		FOR BHF USE					

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: Steven N. Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/20 to 12/31/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) (Date)
* *Subject to the attached Accountants' Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	46,848	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	46,848	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			4,636	4,636	8
9	SNF/PED					9
10	ICF	36,929	404	342	37,675	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,929	404	4,978	42,311	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.32%

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 11/29/1982

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/29/1982 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 4,636

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: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	288,653	46,616	9,478	344,747		344,747		344,747			1
2	Food Purchase		246,329		246,329		246,329	(23)	246,306			2
3	Housekeeping	286,604	79,207		365,811		365,811	3,253	369,064			3
4	Laundry	77,881	8,725		86,606		86,606		86,606			4
5	Heat and Other Utilities			139,953	139,953		139,953	137	140,090			5
6	Maintenance	65,187		81,008	146,195		146,195	(9,352)	136,843			6
7	Other (specify):*							1,550	1,550			7
8	TOTAL General Services	718,325	380,877	230,439	1,329,641		1,329,641	(4,435)	1,325,206			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,329,800	208,975	180,701	2,719,476		2,719,476	(77,683)	2,641,793			10
10a	Therapy	31,759			31,759		31,759		31,759			10a
11	Activities	133,798	7,058	1,193	142,049		142,049		142,049			11
12	Social Services	170,445		3,190	173,635		173,635		173,635			12
13	CNA Training											13
14	Program Transportation			700	700		700		700			14
15	Other (specify):*							3,855	3,855			15
16	TOTAL Health Care and Programs	2,665,802	216,033	203,784	3,085,619		3,085,619	(73,828)	3,011,791			16
	C. General Administration											
17	Administrative	186,107		211,733	397,840		397,840	(129,515)	268,325			17
18	Directors Fees											18
19	Professional Services			519,221	519,221	(1,356)	517,865	(426,990)	90,875			19
20	Dues, Fees, Subscriptions & Promotions			44,752	44,752		44,752	(12,606)	32,146			20
21	Clerical & General Office Expenses	97,685		419,277	516,962		516,962	(190,692)	326,270			21
22	Employee Benefits & Payroll Taxes			562,505	562,505		562,505		562,505			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,851	2,851		2,851	718	3,569			24
25	Other Admin. Staff Transportation			1,092	1,092		1,092	3,230	4,322			25
26	Insurance-Prop.Liab.Malpractice			290,273	290,273		290,273	3,135	293,408			26
27	Other (specify):*							41,466	41,466			27
28	TOTAL General Administration	283,792		2,051,704	2,335,496	(1,356)	2,334,140	(711,254)	1,622,886			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,667,919	596,910	2,485,927	6,750,756	(1,356)	6,749,400	(789,517)	5,959,883			29

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

Facility Name & ID Number Park View Rehab Center #0052092 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			30,425	30,425		30,425	90,942	121,367			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,723	3,723		3,723	223,051	226,774			32
33	Real Estate Taxes					1,356	1,356	169,650	171,005			33
34	Rent-Facility & Grounds			984,920	984,920		984,920	(984,920)				34
35	Rent-Equipment & Vehicles			1,552	1,552		1,552		1,552			35
36	Other (specify):*							76,419	76,419			36
37	**TOTAL Ownership**			1,020,620	1,020,620	1,356	1,021,976	(424,859)	597,117			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		90,592	660,015	750,607		750,607		750,607			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			299,068	299,068		299,068		299,068			42
43	Other (specify):*			15,480	15,480		15,480	(15,480)	0			43
44	**TOTAL Special Cost Centers**		90,592	974,563	1,065,155		1,065,155	(15,480)	1,049,675			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,667,919	687,502	4,481,110	8,836,531		8,836,531	(1,229,856)	7,606,675			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: 01/01/20 Ending: 12/31/20

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,963)	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	90,942	30		9
10	Interest and Other Investment Income	(20,887)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(23)	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	(883)	21		18
19	Entertainment				19
20	Contributions	(997)	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	(231,370)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(15,703)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(283,685)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (464,569)		$	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)	(765,286)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (765,286)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,229,855)		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: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sequestration Expense	$ (75,260)	21	1
2	Bank Charges	(19,502)	21	2
3	Marketing Expense	(2,280)	43	3
4	Miscellaneous Income	(3,817)	21	4
5	Building Co. - Professional Fees	(3,870)	19	5
6	Building Co. - License	(77)	20	6
7	Building Co. - Bank Fees	(1,558)	21	7
8	Building Co. - Closing Costs	(136,796)	21	8
9	Capitalized R&M	(4,429)	06	9
10	PAC Dues	(11,745)	20	10
11	Misellenous Expense - Prior Period	(14,741)	21	11
12	Non-Allowable Legal	(9,612)	19	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**	(283,685)		49

Detail lines 29 and 35 of Page 5 starting in C12. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 5B**

Park View Rehab Center

IDF 0052092

Report Period Beginning: 01/01/20

Ending: 12/31/20

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

Reference 1 Reference 2 Reference 3 Reference 4 Reference 5 Reference 6 Reference 7 Reference 9 Reference 10 Reference 10a Reference 11 Reference 12 Reference 13 Reference 14 Reference 15 Reference 17 Reference 18 Reference 19 Reference 20 Reference 21 Reference 22 Reference 23 Reference 24 Reference 25 Reference 26 Reference 27 Reference 30 Reference 31 Reference 32 Reference 33 Reference 34 Reference 35 Reference 36 Reference 38 Reference 39 Reference 40 Reference 41 Reference 42 Reference 43

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/20 Ending: 12/31/20

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													1
2	Food Purchase	(23)											(23)	2
3	Housekeeping			3,253									3,253	3
4	Laundry													4
5	Heat and Other Utilities	(1,963)		2,100									137	5
6	Maintenance	(4,429)		2,381		(7,304)							(9,352)	6
7	Other (specify):*					1,550							1,550	7
8	**TOTAL General Services**	(6,415)		7,734		(5,754)							(4,435)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records					(77,683)							(77,683)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					3,855							3,855	15
16	**TOTAL Health Care and Programs**					(73,828)							(73,828)	16
	C. General Administration													
17	Administrative			(150,460)		20,945							(129,515)	17
18	Directors Fees													18
19	Professional Services	(13,482)	3,870	(420,197)	1,262	1,556							(426,990)	19
20	Fees, Subscriptions & Promotions	(12,818)	77	87		48							(12,606)	20
21	Clerical & General Office Expenses	(499,630)	138,354	137,835		32,750							(190,692)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			619		99							718	24
25	Other Admin. Staff Transportation					3,230							3,230	25
26	Insurance-Prop.Liab.Malpractice			1,339		1,796							3,135	26
27	Other (specify):*			32,304		9,162							41,466	27
28	**TOTAL General Administration**	(525,930)	142,301	(398,474)	1,262	69,586							(711,254)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(532,345)	142,301	(390,740)	1,262	(9,996)							(789,517)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park View Rehab Center # 0052092 **Report Period Beginning:** 01/01/20 **Ending:** 12/31/20

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	90,942											90,942	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(20,887)	237,683	5	1,801		4,449						223,051	32
33	Real Estate Taxes		161,504		2,073		6,072						169,650	33
34	Rent-Facility & Grounds		(984,920)	23,697	(10,264)		(13,432)						(984,920)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*		76,419										76,419	36
37	**TOTAL Ownership**	70,055	(509,314)	23,701	(6,390)		(2,911)						(424,859)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(2,280)				(13,200)							(15,480)	43
44	**TOTAL Special Cost Centers**	(2,280)				(13,200)							(15,480)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(464,569)	(367,013)	(367,038)	(5,127)	(23,196)	(2,911)						(1,229,856)	45

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 984,920	Park View Rehab Center Realty		$	$ (984,920)	1
2	V	36	MIP		Park View Rehab Center Realty		76,419	76,419	2
3	V	19	Professional Fees		Park View Rehab Center Realty		3,870	3,870	3
4	V	20	Licenses		Park View Rehab Center Realty		77	77	4
5	V	21	Bank Fees		Park View Rehab Center Realty		1,558	1,558	5
6	V	32	Interest Expense		Park View Rehab Center Realty		237,683	237,683	6
7	V	33	Real Estate Taxes		Park View Rehab Center Realty		161,504	161,504	7
8	V	21	Closing Costs		Park View Rehab Center Realty		136,796	136,796	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 984,920			$ 617,907	$ * (367,013)	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: 01/01/20 Ending: 12/31/20

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 & Financial	Skokie	Consulting Co.	1
2	Shimon Webster	19.84%	Pine Crest Health Care	Hazel Crest	Premier HC Real Estate	Skokie	Building Co.	2
3	Chaim Levovitz	3.91%	River View Rehab Center	Elgin	Park View Rehab Center 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	iCare Health Services Inc	Burlington, VT	Insurance	5
6	Howard Wengrow	4.05%	Prairie Oasis	South Holland	8131 Monticello Realty	Skokie	Building Co.	6
7	Jay Wengrow	2.34%	Oak Park Oasis	Oak Park				7
8	David Wengrow	2.34%	Austin Oasis	Chicago				8
9	Dina Braunstein	2.34%						9
10	GPN Family Trust	14.25%						10
11	Menachem Shabat	3.56%						11
12	Ahuva Shabat	3.56%						12
13	Eliana Shabat	3.56%						13
14	Ayelet Shabat	3.56%						14
15	Moshe Levovitz	1.56%						15
16	Yakov Kohen	1.56%						16
17	Sharon Hinkle	1.56%						17
18	Ari Shabat	2.50%						18
19	Shoshana R. Shabat	2.50%						19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	3	HOUSEKEEPING	$	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		$ 3,253	$ 3,253	15
16	V	5	UTILITIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		2,100	2,100	16
17	V	6	REPAIRS AND MAINTENANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		2,381	2,381	17
18	V	17	ADMINISTRATIVE SALARIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		61,273	61,273	18
19	V	19	PROFESSIONAL FEES	423,467	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		3,270	(420,197)	19
20	V	20	DUES FEES SUBSCRIPTIONS		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		87	87	20
21	V	21	CLERICAL AND GENERAL		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		7,719	7,719	21
22	V	21	CLERICAL & GENERAL SALARIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		130,115	130,115	22
23	V	24	SEMINARS & EDUCATION		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		619	619	23
24	V	26	INSURANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		1,339	1,339	24
25	V	27	EMPLOYEE BEN. GEN ADMIN.		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		32,304	32,304	25
26	V	32	INTEREST		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		5	5	26
27	V	34	RENT		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.		23,697	23,697	27
28	V	17	CONSULTING FEES	211,733	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.			(211,733)	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			$ 635,200			$ 268,162	$ * (367,038)	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: 01/01/20 Ending: 12/31/20

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			$			$	$	15
16	V	19	PROFESSIONAL FEES		PREMIER HEALTHCARE REALTY, LLC		1,262	1,262	16
17	V	20	LICENSES & PERMITS		PREMIER HEALTHCARE REALTY, LLC				17
18	V	30	DEPRECIATION		PREMIER HEALTHCARE REALTY, LLC				18
19	V	32	INTEREST EXPENSE		PREMIER HEALTHCARE REALTY, LLC		1,801	1,801	19
20	V	33	REAL ESTATE TAXES		PREMIER HEALTHCARE REALTY, LLC		2,073	2,073	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	10,264	PREMIER HEALTHCARE REALTY, LLC			(10,264)	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			$ 10,264			$ 5,137	$ * (5,127)	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: 01/01/20 Ending: 12/31/20

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	6	REPAIRS AND MAINTENANCE	$ 20,400	ICARE CONSULTING SERVICES LLC		$ 13,096	$ (7,304)	15
16	V	7	R&M EMPLOYEE BENEFITS		ICARE CONSULTING SERVICES LLC		1,550	1,550	16
17	V	10	NURSING SALARIES	108,000	ICARE CONSULTING SERVICES LLC		30,317	(77,683)	17
18	V	15	EMPLOYEE BEN. HC PROGRAMS		ICARE CONSULTING SERVICES LLC		3,855	3,855	18
19	V	17	ADMINISTRATIVE WAGES		ICARE CONSULTING SERVICES LLC		20,945	20,945	19
20	V	19	PROFESSIONAL FEES		ICARE CONSULTING SERVICES LLC		1,556	1,556	20
21	V	20	DUES FEES SUBSCRIPTIONS		ICARE CONSULTING SERVICES LLC		48	48	21
22	V	21	CLERICAL AND GENERAL	25,500	ICARE CONSULTING SERVICES LLC		1,892	(23,608)	22
23	V	21	CLERICAL & GENERAL WAGES		ICARE CONSULTING SERVICES LLC		56,358	56,358	23
24	V	24	SEMINARS & EDUCATION		ICARE CONSULTING SERVICES LLC		99	99	24
25	V	25	AUTO EXPENSE		ICARE CONSULTING SERVICES LLC		3,230	3,230	25
26	V	26	INSURANCE		ICARE CONSULTING SERVICES LLC		1,796	1,796	26
27	V	27	EMPLOYEE BEN. GEN ADMIN.		ICARE CONSULTING SERVICES LLC		9,162	9,162	27
28	V								28
29	V	43	MARKETING CONSULTANT	13,200	ICARE CONSULTING SERVICES LLC			(13,200)	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			$ 167,100			$ 143,904	$ * (23,196)	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: 01/01/20 Ending: 12/31/20

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			$			$	$	15
16	V	19	PROFESSIONAL FEES		8131 MONTICELLO REALTY, LLC				16
17	V	20	LICENSES & PERMITS		8131 MONTICELLO REALTY, LLC				17
18	V	30	DEPRECIATION		8131 MONTICELLO REALTY, LLC				18
19	V	32	INTEREST EXPENSE		8131 MONTICELLO REALTY, LLC		4,449	4,449	19
20	V	33	REAL ESTATE TAXES		8131 MONTICELLO REALTY, LLC		6,072	6,072	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	13,432	8131 MONTICELLO REALTY, LLC			(13,432)	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			$ 13,432			$ 10,521	$ * (2,911)	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: 01/01/20 Ending: 12/31/20

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	26	INSURANCE	$ 267,790	ICARE HEALTH SERVICES INCORPORATED CELL		$ 267,790	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 267,790			$ 267,790	$ *	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: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	4.72	11.80%	Alloc. Salary	$ 16,429	17-7	1
2	Yeruchom Levovitz	Member	Administrative	15.92%	See Attached	4.72	11.80%	Alloc. Salary	15,349	17-7	2
3	Sharon Hinkle	Member	Administrative	1.56%	See Attached	1.80	4.50%	Alloc. Salary	10,627	17-7	3
4	Sharon Hinkle	Member	Nursing	1.56%	See Attached	1.80	4.50%	Alloc. Salary	10,627	10-7	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	$ 53,032		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: 01/01/20 Ending: 12/31/20

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: 01/01/20 Ending: 12/31/20

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 & FIN. SVCS, INC.
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	3	HOUSEKEEPING	PATIENT DAYS	358,626	8	$ 27,572	$	42,311	$ 3,253	1
2	5	UTILITIES	PATIENT DAYS	358,626	8	17,798		42,311	2,100	2
3	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	358,626	8	20,184		42,311	2,381	3
4	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	358,626	8	519,346	519,346	42,311	61,273	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	358,626	8	27,719		42,311	3,270	5
6	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	358,626	8	738		42,311	87	6
7	21	CLERICAL AND GENERAL	PATIENT DAYS	358,626	8	65,429	1,102,850	42,311	7,719	7
8	21	CLERICAL & GENERAL SALA	PATIENT DAYS	358,626	8	1,102,850		42,311	130,115	8
9	24	SEMINARS & EDUCATION	PATIENT DAYS	358,626	8	5,249		42,311	619	9
10	26	INSURANCE	PATIENT DAYS	358,626	8	11,347		42,311	1,339	10
11	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	358,626	8	273,803		42,311	32,304	11
12	32	INTEREST	PATIENT DAYS	358,626	8	39		42,311	5	12
13	34	RENT	PATIENT DAYS	358,626	8	200,851		42,311	23,697	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					$ 2,272,926	$ 1,622,196		$ 268,162	25

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 REALTY, LLC
Street Address: 8153 LAWNDALE
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((773) 945-1000
Fax Number: ((773) 945-6107

	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	19	PROFESSIONAL FEES	PATIENT DAYS	358,626	8	10,700		42,311	1,262	2
3	20	LICENSES & PERMITS	PATIENT DAYS	358,626	8			42,311		3
4	30	DEPRECIATION	PATIENT DAYS	358,626	8			42,311		4
5	32	INTEREST EXPENSE	PATIENT DAYS	358,626	8	15,267		42,311	1,801	5
6	33	REAL ESTATE TAXES	PATIENT DAYS	358,626	8	17,574		42,311	2,073	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					$ 43,541	$		$ 5,137	25

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: ICARE CONSULTING SERVICES LLC
Street Address: 8131 MONTICELLO
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (773) 945-1000
Fax Number: (773) 945-6107

	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	6	REPAIRS AND MAINTENANCE	CONSULTING FEES	1,730,000	8	$ 145,610	$ 145,409	155,600	$ 13,096	1
2	7	R&M EMPLOYEE BENEFITS	CONSULTING FEES	1,730,000	8	17,235		155,600	1,550	2
3	10	NURSING SALARIES	CONSULTING FEES	1,730,000	8	337,071	337,071	155,600	30,317	3
4	15	EMPLOYEE BEN. HC PROGRA	CONSULTING FEES	1,730,000	8	42,861		155,600	3,855	4
5	17	ADMINISTRATIVE WAGES	CONSULTING FEES	1,730,000	8	232,870	232,870	155,600	20,945	5
6	19	PROFESSIONAL FEES	CONSULTING FEES	1,730,000	8	17,301		155,600	1,556	6
7	20	DUES FEES SUBSCRIPTIONS	CONSULTING FEES	1,730,000	8	538		155,600	48	7
8	21	CLERICAL AND GENERAL	CONSULTING FEES	1,730,000	8	21,035		155,600	1,892	8
9	21	CLERICAL & GENERAL WAGE	CONSULTING FEES	1,730,000	8	626,600	626,600	155,600	56,358	9
10	24	SEMINARS & EDUCATION	CONSULTING FEES	1,730,000	8	1,099		155,600	99	10
11	25	AUTO EXPENSE	CONSULTING FEES	1,730,000	8	35,917		155,600	3,230	11
12	26	INSURANCE	CONSULTING FEES	1,730,000	8	19,965		155,600	1,796	12
13	27	EMPLOYEE BEN. GEN ADMIN.	CONSULTING FEES	1,730,000	8	101,871		155,600	9,162	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					$ 1,599,973	$ 1,341,950		$ 143,904	25

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/20 Ending: 12/31/20

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: 8131 MONTICELLO REALTY, LLC
Street Address: 8131 MONTICELLO
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((773) 945-1000
Fax Number: ((773) 945-6107

	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	19	PROFESSIONAL FEES	PATIENT DAYS	358,626	8			42,311		2
3	20	LICENSES & PERMITS	PATIENT DAYS	358,626	8			42,311		3
4	30	DEPRECIATION	PATIENT DAYS	358,626	8			42,311		4
5	32	INTEREST EXPENSE	PATIENT DAYS	358,626	8	37,708		42,311	4,449	5
6	33	REAL ESTATE TAXES	PATIENT DAYS	358,626	8	51,468		42,311	6,072	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 89,176	$		$ 10,521	25

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 HEALTH SERVICES INCORP. CELL
Street Address: 30 MAIN STREET, SUITE 330
City / State / Zip Code: BURLINGTON, VERMONT 05401
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	26	INSURANCE	DIRECT ALLOCATION			$	$		$ 267,790	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					$	$		$ 267,790	25

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/20 Ending: 12/31/20

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: 01/01/20 Ending: 12/31/20

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: 01/01/20 Ending: 12/31/20

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: 01/01/20 Ending: 12/31/20

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: 01/01/20 Ending: 12/31/20

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 Payable			$	$ 7,627,482			$ 237,683	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB Financial		X	Line of Credit							3,723	6
7	Allocated from Premier HC		X								5	7
8	See Supplemental Schedule										6,250	8
9	TOTAL Facility Related						$	$ 7,627,482			$ 247,661	9
	B. Non-Facility Related*											
10	Interest Income		X								(20,887)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (20,887)	14
15	TOTALS (line 9+line14)						$	$ 7,627,482			$ 226,774	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 76,419 Line # 36

* 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: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 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.)		$ 169,649	2
3. Under or (over) accrual (line 2 minus line 1).		$ 36,012	3
4. Real Estate Tax accrual used for 2020 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.)		$ 1,356	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.		$ 171,005	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	140,733	8
	2016	153,822	9
	2017	165,327	10
	2018	158,788	11
	2019	161,504	12

2020 Accrual = 2019 Accrual
Allocated from Premier HC Realty - $2,073
Allocated from 8131 Monticello Realty - $6,072

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 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 Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(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	$ 161,503.67	$ 161,503.67
2.	10-23-324-047-0000	Allocated from Premier RE	$ 34,381.62	$ 4,056.37
3.	10-23-325-045-0000	Allocated from 8131 Monticello RE	$ 51,467.63	$ 6,072.19
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 247,352.92	$ 171,632.23

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2019 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 Steven Lavenda

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	See attached allocations		see attached	7,935	2
3	TOTALS			$ 113,535	3

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 1,566,027	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	22,988		20			22,988	9
10	Various			1994	38,610		20			38,610	10
11	Various			1995	68,517		20			68,517	11
12	Various			1996	107,653		20			107,653	12
13	Various			1997	32,071		20			32,071	13
14	Various			1998	19,271		20			19,271	14
15	Various			1999	16,863		20	2	2	16,863	15
16	Various			2000	50,104		20	2,484	2,484	50,087	16
17	Various			2001	9,165		20	458	458	8,705	17
18	Various			2002	38,362		20	1,919	1,919	34,532	18
19	Various			2003	20,009		20	1,000	1,000	17,008	19
20	Various			2004	38,100		20	1,906	1,906	30,488	20
21	Various			2005	127,366		20	6,369	6,369	95,530	21
22	Various			2006	2,900		20	145	145	2,030	22
23	Various			2007	3,348		20	167	167	2,173	23
24	Various			2008	32,480		20	1,624	1,624	19,488	24
25	Various			2009	33,390		20	(12,154)	(12,154)	12,012	25
26	Various			2010	17,840		20	892	892	8,920	26
27	Various			2012	32,072		20	1,604	1,604	12,832	27
28	Various			2013	417,287		20	20,714	20,714	157,924	28
29	Various			2014	16,299		20	815	815	5,264	29
30	Various			2015	8,313		20	416	416	2,425	30
31	Various			2016	274,587		20	13,730	13,730	60,359	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: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		318,938					297,909	67
68	Related Party Allocations (Pages 12H & 12I)		230,048			8,367	8,367	52,011	68
69	Financial Statement Depreciation			30,425			(30,425)		69
70	TOTAL (lines 4 thru 69)		$ 3,854,981	$ 30,425		$ 98,622	$ 68,197	$ 2,741,697	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: 01/01/20 Ending: 12/31/20

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		$ 3,854,981	$ 30,425		$ 98,622	$ 68,197	$ 2,741,697	1
2	Doors/Locks/Contacts/Electrical Install 8 Door Key Pads	2017	7,164		20	358	358	1,433	2
3	Pump Repair - Water Feeder Replacement	2017	3,837		20	192	192	768	3
4	2Nd Floor Dining Room -Upholster Cornice/Sheers/Led Lighting,I	2017	155,124		20	7,756	7,756	27,793	4
5	Fire Alarm System Modifications	2018	21,475		20	1,074	1,074	2,685	5
6	New Outlets Off The Generator - Ac/Heat Units	2018	3,350		20	168	168	377	6
7	Main Bathroom-Exhaust Fan With New Curb Adaptor/Electical	2018	3,850		20	193	193	386	7
8	Walk-In Freezer Compressor Repair	2019	4,450		20	223	223	316	8
9	Sewer Repairs - Backfill C7 Gravel, Paving, & Cleaning	2019	27,082		20	1,354	1,354	1,805	9
10	Bathroom Leak Repairs	2019	2,547		20	127	127	169	10
11	6 Air Conditioners	2019	3,894		20	195	195	390	11
12	Elevator Car #1 Repair - Install New Selector	2020	4,250		20	213	213	213	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)		$ 4,092,004	$ 30,425		$ 110,475	$ 80,050	$ 2,778,031	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: 01/01/20 Ending: 12/31/20

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		$ 4,092,004	$ 30,425		$ 110,475	$ 80,050	$ 2,778,031	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,092,004	$ 30,425		$ 110,475	$ 80,050	$ 2,778,031	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: 01/01/20 Ending: 12/31/20

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		$ 4,092,004	$ 30,425		$ 110,475	$ 80,050	$ 2,778,031	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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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)		$ 4,092,004	$ 30,425		$ 110,475	$ 80,050	$ 2,778,031	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: 01/01/20 Ending: 12/31/20

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		$ 4,092,004	$ 30,425		$ 110,475	$ 80,050	$ 2,778,031	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,092,004	$ 30,425		$ 110,475	$ 80,050	$ 2,778,031	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: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Heritage Nursing Center Inc	1978	4,510		20			4,510	9
10	Heritage Nursing Center Inc	1981	78,925		20			78,925	10
11	Heritage Nursing Center Inc	1983	6,069		20			6,069	11
12	Heritage Nursing Center Inc	1985	8,483		20			8,483	12
13	Heritage Nursing Center Inc	1986	5,000		20			5,000	13
14	Heritage Nursing Center Inc	1987	2,250		20			2,250	14
15	Heritage Nursing Center Inc	1990	4,919		20			4,919	15
16	Heritage Nursing Center Inc	1991	118,564		20			118,564	16
17	Heritage Nursing Center Inc	1992	23,467		20			23,467	17
18	Heritage Nursing Center Inc	2007	58,551		20			40,987	18
19	Heritage Nursing Center Inc	2009	4,500		20			2,700	19
20	Heritage Nursing Center Inc	2010	3,700		20			2,035	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 318,938	$		$	$	$ 297,909	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: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 318,938	$		$	$	$ 297,909	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)		$ 318,938	$		$	$	$ 297,909	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: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated Premiere Healthcare Realty, LLC	2011	43,937		20	1,255	1,255	11,401	3
4	Allocated Premiere Healthcare Realty, LLC	2012	5,594		20	160	160	1,439	4
5	Allocated from 8131 N. Monticello	2019	96,774		20	2,765	2,765	5,530	5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	Allocated from Premier HC & Financial Services	2012	997		20	50	50	449	10
11	Allocated from Premier HC & Financial Services	2016	2,336		20	117	117	584	11
12									12
13	Allocated Premiere Healthcare Realty, LLC	2011	78,145		20	3,907	3,907	31,588	13
14	Allocated Premiere Healthcare Realty, LLC	2012	2,265		20	113	113	1,019	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)		$ 230,048	$		$ 8,367	$ 8,367	$ 52,011	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: 01/01/20 Ending: 12/31/20

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		$ 230,048	$		$ 8,367	$ 8,367	$ 52,011	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 230,048	$		$ 8,367	$ 8,367	$ 52,011	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: 01/01/20 Ending: 12/31/20

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	$ 71,242	$	$ 7,127	$ 7,127	10	$ 43,649	71
72	Current Year Purchases	37,652		3,765	3,765	10	3,765	72
73	Fully Depreciated Assets	383,611				10	383,611	73
74								74
75	TOTALS	$ 492,505	$	$ 10,892	$ 10,892		$ 431,025	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)	$ 4,698,043	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 30,425	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 121,367	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 90,942	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,209,056	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/20 Ending: 12/31/20

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								6
7	TOTAL				$ **			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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 1,552 Description: See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 247,980	$		$ 247,980	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			130,516			130,516	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			274,085			274,085	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				83,284		83,284	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					7,434	7,308		14,742	13
14	TOTAL			$		$ 660,015	$ 90,592		$ 750,607	14

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/20 (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	$ 3,434,753	$ 3,511,399	1
2	Cash-Patient Deposits	19,771	19,771	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	684,348	684,348	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	377,501	377,501	6
7	Other Prepaid Expenses	29,631	29,631	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	56,983	57,316	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,602,987	$ 4,679,966	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	1,034,016	1,034,016	15
16	Equipment, at Historical Cost	99,660	547,660	16
17	Accumulated Depreciation (book methods)	(460,399)	(2,513,417)	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	182,339	422,184	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 855,616	$ 4,890,391	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,458,603	$ 9,570,357	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 323,137	$ 323,135	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	265,583	265,583	30
31	Accrued Taxes Payable (excluding real estate taxes)	163,129	163,129	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	1,191,708	3,521,609	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,943,557	$ 4,407,093	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,627,482	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)**	$	$ 7,627,482	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,943,557	$ 12,034,575	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,515,046	$ (2,464,218)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,458,603	$ 9,570,357	48

*(See instructions.)

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,860,923	1
2	Restatements (describe):		2
3	Bad Debt Expense	(12,424)	3
4	Sequestration Expense	(5,173)	4
5	State Replacement Tax	398	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,843,724	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,671,322	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)**	$ 1,671,322	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)**	$ 3,515,046	24 *

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

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 8,747,400	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,747,400	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	425,177	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 425,177	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***	20,887	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 20,887	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	1,314,389	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,314,389	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,507,853	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,329,641	31
32	Health Care	3,085,619	32
33	General Administration	2,335,496	33
	B. Capital Expense		
34	Ownership	1,020,620	34
	C. Ancillary Expense		
35	Special Cost Centers	766,087	35
36	Provider Participation Fee	299,068	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,836,531	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,671,322	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,671,322	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,751,446	44
45	Private Pay - Net Inpatient Revenue	77,110	45
46	Medicare - Net Inpatient Revenue	2,861,021	46
47	Other-(specify) Insurance	9,100	47
48	Other-(specify) Hospice	48,723	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,747,400	49

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,889	2,053	$ 101,713	$ 49.54	1
2	Assistant Director of Nursing	1,866	2,027	91,515	45.15	2
3	Registered Nurses	14,083	15,299	497,532	32.52	3
4	Licensed Practical Nurses	22,934	24,914	672,480	26.99	4
5	CNAs & Orderlies	61,461	66,768	936,594	14.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,136	1,234	31,759	25.74	8
9	Activity Director	2,050	2,227	42,376	19.03	9
10	Activity Assistants	6,280	6,822	91,422	13.40	10
11	Social Service Workers	6,612	7,182	170,445	23.73	11
12	Dietician					12
13	Food Service Supervisor	2,157	2,343	49,257	21.02	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,092	17,482	239,396	13.69	15
16	Dishwashers					16
17	Maintenance Workers	2,684	2,916	65,187	22.35	17
18	Housekeepers	19,290	20,956	286,604	13.68	18
19	Laundry	5,167	5,613	77,881	13.88	19
20	Administrator	1,662	1,805	92,675	51.34	20
21	Assistant Administrator	2,153	2,339	93,432	39.95	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,114	6,641	97,685	14.71	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	1,986	2,158	29,966	13.89	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	175,616	190,779	$ 3,667,919 *	$ 19.23	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	172	$ 9,478	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant	Monthly	1,200	10-03	37
38	Nurse Consultant	Monthly	169,391	10-03	38
39	Pharmacist Consultant	Monthly	10,110	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,193	11-03	44
45	Social Service Consultant	54	3,190	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	250	$ 212,562		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Olivia Carey	Assistant Admin	0	$ 93,432
David Zaruba	Administrator	0	24,961
Tina Davis	Administrator	0	67,714
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 186,107

B. Administrative - Other

Description	Amount
Consulting Fees - Premier HC & Financial Services	$ 211,733
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 211,733

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 18,700
Premier Healthcare	Bookkeeping Fees	423,467
Point Click Care	Data Processing	22,523
Reliable Health Care	Data Processing	11,895
Creative Technologies	IT Support	12,069
EON Applications	Computer Services	1,955
Ability Network	Medicare Billing	1,917
OnShift	HR Consulting	11,052
Zirmed	Data Processing	640
Prospect Resources	Energy Consulting	1,300
See Attached	Legal	12,503
See Supplemental Schedule		1,200
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 519,221

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 64,099
Unemployment Compensation Insurance	14,273
FICA Taxes	280,596
Employee Health Insurance	162,960
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	30,692
Employee Expenses	7,914
Xmas Expense	1,971
TOTAL (agree to Schedule V, line 22, col.8)	$ 562,506

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	10,841
Health Care Worker Background Check	
(Indicate # of checks performed 200)	2,001
Patient Background Checks	
Dues IL Council	11,745
Licenses & Fees	3,444
See Supplemental Schedule	135
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,146

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,851
See Supplemental Schedule	718
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,569

**See instructions.

Facility Name & ID Number Park View Rehab Center # 0052092 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 - $23,489**

(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. $ **9,953** 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 **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. $ **299,068**
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? **N/A** Indicate the amount. $

(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? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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