	5
6	Maintenance	(2,444)	0	2,737	0	(7,826)	0	0	0	0	0	0	(7,533)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,797)	0	8,988	0	(7,294)	0	0	0	0	0	0	(3,103)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(20)	0	0	0	(72,046)	0	0	0	0	0	0	(72,066)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	3,928	0	0	0	0	0	0	3,928	15
16	**TOTAL Health Care and Programs**	(20)	0	0	0	(68,118)	0	0	0	0	0	0	(68,138)	16
	C. General Administration													
17	Administrative	0	0	(452,758)	0	18,044	0	0	0	0	0	0	(434,714)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,170)	6,184	1,140	102	2,935	0	0	0	0	0	0	191	19
20	Fees, Subscriptions & Promotions	(11,914)	0	291	8	39	0	0	0	0	0	0	(11,576)	20
21	Clerical & General Office Expenses	(196,851)	4,944	103,341	0	38,516	0	0	0	0	0	0	(50,050)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	647	0	453	0	0	0	0	0	0	1,100	24
25	Other Admin. Staff Transportation	0	0	0	0	4,418	0	0	0	0	0	0	4,418	25
26	Insurance-Prop.Liab.Malpractice	0	0	549	0	1,288	0	0	0	0	0	0	1,837	26
27	Other (specify):*	0	0	24,927	0	10,735	0	0	0	0	0	0	35,662	27
28	**TOTAL General Administration**	(218,935)	11,128	(321,863)	110	76,428	0	0	0	0	0	0	(453,132)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(223,752)	11,128	(312,875)	110	1,016	0	0	0	0	0	0	(524,373)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park View Rehab Center # 0052092 **Report Period Beginning:** 01/01/2018 **Ending:** 12/31/2018

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	160,857	0	0	0	0	0	0	0	0	0	0	160,857	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,210)	301,566	0	1,843	0	0	0	0	0	0	0	297,199	32
33	Real Estate Taxes	0	0	0	4,083	0	0	0	0	0	0	0	4,083	33
34	Rent-Facility & Grounds	0	(825,263)	23,170	(7,349)	0	0	0	0	0	0	0	(809,442)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	154,647	(523,697)	23,170	(1,423)	0	0	0	0	0	0	0	(347,303)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,113)	0	0	0	(17,400)	0	0	0	0	0	0	(18,513)	43
44	**TOTAL Special Cost Centers**	(1,113)	0	0	0	(17,400)	0	0	0	0	0	0	(18,513)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(70,218)	(512,569)	(289,705)	(1,313)	(16,384)	0	0	0	0	0	0	(890,189)	45

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 Supplemental Schedule		See Supplemental Schedule		See Supplemental Schedule		

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	$ 825,263	Park View Rehab Center Realty	100.00%	$	$ (825,263)	1
2	V	32	Interest Income	2,255	Park View Rehab Center Realty	100.00%		(2,255)	2
3	V	19	Professional Fees		Park View Rehab Center Realty	100.00%	6,184	6,184	3
4	V	32	Interest Expense		Park View Rehab Center Realty	100.00%	303,821	303,821	4
5	V	33	Real Estate Taxes	165,327	Park View Rehab Center Realty	100.00%	165,327		5
6	V	21	Miscellaneous Expense		Park View Rehab Center Realty	100.00%	4,944	4,944	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 992,845			$ 480,276	$ * (512,569)	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: 01/01/2018 Ending: 12/31/2018

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 HC & Financi	Skokie	Consulting Co.	1
2	Shimon Webster	19.84%	Pine Crest Health Care	Hazel Crest	Premier HC Real Esta	Skokie	Building Co.	2
3	Chaim Levovitz	3.91%	River View Rehab Center	Elgin	PV Rehab Realty	Chicago	Building Co.	3
4	Jeffrey Webster	4.84%	Forest City Rehab & Nursing	Rockford	iCare Consulting	Skokie	Consulting Co.	4
5	Mikel Chldren 2012 Trust	6.25%	Rock River Health Care	Rockford				5
6	Howard Wengrow	4.05%	Pearl Pavilion	Freeport				6
7	Jay Wengrow	2.34%	Prairie Oasis	South Holland				7
8	David Wengrow	2.34%	Oak Park Oasis	Oak Park				8
9	Dina Braunstein	2.34%	Austin Oasis	Chicago				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: 01/01/2018 Ending: 12/31/2018

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	02	Food	$	Premier Healthcare & Financial Services Inc	100.00%	$ 1,480	$ 1,480	15
16	V	03	Housekeeping		Premier Healthcare & Financial Services Inc	100.00%	2,918	2,918	16
17	V	05	Utilities		Premier Healthcare & Financial Services Inc	100.00%	1,853	1,853	17
18	V	06	Repairs & Maintenance		Premier Healthcare & Financial Services Inc	100.00%	2,737	2,737	18
19	V	17	Administrative Expenses		Premier Healthcare & Financial Services Inc	100.00%	61,242	61,242	19
20	V	19	Professional Fees		Premier Healthcare & Financial Services Inc	100.00%	1,140	1,140	20
21	V	20	Dues & Subscriptions		Premier Healthcare & Financial Services Inc	100.00%	291	291	21
22	V	21	Clerical & General Salaries		Premier Healthcare & Financial Services Inc	100.00%	97,799	97,799	22
23	V	21	Clerical & General Other Costs		Premier Healthcare & Financial Services Inc	100.00%	5,542	5,542	23
24	V	24	Seminar & Education		Premier Healthcare & Financial Services Inc	100.00%	647	647	24
25	V	26	Insurance		Premier Healthcare & Financial Services Inc	100.00%	549	549	25
26	V	27	Employee Benefits		Premier Healthcare & Financial Services Inc	100.00%	24,927	24,927	26
27	V	34	Rent Expense		Premier Healthcare & Financial Services Inc	100.00%	23,170	23,170	27
28	V	17	Consulting Fees	514,000	Premier Healthcare & Financial Services Inc	100.00%		(514,000)	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			$ 514,000			$ 224,295	$ * (289,705)	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: 01/01/2018 Ending: 12/31/2018

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 Esate	100.00%	$ 102	$ 102	15
16	V	20	Dues & Subscriptions		Premier HC Real Esate	100.00%	8	8	16
17	V	32	Interest Expense		Premier HC Real Esate	100.00%	1,843	1,843	17
18	V	33	Real Estate Taxes		Premier HC Real Esate	100.00%	4,083	4,083	18
19	V	34	Rental Income	7,349	Premier HC Real Esate	100.00%		(7,349)	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			$ 7,349			$ 6,036	$ * (1,313)	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: 01/01/2018 Ending: 12/31/2018

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	02	Food	$	iCare Consulting Services LLC	100.00%	$ 532	$ 532	15
16	V	06	Maint & Plant Operation Salary	18,500	iCare Consulting Services LLC	100.00%	10,674	(7,826)	16
17	V	10	Nursing Salary	103,300	iCare Consulting Services LLC	100.00%	31,254	(72,046)	17
18	V	15	Nursing Benefits/Taxes		iCare Consulting Services LLC	100.00%	3,928	3,928	18
19	V	17	Admin Salary- Non Related		iCare Consulting Services LLC	100.00%	18,044	18,044	19
20	V	19	Professional Fees		iCare Consulting Services LLC	100.00%	2,935	2,935	20
21	V	20	Dues & Subscriptions		iCare Consulting Services LLC	100.00%	39	39	21
22	V	21	A&G Expenses	20,300	iCare Consulting Services LLC	100.00%	2,126	(18,174)	22
23	V	21	A&G Salaries		iCare Consulting Services LLC	100.00%	56,690	56,690	23
24	V	24	Seminars & Education		iCare Consulting Services LLC	100.00%	453	453	24
25	V	25	Auto & Travel		iCare Consulting Services LLC	100.00%	4,418	4,418	25
26	V	26	Insurance		iCare Consulting Services LLC	100.00%	1,288	1,288	26
27	V	27	Employee Benefits/PR Taxes		iCare Consulting Services LLC	100.00%	10,735	10,735	27
28	V	43	Marketing Consultant	17,400	iCare Consulting Services LLC	100.00%		(17,400)	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			$ 159,500			$ 143,116	$ * (16,384)	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: 01/01/2018 Ending: 12/31/2018

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	Member	Administrative	19.84%	See Attached	4.08	10.21%	Alloc. Salary	$ 20,414	17-7	1
2	Yeruchom Levovitz	Member	Administrative	15.92%	See Attached	4.08	10.21%	Alloc. Salary	20,414	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 40,828		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: 01/01/2018 Ending: 2/31/2018

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: 01/01/2018 Ending: 2/31/2018

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 & Financial Services
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	02	Food	Resident Days	427,478	10	$ 14,500	$	43,633	$ 1,480	1
2	03	Housekeeping	Resident Days	427,478	10	28,586		43,633	2,918	2
3	05	Utilities	Resident Days	427,478	10	18,155		43,633	1,853	3
4	06	Repairs & Maintenance	Resident Days	427,478	10	26,817		43,633	2,737	4
5	17	Administrative Expenses	Resident Days	427,478	10	600,000	600,000	43,633	61,242	5
6	19	Professional Fees	Resident Days	427,478	10	11,167		43,633	1,140	6
7	20	Dues & Subscriptions	Resident Days	427,478	10	2,851		43,633	291	7
8	21	Clerical & General Salaries	Resident Days	427,478	10	958,147	958,147	43,633	97,799	8
9	21	Clerical & General Other Costs	Resident Days	427,478	10	54,299		43,633	5,542	9
10	24	Seminar & Education	Resident Days	427,478	10	6,339		43,633	647	10
11	26	Insurance	Resident Days	427,478	10	5,376		43,633	549	11
12	27	Employee Benefits	Resident Days	427,478	10	244,216		43,633	24,927	12
13	34	Rent Expense	Resident Days	427,478	10	227,000		43,633	23,170	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,197,453	$ 1,558,147		$ 224,295	25

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

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
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	Resident Days	427,478	10	$ 1,000	$	43,633	$ 102	1
2	20	Dues & Subscriptions	Resident Days	427,478	10	75		43,633	8	2
3	32	Interest Expense	Resident Days	427,478	10	18,053		43,633	1,843	3
4	33	Real Estate Taxes	Resident Days	427,478	10	40,000		43,633	4,083	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					$ 59,128	$		$ 6,036	25

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

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
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	02	Food	Resident Days	313,091	7	$ 3,818	$	43,633	$ 532	1
2	06	Maint & Plant Operation Salary	Resident Days	313,091	7	76,592	76,576	43,633	10,674	2
3	10	Nursing Salary	Resident Days	313,091	7	224,262	224,262	43,633	31,254	3
4	15	Nursing Benefits/Taxes	Resident Days	313,091	7	28,189		43,633	3,928	4
5	17	Admin Salary- Non Related	Resident Days	313,091	7	129,477	129,477	43,633	18,044	5
6	19	Professional Fees	Resident Days	313,091	7	21,060		43,633	2,935	6
7	20	Dues & Subscriptions	Resident Days	313,091	7	280		43,633	39	7
8	21	A&G Expenses	Resident Days	313,091	7	15,257		43,633	2,126	8
9	21	A&G Salaries	Resident Days	313,091	7	406,781	406,781	43,633	56,690	9
10	24	Seminars & Education	Resident Days	313,091	7	3,253		43,633	453	10
11	25	Auto & Travel	Resident Days	313,091	7	31,703		43,633	4,418	11
12	26	Insurance	Resident Days	313,091	7	9,242		43,633	1,288	12
13	27	Employee Benefits/PR Taxes	Resident Days	313,091	7	77,031		43,633	10,735	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,026,943	$ 837,096		$ 143,116	25

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

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: 01/01/2018 Ending: 12/31/2018

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			$	$ 5,525,725			$ 303,821	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB Financial		X	Line of Credit							1,086	6
7	Allocated From Premier RE		X								1,843	7
8												8
9	TOTAL Facility Related						$	$ 5,525,725			$ 306,750	9
	B. Non-Facility Related*											
10	Interest Income		X								(6,210)	10
11	Interest Income- Bldg Co.		X								(2,255)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (8,465)	14
15	TOTALS (line 9+line14)						$	$ 5,525,725			$ 298,285	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: 01/01/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 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.)	$	167,641	2
3. Under or (over) accrual (line 2 minus line 1).	$	34,004	3
4. Real Estate Tax accrual used for 2018 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.)**	$	250	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.	$	167,891	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	128,430	8
	2014	131,017	9
	2015	140,733	10
	2016	153,822	11
	2017	165,327	12

Allocated From Premier Real Estate $4,083

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.**

2017 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 Joshua S. Banach

TELEPHONE (773) 945-9528 FAX #: (773) 945-9521

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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 Property	$ 165,327.22	$ 165,327.22
2.	10-23-324-047-0000	Home Office Allocation	$ 36,245.26	$ 3,699.58
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 201,572.48	$ 169,026.80

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 01/01/2018 Ending: 12/31/2018

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 RE			1,939	2
3	TOTALS			$ 107,539	3

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 1,469,699	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	22,988		20	1,149	1,149	22,988	9
10	Various			1994	38,610		20	1,931	1,931	38,610	10
11	Various			1995	68,517		20	3,426	3,426	68,517	11
12	Various			1996	107,653		20	5,383	5,383	107,653	12
13	Various			1997	32,071		20	1,604	1,604	32,071	13
14	Various			1998	19,271		20	964	964	19,271	14
15	Various			1999	16,863		20	843	843	16,863	15
16	Various			2000	50,104		20	2,505	2,505	47,602	16
17	Various			2001	9,165		20	458	458	8,247	17
18	Various			2002	38,362		20	1,918	1,918	32,612	18
19	Various			2003	20,009		20	1,000	1,000	16,008	19
20	Various			2004	38,100		20	1,905	1,905	28,581	20
21	Various			2005	127,366		20	6,368	6,368	89,160	21
22	Various			2006	2,900		20	145	145	1,885	22
23	Various			2007	3,348		20	167	167	2,006	23
24	Various			2008	32,480		20	1,624	1,624	17,864	24
25	Various			2009	33,390		20	1,670	1,670	23,419	25
26	Various			2010	17,840		20	892	892	8,028	26
27	Various			2012	32,072		20	1,604	1,604	11,228	27
28	Various			2013	417,287		20	20,864	20,864	116,395	28
29	Various			2014	16,292		20	815	815	5,153	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: 01/01/2018 Ending: 12/31/2018

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									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,023,088	$		$ 105,399	$ 105,399	$ 2,183,861	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: 01/01/2018 Ending: 12/31/2018

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		$ 3,023,088	$		$ 105,399	$ 105,399	$ 2,183,861	1
2	Security Camera	2015	8,313		20	416	416	1,594	2
3	Install New Maxton Valve for Passenger Elevator	2016	3,900		20	195	195	504	3
4	Install New 2 Zone Fujitsu BTGU System	2016	5,450		20	273	273	1,999	4
5	Replace Supply Line Including 2 3 Bulb Valve	2016	3,440		20	172	172	401	5
6	Install Flooring, Carpet, Corner Guards, 2nd/3rd Floor Corner Re	2016	261,797		20	13,090	13,090	28,361	6
7	Doors/Locks/Contacts/Electrical Install 8 Door Key Pads	2017	7,164		20	358	358	1,791	7
8	2nd Floor Dining Room- Upholster Cornice/Sheers/LED Lighting	2017			20			4,492	8
9	-2nd & 3rd Floor Corridor Signage, LED Lights/Cove Bases	2017			20				9
10	-1st/2nd/3rd Floor Resid Room- Roller Shades/Cubicle Curtains	2017			20				10
11	-Repair Shower Room Floors in 6 Rooms/Mens Room	2017			20				11
12	-Plumbing in Utility Room, Cubicle Curtains/Replace leaking Pipe	2017			20				12
13	-Prep & Paint Walls and Trims on 3rd Floor, Acrovyn Sheets	2017			20				13
14	-Kickplates, Chair Rails, Corner Guards/Vanity Lights	2017	155,124		20	7,756	7,756	15,512	14
15	Pump Repair- Water Feeder Replacement	2017	3,837		20	192	192	384	15
16	Main Bathroom-exhaust fan with new curb adaptor/electrical	2018	3,850		20	193	193	193	16
17	Fire Alarm System Modifications	2018	21,475		20	1,074	1,074	1,074	17
18	New Outlets Off the Generator- AC/Heat Units	2018	3,350		20	168	168	168	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)		$ 3,500,788	$		$ 129,284	$ 129,284	$ 2,240,332	34

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

Park View Rehab Center
12/31/2018
Capital Report Reconciliation

During 2018, the 6/30/2017 capital report was finalized.

The following 2017 improvements were included on the final 6/30/2017 capital report

Page	Line	Description	Cost
12B	7	Doors/Locks/Contacts/Electrical Install 8 Door Key Pads	$ 7,164
12B	8-14	2nd Floor Dining Room- Upholster Cornice/Sheers/LED Lighting -2nd & 3rd Floor Corridor Signage, LED Lights/Cove Bases -1st/2nd/3rd Floor Resid Room- Roller Shades/Cubicle Curtains -Repair Shower Room Floors in 6 Rooms/Mens Room -Plumbing in Utility Room, Cubicle Curtains/Replace leaking Pipe -Prep & Paint Walls and Trims on 3rd Floor, Acrovyn Sheets -Kickplates, Chair Rails, Corner Guards/Vanity Lights	$ 155,124
		Total	$ 162,288

The following 2017 improvements were added between 7/1/17-12/31/17

Page	Line	Description	Cost
12B	15	Pump Repair- Water Feeder Replacement	$ 3,837
		Total	$ 3,837
		Total 2017 Improvements	$ 166,125

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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		$ 3,500,788	$		$ 129,284	$ 129,284	$ 2,240,332	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,500,788	$		$ 129,284	$ 129,284	$ 2,240,332	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: 01/01/2018 Ending: 12/31/2018

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		$ 3,500,788	$		$ 129,284	$ 129,284	$ 2,240,332	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,500,788	$		$ 129,284	$ 129,284	$ 2,240,332	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: 01/01/2018 Ending: 12/31/2018

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		$ 3,500,788	$		$ 129,284	$ 129,284	$ 2,240,332	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,500,788	$		$ 129,284	$ 129,284	$ 2,240,332	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: 01/01/2018 Ending: 12/31/2018

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 12E, Carried Forward		$ 3,500,788	$		$ 129,284	$ 129,284	$ 2,240,332	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements- Building Company								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	35,131	18
19	Heritage Nursing Center Inc	2009	4,500		20	225	225	2,250	19
20	Heritage Nursing Center Inc	2010	3,700		20	185	185	1,665	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)		$ 3,819,726	$		$ 132,621	$ 132,621	$ 2,531,564	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: 01/01/2018 Ending: 12/31/2018

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		$ 3,819,726	$		$ 132,621	$ 132,621	$ 2,531,564	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)		$ 3,819,726	$		$ 132,621	$ 132,621	$ 2,531,564	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: 01/01/2018 Ending: 12/31/2018

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 12G, Carried Forward		$ 3,819,726	$		$ 132,621	$ 132,621	$ 2,531,564	1
2	Buildings- Related Parties								2
3	Allocated From Premier Realty	2011	38,012		20	1,086	1,086	8,688	3
4	Allocated From Premier Realty	2012	4,840		20	138	138	968	4
5									5
6									6
7									7
8	Leashold Improvements- Related Parties								8
9	Allocated From Premier Realty	2011	67,607		20	3,380	3,380	27,043	9
10	Allocated From Premier Realty	2012	1,960		20	98	98	686	10
11									11
12									12
13	Allocated From Premier HC & Financial Services	2012	862		20	43	43	302	13
14	Allocated From Premier HC & Financial Services	2016	2,021		20	101	101	303	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)		$ 3,935,028	$		$ 137,467	$ 137,467	$ 2,569,554	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: 01/01/2018 Ending: 12/31/2018

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		$ 3,935,028	$		$ 137,467	$ 137,467	$ 2,569,554	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
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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)		$ 3,935,028	$		$ 137,467	$ 137,467	$ 2,569,554	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: 01/01/2018 Ending: 12/31/2018

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	$ 151,955	$	$ 23,390	$ 23,390		$ 151,448	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	286,862					286,862	73
74								74
75	TOTALS	$ 438,817	$	$ 23,390	$ 23,390		$ 438,310	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)	$ 4,481,384	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)	$ 160,857	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 160,857	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,007,864	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.

Park View Rehab Center
12/31/2018
Moveable Equipment

Prior Year Equipment	Cost	Book Depreicaton	Straight Line Depreciation	Adjustment	Accumulated Depreciation
Park View Rehab Center	122,122		20,406	20,406	114,713
Premier Healthcare & Financial	7,507		751	751	4,924
Premier Real Estate	22,326		2,233	2,233	15,788
Park View Realty			-	-	16,023
Total	151,955	-	23,390	23,390	151,448

Current Year Equipment	Cost	Book Depreicaton	Straight Line Depreciation	Adjustment	Accumulated Depreciation
Park View Rehab Center					
Premier Healthcare & Financial					
Premier Real Estate					
Park View Realty					
Total	-	-	-	-	-

Fully Depreciated Equipment	Cost	Book Depreicaton	Straight Line Depreciation	Adjustment	Accumulated Depreciation
Park View Rehab Center	286,862				286,862
Premier Healthcare & Financial					
Premier Real Estate					
Park View Realty					
Total	286,862	-	-	-	286,862

Total Equipment	Cost	Book Depreicaton	Straight Line Depreciation	Adjustment	Accumulated Depreciation
Park View Rehab Center	408,984	-	20,406	20,406	401,575
Premier Healthcare & Financial	7,507	-	751	751	4,924
Premier Real Estate	22,326	-	2,233	2,233	15,788
Park View Realty	-	-	-	-	16,023
Total	438,817	-	23,390	23,390	438,310

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated From Premier HC				15,821			6
7	TOTAL				$ 15,821 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 1,728 Description: ____
(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	**Park View Rehab Center**
FACILITY NUMBER	**0052092**
REPORT BEGINNING	**01/01/2018**
REPORT ENDING	**12/31/2018**

SUPPLEMENTAL SCHEDULE DETAILING EQUIPMENT RENTAL

EQUIPMENT RENTAL

DESCRIPTION	AMOUNT
COPIER	1,728
TOTAL	1,728

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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.

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		hrs	$		$ 256,037	$		$ 256,037	1
2	Licensed Speech and Language Development Therapist		hrs			134,756			134,756	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			282,988			282,988	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				84,610		84,610	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					25,630	38,250		63,880	13
14	TOTAL			$		$ 699,411	$ 122,860		$ 822,272	14

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

FACILITY NAME	**Park View Rehab Center**
FACILITY NUMBER	**0052092**
REPORT BEGINNING	**01/01/2018**
REPORT ENDING	**12/31/2018**

SUPPLEMENTAL SCHEDULE DETAILING SPECIAL SERVICES

SUPPLIES- SPECIAL SERVICES (PAGE 16, LINE 13, COLUMN 6)

DESCRIPTION	AMOUNT
OXYGEN SUPPLY	583
NURSING SUPPLIES	34,191
GLOVES	3,476
	-
	-
	-
	-
	-
	-
	-
	38,250

OTHER- SPECIAL SERVICES (PAGE 16, LINE 13, COLUMN 5)

DESCRIPTION	AMOUNT
G TUBE	10,422
RESIDENT EXPENSE	1,525
X-RAYS	2,674
LABORATORY	11,009
	-
	-
	-
	-
	-
	-
	25,630

SALARIES- SPECIAL SERVICES (PAGE 16, LINE 13, COLUMN 3)

DESCRIPTION	AMOUNT
	-
	-
	-
	-
	-
	-
	-
	-

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2018 (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	$ 271,340	$ 324,757	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,589,421	1,589,421	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	67,009	67,009	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	90,812	166,503	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,018,583	$ 2,147,691	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	994,037	994,037	15
16	Equipment, at Historical Cost	66,800	514,800	16
17	Accumulated Depreciation (book methods)	(284,057)	(1,693,443)	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	25,000	74,679	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 801,781	$ 5,290,021	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,820,363	$ 7,437,712	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 342,276	$ 342,276	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	268,899	268,899	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,671	8,671	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	13,634	13,634	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 633,480	$ 767,117	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		2,659,756	39
40	Mortgage Payable		5,525,725	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	4,031	4,031	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,031	$ 8,189,512	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 637,511	$ 8,956,629	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,182,852	$ (1,518,917)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,820,363	$ 7,437,712	48

***(See instructions.)**

FACILITY NAME	**Park View Rehab Center**
FACILITY NUMBER	**0052092**
REPORT BEGINNING	**01/01/2018**
REPORT ENDING	**12/31/2018**

SUPPLEMENTAL SCHEDULE DETAILING OTHER ASSETS AND LIABILITIES

OTHER CURRENT ASSETS (PAGE 17, LINE 09)

DESCRIPTION	AMOUNT	CONSOLIDATED AMOUNT
DUE FROM COST REPORT	49,503	49,503
DUE TO MEDICAID	41,310	41,310
MORTGAGE ESCROW		75,691
	90,812	166,503

OTHER CURRENT LIABILITIES (PAGE 17, LINE 36)

DESCRIPTION	AMOUNT	CONSOLIDATED AMOUNT
DUE FROM PRIOR OWNER	70	70
ACCRUED BED TAX	13,564	13,564
	13,634	13,634

OTHER NON-CURRENT ASSETS (PAGE 17, LINE 23)

DESCRIPTION	AMOUNT	CONSOLIDATED AMOUNT
DUE FROM OTHERS	25,000	25,000
LOAN COSTS		106,455
A/A LOAN COSTS		(56,776)
	25,000	74,679

OTHER NON-CURRENT LIABILITIES (PAGE 17, LINE 43)

DESCRIPTION	AMOUNT	CONSOLIDATED AMOUNT
DUE TO AFFILIATES	4,031	4,031
	4,031	4,031

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,057,882	1
2	Restatements (describe):		2
3	2017 Bad Debt Expense & Rate Adjustments	(92,910)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,964,972	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	685,413	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	(467,533)	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)**	$ 217,880	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)**	$ 2,182,852	24 *

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 8,144,370	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,144,370	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,210	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,210	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Attached	224,977	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 224,977	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,375,557	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,099,754	31
32	Health Care	2,449,268	32
33	General Administration	1,996,924	33
	B. Capital Expense		
34	Ownership	991,885	34
	C. Ancillary Expense		
35	Special Cost Centers	840,784	35
36	Provider Participation Fee	311,529	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,690,144	40
41	**Income before Income Taxes (line 30 minus line 40)****	685,413	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 685,413	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,690,270	44
45	Private Pay - Net Inpatient Revenue	56,399	45
46	Medicare - Net Inpatient Revenue	2,284,331	46
47	Other-(specify) Hospice	79,951	47
48	Other-(specify) Commercial	33,419	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,144,370	49

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

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

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

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

FACILITY NAME	**Park View Rehab Center**
FACILITY NUMBER	**0052092**
REPORT BEGINNING	**01/01/2018**
REPORT ENDING	**12/31/2018**

SUPPLEMENTAL SCHEDULE DETAILING OTHER INCOME

OTHER INCOME (PAGE 19, LINE 28)

DESCRIPTION	AMOUNT
MEDICAID W/O CO-INSURANCE	221,035
MISCELLANEOUS INCOME (ADJ PG 5A)	3,922
MEDICAL RECORDS INCOME (ADJ PG 5A)	20
TOTAL	224,977

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,936	2,082	$ 89,708	$ 43.09	1
2	Assistant Director of Nursing	1,920	2,080	84,007	40.39	2
3	Registered Nurses	8,136	9,071	298,542	32.91	3
4	Licensed Practical Nurses	23,660	25,341	693,631	27.37	4
5	CNAs & Orderlies	52,760	56,948	782,831	13.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,680	1,942	32,925	16.95	8
9	Activity Director	1,904	2,078	43,058	20.72	9
10	Activity Assistants	5,568	6,027	70,548	11.71	10
11	Social Service Workers	8,254	8,833	167,674	18.98	11
12	Dietician					12
13	Food Service Supervisor	1,832	2,072	39,502	19.06	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,015	14,951	187,005	12.51	15
16	Dishwashers					16
17	Maintenance Workers	5,821	6,332	99,308	15.68	17
18	Housekeepers	9,924	11,188	142,885	12.77	18
19	Laundry	4,245	4,891	58,131	11.89	19
20	Administrator	1,964	2,080	101,500	48.80	20
21	Assistant Administrator	1,872	2,080	86,312	41.50	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,784	5,196	57,308	11.03	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	1,885	2,038	23,334	11.45	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached					33
34	TOTAL (lines 1 - 33)	152,160	165,230	$ 3,058,210 *	$ 18.51	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	152	$ 8,330	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant	Monthly	1,600	10-03	37
38	Nurse Consultant	Monthly	103,300	10-03	38
39	Pharmacist Consultant	Monthly	7,280	10-03	39
40	Physical Therapy Consultant			10A-03	40
41	Occupational Therapy Consultant			10A-03	41
42	Respiratory Therapy Consultant			10A-03	42
43	Speech Therapy Consultant			10A-03	43
44	Activity Consultant	49	2,472	11-03	44
45	Social Service Consultant	45	2,645	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	246	$ 143,627		49

C. CONTRACT NURSES

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
David Zaruba	Administrator	0.00%	$ 101,500
Olivia Carey	Asst. Admin	0.00%	86,312
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 187,812

B. Administrative - Other

Description	Amount
Consulting Fees- Premier HC & Financial Services	$ 514,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 514,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 16,183
Marcum	Accounting	15,893
Prospect Resources	Energy Consulting	1,300
Reliable Health Systems	Data Processing	12,540
Point Click Care	Data Processing	23,860
Streamline HR	HR Consulting	182
Creative Tech	IT Support	7,828
Zirmed	Data Processing- Claims	575
Experian	HR Consulting Software	127
OnShift	HR Consulting	11,052
Ability	Data Processing- Claims	1,767
See Supplemental Schedule		12,293
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 103,601

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 102,417
Unemployment Compensation Insurance	16,568
FICA Taxes	221,701
Employee Health Insurance	150,014
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	24,252
Other Employee Expense	15,470
Holiday Expense	2,088
TOTAL (agree to Schedule V, line 22, col.8)	$ 532,510

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	19,875
Health Care Worker Background Check	2,482
(Indicate # of checks performed 248)	
Patient Background Checks	
Dues	10,281
Licenses & Fees	7,981
Allocated From Premier HC & Financial	291
Allocated From Premier RE	8
Allocated From iCare Consulting	39
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 44,937

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	487
Allocated From Premier HC & Financial	647
Allocated From iCare Consulting	453
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,587

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

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

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
EON Applications	HR Mgmt Consulting	$ 382
Survey Monkey	Survey System	5
Assurance Agency	Safety Consulting	5,500
Skidelsky & Associates	RE Tax Appeal	250
2401 Inc	Architeture- Fire Safety	4,480
Mowery & Schoenfeld	Accounting	1,507
Aatrix	Electronic Forms Consulting	52
Coordinated Benefits	Compliance Consulting	117
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 12,293

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$

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	
Health Care Worker Background Check	
(Indicate # of checks performed ___)	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Park View Rehab Center
Detail of Legal Expense
12/31/2018

GL Account	Date	Vendor	Description of Service	Amount	Adjustment	Allowable
8380.6	5/1/2018	Much Shelist	Ongoing Counseling- Resident Matters	78.00		78.00
8380.6	6/1/2018	Much Shelist	Ongoing Counseling- Resident Matters	156.00		156.00
8380.6	9/24/2018	Much Shelist	Annual Report Maint Fee	500.00	(500.00)	-
8380.6	7/10/2018	Field & Goldberg	Loan Modification	636.00	(636.00)	-
8380.6	5/10/2017	Neal Gerber & Eisenberg	Prior Period Legal Services	65.40	(65.40)	-
8380.6	6/16/2017	Neal Gerber & Eisenberg	Prior Period Legal Services	81.75	(81.75)	-
8380.6	11/13/2017	Neal Gerber & Eisenberg	Prior Period Legal Services	196.20	(196.20)	-
8380.6	12/19/2017	Neal Gerber & Eisenberg	Prior Period Legal Services	45.23	(45.23)	-
8380.6	7/30/2018	Neal Gerber & Eisenberg	Employment Matters	17.25		17.25
8380.6	8/21/2017	Meyer Magence	Prior Period Legal Services	375.00	(375.00)	-
8380.6	7/23/2018	Meyer Magence	General Counseling	150.00		150.00
8380.6	6/26/2018	Meyer Magence	General Counseling	225.00		225.00
8380.6	11/14/2018	Ashman & Stein	Litigations	1,386.00		1,386.00
8380.6	2/21/2018	SB2	Monthly PA Review	550.00		550.00
8380.6	3/23/2018	SB2	Prior Period Services	1,577.78	(1,577.78)	-
8380.6	3/12/2018	SB2	Monthly PA Review	192.36		192.36
8380.6	3/21/2018	SB2	Monthly PA Review	506.25		506.25
8380.6	4/12/2018	SB2	Monthly PA Review	187.50		187.50
8380.6	7/31/2018	Polsinelli	Managed Care Contracts	3,821.96	(508.32)	3,313.64
8380.6	10/31/2018	Polsinelli	Managed Care Contracts	1,207.60		1,207.60
8360.6	12/31/2018	Additional Legal Expense	General Counseling	4,227.95		4,227.95
				16,183.23	(3,985.68)	12,197.55

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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- $20,561**

(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. $ **8,527** 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 11/1/1992

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **311,529**
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%**
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