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: 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 1/1/2018 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)
(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: 1/1/2018 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 _____

	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			2,922	2,922	8
9	SNF/PED					9
10	ICF	11,162	823		11,985	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,162	823	2,922	14,907	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.08%

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 2,463

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: 12/31/18 Fiscal Year: 12/31/18

* 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: 1/1/2018 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	142,064	4,451	4,708	151,223		151,223		151,223			1
2	Food Purchase		89,326		89,326		89,326		89,326			2
3	Housekeeping	67,325	19,643		86,968		86,968		86,968			3
4	Laundry	24,320	22		24,342		24,342		24,342			4
5	Heat and Other Utilities			66,394	66,394		66,394	230	66,624			5
6	Maintenance	53,783		36,750	90,533		90,533	5,869	96,402			6
7	Other (specify):* Waste Removal			5,598	5,598		5,598		5,598			7
8	**TOTAL General Services**	287,492	113,442	113,450	514,384		514,384	6,099	520,483			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,089,857	130,986	102,608	1,323,451		1,323,451	18,461	1,341,912			10
10a	Therapy		830	15,047	15,877		15,877	(647)	15,230			10a
11	Activities	26,056		330	26,386		26,386		26,386			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation			6,709	6,709		6,709		6,709			14
15	Other (specify):* Mgmt Co Benefits Alloc							3,967	3,967			15
16	**TOTAL Health Care and Programs**	1,115,913	131,816	136,694	1,384,423		1,384,423	21,781	1,406,204			16
	C. General Administration											
17	Administrative	105,466		192,440	297,906		297,906	(176,588)	121,318			17
18	Directors Fees											18
19	Professional Services			116,359	116,359		116,359	28,673	145,032			19
20	Dues, Fees, Subscriptions & Promotions			22,247	22,247		22,247	2,507	24,754			20
21	Clerical & General Office Expenses	82,290	12,192	91,253	185,735		185,735	44,182	229,917			21
22	Employee Benefits & Payroll Taxes			160,079	160,079		160,079		160,079			22
23	Inservice Training & Education											23
24	Travel and Seminar			117	117		117	20	137			24
25	Other Admin. Staff Transportation			6,692	6,692		6,692	537	7,229			25
26	Insurance-Prop.Liab.Malpractice			53,342	53,342		53,342	671	54,013			26
27	Other (specify):* Mgmt Co Benefits Alloc							12,353	12,353			27
28	**TOTAL General Administration**	187,756	12,192	642,529	842,477		842,477	(87,645)	754,832			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,591,161	257,450	892,673	2,741,284		2,741,284	(59,765)	2,681,519			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: 1/1/2018 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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			41,272	41,272		41,272	77,938	119,210			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			62,169	62,169		62,169	523,936	586,105			32
33	Real Estate Taxes							218,807	218,807			33
34	Rent-Facility & Grounds			759,321	759,321		759,321	(753,419)	5,902			34
35	Rent-Equipment & Vehicles			50,020	50,020		50,020	2,024	52,044			35
36	Other (specify):*											36
37	**TOTAL Ownership**			912,782	912,782		912,782	69,286	982,068			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		97,788	384,928	482,716		482,716	(79,992)	402,724			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,136	82,136		82,136		82,136			42
43	Other (specify):* **Disallowed Costs**		4,492	1,294,538	1,299,030		1,299,030	(1,299,030)				43
44	**TOTAL Special Cost Centers**		102,280	1,761,602	1,863,882		1,863,882	(1,379,022)	484,860			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,591,161	359,730	3,567,057	5,517,948		5,517,948	(1,369,501)	4,148,447			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: 1/1/2018 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	(2,216)	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	91,203	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(15,523)	43		18
19	Entertainment				19
20	Contributions	(324)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,015)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,554,332)	43		24
25	Fund Raising, Advertising and Promotional	(2,214)	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	(49,656)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,534,077)		$	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)	164,576		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 164,576		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,369,501)		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: 1/1/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Expense	(8,257)	43	1
2	Prior Year Contribution Accrual Reversal	14,100	43	2
3	Disallow Amortization Expense	(61,322)	36	3
4	Expense Repairs under $2,500	5,823	6	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(49,656)		49

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2018 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 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%	$ 24,380	$ 24,380	1
2	V	30	Depreciation		Pershing Gardens Realty, LLC	100.00%	(14,918)	(14,918)	2
3	V	32	Interest	1,475	Pershing Gardens Realty, LLC	100.00%	522,559	521,084	3
4	V	33	Real Estate Tax Expense		Pershing Gardens Realty, LLC	100.00%	218,807	218,807	4
5	V	34	Rent-Facility & Grounds	759,321	Pershing Gardens Realty, LLC	100.00%		(759,321)	5
6	V	36	Amortization		Pershing Gardens Realty, LLC	100.00%	61,322	61,322	6
7	V	43	Nonallowable Expenses		Pershing Gardens Realty, LLC	100.00%	269,736	269,736	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 760,796			$ 1,081,886	$ * 321,090	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: 1/1/2018 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	5	Heat and Other Utilities	$	Premier Healthcare Management, LLC	100.00%	$ 230	$ 230	15
16	V	6	Maintenance		Premier Healthcare Management, LLC	100.00%	46	46	16
17	V	10	Nursing and Medical Records		Premier Healthcare Management, LLC	100.00%	18,461	18,461	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%	3,967	3,967	19
20	V	15	Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	100.00%	0		20
21	V	17	Administrative	192,440	Premier Healthcare Management, LLC	100.00%	9,814	(182,626)	21
22	V	17	Administrative		Premier Healthcare Management, LLC	100.00%	6,038	6,038	22
23	V	19	Professional Services		Premier Healthcare Management, LLC	100.00%	2,459	2,459	23
24	V	20	Dues, Fees, Subs & Promo		Premier Healthcare Management, LLC	100.00%	207	207	24
25	V	21	Clerical & Gen Office Expenses		Premier Healthcare Management, LLC	100.00%	43,877	43,877	25
26	V	24	Travel and Seminar		Premier Healthcare Management, LLC	100.00%	20	20	26
27	V	25	Other Admin. Staff Trans		Premier Healthcare Management, LLC	100.00%	216	216	27
28	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	11,056	11,056	28
29	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	1,297	1,297	29
30	V	34	Rent-Facility & Grounds		Premier Healthcare Management, LLC	100.00%	5,902	5,902	30
31	V	35	Equipment Rental		Premier Healthcare Management, LLC	100.00%	2,024	2,024	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 192,440			$ 105,614	$ * (86,826)	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: 1/1/2018 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	10A	Therapy	$ 647	REX Therapeutics	100.00%	$	$ (647)	15
16	V	19	Professional Services		REX Therapeutics	100.00%	2,849	2,849	16
17	V	20	Fees and Subscriptions		REX Therapeutics	100.00%	2,300	2,300	17
18	V	21	Clerical & General Office Exp		REX Therapeutics	100.00%	305	305	18
19	V	25	Other Admin Staff Transp		REX Therapeutics	100.00%	321	321	19
20	V	26	Insurance-Prop.Liab.Malp		REX Therapeutics	100.00%	671	671	20
21	V	30	Depreciation		REX Therapeutics	100.00%	1,653	1,653	21
22	V	32	Interest Expense		REX Therapeutics	100.00%	2,852	2,852	22
23	V	39	Therapy Consultant		REX Therapeutics	100.00%	3,459	3,459	23
24	V	39	Therapy Management Wages		REX Therapeutics	100.00%	11,416	11,416	24
25	V								25
26	V								26
27	V	39	Therapy Wages		REX Therapeutics	100.00%	230,359	230,359	27
28	V	39	Contract Therapy	380,528	REX Therapeutics	100.00%	28,469	(352,059)	28
29	V	39	Allocated Employee Benefits		REX Therapeutics	100.00%	26,833	26,833	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			$ 381,175			$ 311,487	$ * (69,688)	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: 1/1/2018 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	Barak Baver	0.5	Gilman Healthcare Center	Gilman	Premier Healthcare	Skokie	Management Co.	1
2	David Cheplowitz	0.5	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			Premier Healthcare of New Harmony, LLC	New Harmony, IN				11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2018 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	David Cheplowitz	Shareholder	Administrative	0.50	See Att Sch 7A	1.68	4.20	Alloc Salary	$ 227	17-7	1
2	Barak Baver	Shareholder	Administrative	0.50	See Att Sch 7A	1.68	4.20	Alloc Salary	227	17-7	2
3	Sara Baver	Relative	Clerical	0	See Att Sch 7A	1.68	4.20	Alloc Salary	1,852	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	$ 2,306		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2018 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 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	355,708	12	$ 5,481	$	14,907	$ 230	1
2	6	Maintenance	Census Days	355,708	12	1,104		14,907	46	2
3	10	Nursing and Medical Records	Illinois Census Days	299,107	7	370,422	370,422	14,907	18,461	3
4	10	Nursing and Medical Records	Indiana Census Days	56,601	5	115,384	115,384		0	4
5	15	Emp Benefit Alloc-Healthcare	Illinois Census Days	299,107	7	79,596		14,907	3,967	5
6	15	Emp Benefit Alloc-Healthcare	Indiana Census Days	56,601	5	24,794			0	6
7	17	Administrative	Census Days	355,708	12	234,180	234,180	14,907	9,814	7
8	17	Administrative	Illinois Census Days	299,107	7	121,153	121,153	14,907	6,038	8
9	19	Professional Services	Census Days	355,708	12	58,680		14,907	2,459	9
10	20	Dues, Fees, Subs & Promo	Census Days	355,708	12	4,939		14,907	207	10
11	21	Clerical & Gen Office Expenses	Census Days	355,708	12	1,047,000	993,525	14,907	43,877	11
12	24	Travel and Seminar	Census Days	355,708	12	481		14,907	20	12
13	25	Other Admin. Staff Trans	Census Days	355,708	12	5,164		14,907	216	13
14	27	Emp Benefit Alloc-Gen Admin	Census Days	355,708	12	263,809		14,907	11,056	14
15	27	Emp Benefit Alloc-Gen Admin	Illinois Census Days	299,107	7	26,033		14,907	1,297	15
16	34	Rent-Facility & Grounds	Census Days	355,708	12	140,839		14,907	5,902	16
17	35	Equipment Rental	Census Days	355,708	12	48,305		14,907	2,024	17
18								14,907		18
19								14,907		19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,547,364	$ 1,834,664		$ 105,614	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2018 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: 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	7,935,857	9	$ 59,273	$	381,269	$ 2,849	1
2	20	Fees and Subscriptions	Therapy Revenue	7,935,857	9	47,896		381,269	2,300	2
3	21	Clerical & General Office Exp	Therapy Revenue	7,935,857	9	6,340		381,269	305	3
4	25	Other Admin Staff Transp	Therapy Revenue	7,935,857	9	6,672		381,269	321	4
5	26	Insurance-Prop.Liab.Malp	Therapy Revenue	7,935,857	9	13,964		381,269	671	5
6	30	Depreciation	Therapy Revenue	7,935,857	9	34,399		381,269	1,653	6
7	32	Interest Expense	Therapy Revenue	7,935,857	9	59,365		381,269	2,852	7
8	39	Therapy Consultant	Therapy Revenue	7,935,857	9	72,000		381,269	3,459	8
9	39	Therapy Management Wages	Therapy Revenue	7,935,857	9	237,615	237,615	381,269	11,416	9
10								381,269		10
11										11
12	39	Therapy Wages	Direct Allocation	5,139,566	9	5,139,566	5,139,566	230,359	230,359	12
13	39	Contract Therapy	Direct Allocation	528,258	4	528,258		28,469	28,469	13
14	39	Allocated Employee Benefits	Total Wages	5,377,181	9	596,271		241,775	26,833	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,801,619	$ 5,377,181		$ 311,487	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2018 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	Bank Leumi		X	Mortgage		7/12/2016	5,000,000	4,516,667	7/12/2021	variable	522,559	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank Leumi		X	Line of Credit		8/1/2016		716,940	8/1/2017	variable	59,587	6
7												7
8												8
9	TOTAL Facility Related						$ 5,000,000	$ 5,233,607			$ 582,146	9
	B. Non-Facility Related*											
10												10
11								Allocated from REX Therapeutics			2,852	11
12								Offset Interest Income			(1,475)	12
13								Other Interest Expense			2,582	13
14	TOTAL Non-Facility Related						$	$			$ 3,959	14
15	TOTALS (line 9+line14)						$ 5,000,000	$ 5,233,607			$ 586,105	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: 1/1/2018 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.**		$ 191,001	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.)	2017	$	2
3. Under or (over) accrual (line 2 minus line 1).		$ (191,001)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 409,808	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 $ 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.		$ 218,807	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2013	74,020	8
2014	104,257	9
2015	107,279	10
2016	110,790	11
2017	133,925	12

Accrual based on prior year tax bill.

	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.

SEE ACCOUNTANTS' PREPARATION REPORT

2017 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 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.	19-06-103-035-0000	Long Term Care Property	$ 96,965.31	$ 96,965.31
2.	19-06-103-034-0000	Long Term Care Property	$ 36,959.69	$ 36,959.69
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 133,925.00	$ 133,925.00

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 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 Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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: 1/1/2018 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	51		2012	1964	$ 1,220,815	$	35	$ 34,880	$ 34,880	$ 197,319	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	23,729	9
10	Fire Protection Coverage-ISt & 2Nd Floor Dining Rooms			2012	4,560		20	228	228	1,596	10
11	Removal Of Underground Storage Tank			2012	4,036		20	202	202	1,413	11
12	Installation Of Wander System And Cables			2012	5,721		20	286	286	2,002	12
13	New Signage			2012	9,858		20	493	493	3,451	13
14	Replace A/C System On Second Floor			2012	3,000		20	150	150	1,050	14
15	Fire Alarm Installation			2012	3,200		20	160	160	1,120	15
16	A: 1St Floor Day Room- New Blinds And Custom Fireplace			2012	3,857		20	193	193	1,350	16
17	B: Porch- Demolish Existing Porches And Build New Stairs Railings And			2012	9,904		20	495	495	3,466	17
18	C: Lobby- New Custom Baseboard Heaters			2012	3,792		20	190	190	1,328	18
19	D: 1St Floor Day Room-Structural Wood Repair; Replace Ceiling; New D			2012	28,689		20	1,434	1,434	10,040	19
20	E: Lobby-New Flooring;Ceiling; Lighting;Wallcoverings;Window Treatm			2012	19,878		20	994	994	6,958	20
21	F: Basement Corridor-New Flooring; Signage; Lighting			2012	6,453		20	323	323	2,260	21
22	G: Therapy Room-New Flooring;Wall Partitions; Lighting; Electrical; Do			2012	54,039		20	2,702	2,702	18,914	22
23	H: 1St Floor Corridor-Removal Of Old Cove Base; New Flooring;Wall Ba			2012	30,741		20	1,537	1,537	10,759	23
24	I: 2Nd Floor Corridor- New Flooring; Removal Of Old Cove Base; New W			2012	35,164		20	1,758	1,758	12,307	24
25	J: New Elevator			2012	8,123		20	406	406	2,843	25
26	K: 2Nd Floor Day Room- Replace Ceiling; Millwork Base; Window Treat			2012	18,891		20	945	945	6,613	26
27	L: Resident Rooms- New Flooring; Paint Walls; Lighting; Cubicle Curtai			2012	82,484		20	4,124	4,124	29,720	27
28	M: Various Areas-New Wooden Handrails And Bumper Gaurds; Painting			2012	65,457		20	3,273	3,273	22,910	28
29	New Fire Alarm Panel Analog Notifier			2012	4,950		20	248	248	1,734	29
30	Various Bathroom Remodels: Remove & Replace Tub,Toilet,Sink, New Fl			2012	48,310		20	2,416	2,416	12,079	30
31	New Wiring And Motor For Kitchen Exhaust Fan			2013	2,837		20	142	142	852	31
32	New Outlets For Window A/C Units			2013	2,900		20	145	145	810	32
33	New Generator, New 400 Amp Main Service			2013	141,085		20	7,054	7,054	38,210	33
34	Additional Work On Exterior Remodel: Demo Existing, New Concrete, De			2013	16,903		20	845	845	4,507	34
35	Fire Alarm Installation Charge			2013	9,423		20	471	471	2,355	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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2018 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	Install Door Automator To Front Entry	2013	5,575		20	279	$ 279	$ 1,394	37
38	Various Areas: Light Fixtures;Floor & Wall Tile;	2013	$ 24,566	$	20	$ 1,228	1,228	6,141	38
39	Main Entrance Exterior Remodel: Demolish Entire Old Exterior-	2013	59,204		20	2,960	2,960	14,800	39
40	Fire System	2014	3,103		20	155	155	775	40
41	Tuckpoint Wall Where Overhang From Roof Was Removed	2014	5,800		20	290	290	1,450	41
42	Hot Water Tank Wiring	2014	3,125		20	156	156	781	42
43	Champion Roofing	2014	2,850		20	143	143	714	43
44	Install Wire Panelboard In Boiler Room	2014	7,000		20	350	350	1,750	44
45	Elevator Wiring & Shunt Trip Breaker	2014	19,000		20	950	950	4,750	45
46	Champion Roofing	2014	3,248		20	162	162	811	46
47	New Elevator	2014	2,500		20	125	125	625	47
48	Elevator Modernization	2014	125,000		20	6,250	6,250	31,250	48
49	Install Fire Alarm System In Basement Elevator Room	2014	10,548		20	527	527	1,581	49
50	Repaired 2 Lower Level Circuits, 1 Battery Pack, And 2 Fluoresce	2015	7,675		20	384	384	1,536	50
51	Rewired Kitchen With Two 20 Amp 120 Volt Circuits	2015	4,750		20	238	238	952	51
52	Replace Kitchen Door and Drywall in Dining Rm Ceiling	2017	4,125		20	206	206	309	52
53	Install New Circuit and Feeder in Laundry Room	2017	4,215		20	211	211	316	53
54	Replace Condenser Unit on Walk-In-Freezer	2018	4,739		20	118	118	118	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	1,399		20	70	70	363	64
65									65
66	Allocated from REX Therapeutics					1,653	1,653		66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,211,285	$		$ 85,939	$ 85,939	$ 492,111	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: 1/1/2018 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	$ 332,708	$	$ 33,271	$ 33,271	10	$ 193,460	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 332,708	$	$ 33,271	$ 33,271		$ 193,460	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)	$ 2,558,779	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)	$ 119,210	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 119,210	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 685,571	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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.				5,902			5
6								6
7	TOTAL				$ 5,902 **			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: $ 50,020 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17				$	17
18					18
19	Allocated from Management Co			2,024	19
20					20
21	TOTAL		$	$ 2,024	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: **12/31/2018**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Nursing Equipment	46,116
Dietary Equipment	3,264
Office Equipment	640
Total - Line 16	**50,020**

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2018 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.

SEE ACCOUNTANTS' PREPARATION REPORT

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)	2901 hrs	$ 104,099		$ 12,258	$	2,901	$ 116,357	1
2	Licensed Speech and Language Development Therapist	39(7)	522 hrs	18,749		2,208		522	20,957	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 39 (7)	3314 hrs	118,927		14,003	830	3,314	133,760	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				97,788		97,788	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab/Xray	39(3)				4,400			4,400	12
13	Other (specify):									13
14	TOTAL			$ 241,775		$ 32,869	$ 98,618	6,737	$ 373,262	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

STATE OF ILLINOIS

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2018 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	$ 2,954	$ 2,954	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,026,259)	1,205,890	1,205,890	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	65,127	65,127	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,273,971	$ 1,273,971	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	1,106,441	2,211,285	15
16	Equipment, at Historical Cost	282,423	332,708	16
17	Accumulated Depreciation (book methods)	(874,193)	(685,571)	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		376,643	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 514,671	$ 2,249,851	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,788,642	$ 3,523,822	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 825,774	$ 1,479,582	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	716,940	716,940	29
30	Accrued Salaries Payable	122,580	122,580	30
31	Accrued Taxes Payable (excluding real estate taxes)	307,929	307,929	31
32	Accrued Real Estate Taxes(Sch.IX-B)		409,808	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	86,131	86,131	36
37	Due to Related Parties	2,832,619	2,047,626	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,891,973	$ 5,170,596	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,516,667	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)**	$	$ 4,516,667	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,891,973	$ 9,687,263	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,103,331)	$ (6,163,441)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,788,642	$ 3,523,822	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name: **Pershing Gardens HC Center**
IDPH License ID Number: **0051854**
Fiscal Year End: **12/31/2018**

Schedule 17A

XV. Balance Sheet

Line 23 Other Assets (specify):

Description	Operating	After Consolidation
Loan Costs		70,036
Intangibles		306,607
Total - Line 23	**-**	**376,643**

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Accrued MDS Tax	5,293	5,293
Accrued Expenses	50,955	50,955
Accrued Bed Tax	7,038	7,038
Payroll Withholdings	96	96
Security Deposits	22,749	22,749
Total - Line 36	**86,131**	**86,131**

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,855,967)	1
2	Restatements (describe):		2
3	**Post closing adjustments -Bad Debt Reversals**	478,825	3
4	**Post closing adjustments -Depreciation Expense**	(146,342)	4
5	**Post closing adjustments -Misc Expense Corrections**	(20,438)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,543,922)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,559,409)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,559,409)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,103,331)	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: 1/1/2018 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	$ 3,221,399	1
2	Discounts and Allowances for all Levels	472,151	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,693,550	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	155,662	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 155,662	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	(893)	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	486	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ (407)	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Misc Income - Prior Year Accrued Exp Corrections**	109,734	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 109,734	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,958,539	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	514,384	31
32	Health Care	1,384,423	32
33	General Administration	842,477	33
	B. Capital Expense		
34	Ownership	912,782	34
	C. Ancillary Expense		
35	Special Cost Centers	1,781,746	35
36	Provider Participation Fee	82,136	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,517,948	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,559,409)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,559,409)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,868,431	44
45	Private Pay - Net Inpatient Revenue	140,870	45
46	Medicare - Net Inpatient Revenue	1,482,371	46
47	Other-(specify) **Insurance**	163,304	47
48	Other-(specify) **Hospice**	38,574	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,693,550	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: 1/1/2018 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	2,326	2,562	$ 92,412	$ 36.07	1
2	Assistant Director of Nursing	1,209	1,244	41,395	33.28	2
3	Registered Nurses	6,838	7,074	219,332	31.01	3
4	Licensed Practical Nurses	10,600	10,943	296,007	27.05	4
5	CNAs & Orderlies	30,195	31,600	397,946	12.59	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,968	2,047	26,056	12.73	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,984	2,016	37,214	18.46	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,980	8,371	104,850	12.53	15
16	Dishwashers					16
17	Maintenance Workers	3,537	3,601	53,783	14.94	17
18	Housekeepers	6,198	6,478	67,325	10.39	18
19	Laundry	2,159	2,221	24,320	10.95	19
20	Administrator	2,168	2,200	105,466	47.94	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,944	5,105	82,290	16.12	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) Care Plan Coord	1,217	1,306	42,765	32.75	33
34	TOTAL (lines 1 - 33)	83,323	86,768	$ 1,591,161 *	$ 18.34	34

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	$ 4,708	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	9,830	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				45
46	Other(specify) Rehab Mgmt	Monthly	14,400	L10a, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 40,938		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	242	$ 14,693	L10, C3	50
51	Licensed Practical Nurses	1,564	78,085	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,806	$ 92,778		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Richard Taylor	Administrator	0	$ 55,000
Michael Jacobson	Administrator	0	50,466
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 105,466

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 192,440
TOTAL (agree to Schedule V, line 17, col. 3)	$ 192,440
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 14,346
CohnReznick LLP	Accounting	16,640
David Hyams	Accounting	336
Focus	Accounting	2,081
Plante & Moran	Accounting	1,125
Richard Peelo & Associates, Inc	Accounting	2,800
Templin Healthcare Accounting Servi	Accounting	2,650
GCHMO	Managed Care Contracting Serv	10,150
M & M Financial	Financial Consultant	500
MGKappy Consulting Inc.	Financial Services Consultant	16,500
Resolute Healthcare Solutions	Healthcare Billing	11,828
See Attached Schedule 21A		37,403
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 116,359

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,891
Unemployment Compensation Insurance	(23,522)
FICA Taxes	120,492
Employee Health Insurance	28,791
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	3,069
Physical Exams	1,358
TOTAL (agree to Schedule V, line 22, col.8)	$ 160,079

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	11,486
Health Care Worker Background Check	
(Indicate # of checks performed)	(256)
Patient Background Checks 105	1,053
Dues & Subscriptions	4,279
Licenses & Permits	1,705
Aoocated from REX Therapeutics	2,300
Allocated from Management Co.	207
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,754

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	117
Allocated from Management Co.	20
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 137

* 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: **12/31/2018**

Schedule 21A

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
Sharon Lofgren	Medicare Billing	3,600
Terrill Consulting Services, Inc.	Billing Consultant	5,891
Ability Network Inc	Data Processing	1,108
Casamba	Data Processing	1,325
eSolutions Inc	Data Processing	188
HDSI	Data Processing	3,500
Matrixcare	Data Processing	10,984
Paycor	Payroll Processing	10,185
Quickbooks	Accounting Software	503
Sedgwick CMS	Claims Management	333
Singer Networks, LLC	Data Processing	3,071
TaxSaver Plan	Benefits Administration	159
Adjust Prior Year Accruals	Miscellaneous	(3,444)
Total		**37,403**

Facility Name & ID Number Pershing Gardens HC Center # 0051854 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(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? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **324** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **82,136**
This amount is to be recorded on line 42 of Schedule V.

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

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

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

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

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