FOR BHF USE

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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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0050880

Facility Name: PARKER NURSING & REHAB CTR

Address: 516 WEST FRENCH ST (Number) STREATOR (City) 61364 (Zip Code)

County: LASALLE

Telephone Number: (708)449-1900 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: 5/1/98

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: Alan Sorscher **Telephone Number:** (708)449-1900
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/14 to 12/31/14 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) alan Sorscher
(Title) CFO

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number PARKER NURSING & REHAB CTR # 0050880 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	102	Skilled (SNF)	102	37,230	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	102	TOTALS	102	37,230	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	14,200	1,325	2,979	18,504	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,200	1,325	2,979	18,504	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 49.70%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
n/a

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 5/1/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/1/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 102 and days of care provided 2,698

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: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number PARKER NURSING & REHAB CTR # 0050880 Report Period Beginning: 1/1/14 Ending: 12/31/14

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	164,752	16,108	4,912	185,772		185,772	461	186,233			1
2	Food Purchase		108,640		108,640		108,640		108,640			2
3	Housekeeping	81,619	13,825		95,444		95,444		95,444			3
4	Laundry	17,288	9,670		26,958		26,958		26,958			4
5	Heat and Other Utilities			94,301	94,301		94,301	444	94,745			5
6	Maintenance	32,518	17,260	17,979	67,757		67,757	429	68,186			6
7	Other (specify):*											7
8	TOTAL General Services	296,177	165,503	117,192	578,872		578,872	1,334	580,206			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	974,368	109,532	6,267	1,090,167		1,090,167	21,498	1,111,665			10
10a	Therapy			371,789	371,789		371,789		371,789			10a
11	Activities	41,799	7,316		49,115		49,115		49,115			11
12	Social Services	38,155		3,013	41,168		41,168		41,168			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharmacy Consultant			5,355	5,355		5,355		5,355			15
16	TOTAL Health Care and Programs	1,054,322	116,848	391,224	1,562,394		1,562,394	21,498	1,583,892			16
	C. General Administration											
17	Administrative	77,993			77,993		77,993		77,993			17
18	Directors Fees											18
19	Professional Services			174,630	174,630		174,630	(125,071)	49,559			19
20	Dues, Fees, Subscriptions & Promotions			11,396	11,396		11,396		11,396			20
21	Clerical & General Office Expenses	73,771	28,188	18,044	120,003		120,003	43,707	163,710			21
22	Employee Benefits & Payroll Taxes			240,190	240,190		240,190	12,930	253,120			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,375	13,375		13,375	(374)	13,001			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			38,661	38,661		38,661	443	39,104			26
27	Other (specify):*											27
28	TOTAL General Administration	151,764	28,188	496,296	676,248		676,248	(68,365)	607,883			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,502,263	310,539	1,004,712	2,817,514		2,817,514	(45,533)	2,771,981			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 PARKER NURSING & REHAB CTR #0050880 Report Period Beginning: 1/1/14 Ending: 12/31/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			87,834	87,834		87,834	7,366	95,200			30
31	Amortization of Pre-Op. & Org.			66,667	66,667		66,667		66,667			31
32	Interest			222,654	222,654		222,654	(97,951)	124,703			32
33	Real Estate Taxes			62,700	62,700		62,700		62,700			33
34	Rent-Facility & Grounds			429,000	429,000		429,000	(422,033)	6,967			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			868,855	868,855		868,855	(512,618)	356,237			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		123,571		123,571		123,571		123,571			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			161,160	161,160		161,160		161,160			42
43	Other (specify):* Bad Debt			299,875	299,875		299,875	(299,875)				43
44	TOTAL Special Cost Centers		123,571	461,035	584,606		584,606	(299,875)	284,731			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,502,263	434,110	2,334,602	4,270,975		4,270,975	(858,026)	3,412,949			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 PARKER NURSING & REHAB CTR # 0050880 Report Period Beginning: 1/1/14 Ending: 12/31/14

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	7,366	30		9
10	Interest and Other Investment Income	(97,951)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(299,875)	43		24
25	Fund Raising, Advertising and Promotional	(3,724)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule various	(429,850)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (824,034)		$	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)	(33,992)	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (33,992)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (858,026)		37

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

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

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

PARKER NURSING & REHAB CTR

ID# 0050880

Report Period Beginning: 1/1/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (542)	6	1
2	Miscellaneous Income	(308)	21	2
3	Rent	(429,000)	34	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
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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**	(429,850)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PARKER NURSING & REHAB CTR # 0050880 **Report Period Beginning:** 1/1/14 **Ending:** 12/31/14

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	461	0	0	0	0	0	0	0	0	0	461	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	444	0	0	0	0	0	0	0	0	0	444	5
6	Maintenance	(542)	971	0	0	0	0	0	0	0	0	0	429	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(542)	1,876	0	0	0	0	0	0	0	0	0	1,334	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	21,498	0	0	0	0	0	0	0	0	0	21,498	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	21,498	0	0	0	0	0	0	0	0	0	21,498	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(125,071)	0	0	0	0	0	0	0	0	0	(125,071)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(4,032)	47,739	0	0	0	0	0	0	0	0	0	43,707	21
22	Employee Benefits & Payroll Taxes	0	12,930	0	0	0	0	0	0	0	0	0	12,930	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(374)	0	0	0	0	0	0	0	0	0	(374)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	443	0	0	0	0	0	0	0	0	0	443	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(4,032)	(64,333)	0	0	0	0	0	0	0	0	0	(68,365)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(4,574)	(40,959)	0	0	0	0	0	0	0	0	0	(45,533)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PARKER NURSING & REHAB CTR # 0050880 Report Period Beginning: 1/1/14 Ending: 12/31/14

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

	Capital Expense D. Ownership	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)	
30	Depreciation	7,366	0	0	0	0	0	0	0	0	0	0	7,366	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(97,951)	0	0	0	0	0	0	0	0	0	0	(97,951)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(429,000)	6,967	0	0	0	0	0	0	0	0	0	(422,033)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(519,585)	6,967	0	0	0	0	0	0	0	0	0	(512,618)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(299,875)	0	0	0	0	0	0	0	0	0	0	(299,875)	43
44	TOTAL Special Cost Centers	(299,875)	0	0	0	0	0	0	0	0	0	0	(299,875)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(824,034)	(33,992)	0	0	0	0	0	0	0	0	0	(858,026)	45

Facility Name & ID Number PARKER NURSING & REHAB CTR # 0050880 Report Period Beginning: 1/1/14 Ending: 12/31/14

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
Moishe Gubin	30			Infinity Healthcare	Hillside, IL	Management Co.
Michael Blisko	30					
Joe Blisko	20					
Dave Schechter	20					

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	1	DIETARY WAGES	$ 4,912	INFINITY HEALTHCARE MANAGEMENT		$ 5,373	$ 461	1
2	V	6	MAINTENANCE WAGES		INFINITY HEALTHCARE MANAGEMENT		815	815	2
3	V	10	NURSING WAGES	3,744	INFINITY HEALTHCARE MANAGEMENT		25,242	21,498	3
4	V	21	OFFICE WAGES		INFINITY HEALTHCARE MANAGEMENT		83,261	83,261	4
5	V	5	UTILITIES		INFINITY HEALTHCARE MANAGEMENT		444	444	5
6	V	6	MAINTENANCE WAGES		INFINITY HEALTHCARE MANAGEMENT		156	156	6
7	V	19	PROFESSIONAL SERVICES	127,882	INFINITY HEALTHCARE MANAGEMENT		2,811	(125,071)	7
8	V	21	OFFICE EXPENSES	40,515	INFINITY HEALTHCARE MANAGEMENT		4,993	(35,522)	8
9	V	22	EMPLOYEE BENEFITS	1,878	INFINITY HEALTHCARE MANAGEMENT		14,808	12,930	9
10	V	24	TRAVEL	685	INFINITY HEALTHCARE MANAGEMENT		311	(374)	10
11	V	26	INSURANCE		INFINITY HEALTHCARE MANAGEMENT		443	443	11
12	V	32	INTEREST		INFINITY HEALTHCARE MANAGEMENT				12
13	V	34	RENT		INFINITY HEALTHCARE MANAGEMENT		6,967	6,967	13
14	Total			$ 179,616			$ 145,624	$ * (33,992)	14

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

Facility Name & ID Number PARKER NURSING & REHAB CTR # 0050880 Report Period Beginning: 1/1/14 Ending: 12/31/14

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
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24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number PARKER NURSING & REHAB CTR # 0050880 Report Period Beginning: 1/1/14 Ending: 12/31/14

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									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		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 PARKER NURSING & REHAB CTR # 0050880 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 PARKER NURSING & REHAB CTR # 0050880 Report Period Beginning: 1/1/14 Ending: 12/31/14

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	eugene lerner		x	property	interest only	various	$ 300,000	$ 300,000	various	3.3000	$	1
2	first midwest bank		x	property	interest only	5/1/14	2,960,000	2,960,000	4/1/17	3.4170	132,285	2
3												3
4												4
5												5
	Working Capital											
6	capital one		x	working capital	none	8/31/14	15,000,000	2,394,067	08/31/20185	2.7500	66,529	6
7	infinity funding	x		working capital	none	various	various		none	various	23,840	7
8												8
9	TOTAL Facility Related						$ 18,260,000	$ 5,654,067			$ 222,654	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 18,260,000	$ 5,654,067			$ 222,654	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** n/a **Line #** _____

*** 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 PARKER NURSING & REHAB CTR # 0050880 Report Period Beginning: 1/1/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 163,387	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.)		$ 33,855	2
3. Under or (over) accrual (line 2 minus line 1).		$ (129,532)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 192,232	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 62,700	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	36,264	8
	2010	35,170	9
	2011	35,328	10
	2012	32,536	11
	2013	33,855	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PARKER NURSING & REHAB CTR COUNTY LASALLE

FACILITY IDPH LICENSE NUMBER 0050880

CONTACT PERSON REGARDING THIS REPORT Alan Sorscher

TELEPHONE (708)449-1900 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	33-23-401-004	NURSING HOME	$ 33,855.12	$ 33,855.12
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 33,855.12	$ 33,855.12

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 PARKER NURSING & REHAB CTR # 0050880 Report Period Beginning: 1/1/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,000 B. General Construction Type: Exterior BRICK Frame CONCRETE/STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [X] (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. [ ] (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				$ 25,000	1
2					2
3	TOTALS			$ 25,000	3

Facility Name & ID Number PARKER NURSING & REHAB CTR # 0050880 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	102				$ 800,000	$ 20,508	39	$ 20,513	$ 5	$ 82,042	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SIGNS			4/30/2010	680	17	39	17		80	9
10	ROOF			4/7/2010	30,000	769	39	769		3,516	10
11	SHOWER TILES			10/19/2010	1,000	26	39	26		117	11
12	SIGNS			4/6/2010	684	18	39	18		80	12
13	EXHAUST FAN AND HOOD			5/28/2010	1,253	32	39	32		147	13
14	DRYWALL, WINDOWS, INSULATION, CEILING TILES			4/15/2010	6,300	162	39	162		738	14
15	PAINTING, VINYL COVE BASE, REMOVE WALL COVERING			5/3/2010	3,868	99	39	99		453	15
16	INSTALL BATHROOM ACCESSORIES, PATIO, AND WALL			5/13/2010	127,000	3,256	39	3,256		14,884	16
17	INSTALLATION OF DATA LINES AND PHONES			6/11/2010	1,750	45	39	45		205	17
18	BACKFLOW REPAIR			7/6/2012	6,249	160	39	160		480	18
19											19
20	Paint walls / ceiling - 1st wing			4/10/2013	3,135	80	39	80		121	20
21	wallpaper - 2nd wing			5/9/2013	2,626	67	39	67		101	21
22	paint - bathroom			8/9/2013	1,986	51	39	51		76	22
23	Fire alarm system			5/20/2013	26,980	691	39	692	1	1,037	23
24											24
25	Repair leak in hydronic heating system			1/23/2014	1,808	46	39	46		46	25
26	Install new gas hot water boiler			2/4/2014	4,422	113	39	113		113	26
27	Cubicle curtains			3/26/2014	1,582	41	39	41		41	27
28	Vinyl planking / adhesive			5/20/2014	2,020	52	39	52		52	28
29	Vinyl planking / adhesive, spackle, cove base			6/19/2014	2,116	54	39	54		54	29
30	William Viette Concrete			6/3/2014	5,530	142	39	142		142	30
31	Supply and install cabling for office			3/13/2014	6,484	166	39	166		166	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 PARKER NURSING & REHAB CTR # 0050880 Report Period Beginning: 1/1/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,037,473	$ 26,595		$ 26,601	$ 6	$ 104,691	70

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

Facility Name & ID Number PARKER NURSING & REHAB CTR # 0050880 Report Period Beginning: 1/1/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 332,052	$ 55,223	$ 66,410	$ 11,187	5	$ 255,538	71
72	Current Year Purchases	10,934	6,014	2,187	(3,827)	5	6,014	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 342,986	$ 61,237	$ 68,597	$ 7,360		$ 261,552	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)	$ 1,405,459	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 87,832	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 95,198	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 7,366	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 366,243	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 PARKER NURSING & REHAB CTR # 0050880 Report Period Beginning: 1/1/14 Ending: 12/31/14

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number PARKER NURSING & REHAB CTR # 0050880 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 PARKER NURSING & REHAB CTR # 0050880 Report Period Beginning: 1/1/14 Ending: 12/31/14

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A-3	hrs	$		$ 276,070	$		$ 276,070	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs			42,860			42,860	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs			52,859			52,859	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				110,902		110,902	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): RADIOLOGY/LAB	39-2					12,669		12,669	12
13	Other (specify):									13
14	TOTAL			$		$ 371,789	$ 123,571		$ 495,360	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 PARKER NURSING & REHAB CTR # 0050880 Report Period Beginning: 1/1/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (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	$ 139,177	$ 151,741	1
2	Cash-Patient Deposits	(11,955)	(11,955)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,302,116	1,302,116	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(11,113)	(11,113)	6
7	Other Prepaid Expenses	(69,289)	1,600,711	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,348,936	$ 3,031,500	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		25,000	13
14	Buildings, at Historical Cost		800,000	14
15	Leasehold Improvements, at Historical Cost	237,472	237,472	15
16	Equipment, at Historical Cost	117,985	342,985	16
17	Accumulated Depreciation (book methods)	(104,203)	(366,245)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		1,000,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(266,668)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): security deposit	1,955	1,955	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 253,209	$ 1,774,499	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,602,145	$ 4,805,999	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 362,295	$ 545,579	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	422,041	422,041	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	working capital	2,394,067	2,394,067	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,178,403	$ 3,361,687	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		3,260,000	39
40	Mortgage Payable			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)**	$	$ 3,260,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,178,403	$ 6,621,687	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,576,258)	$ (1,815,688)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,602,145	$ 4,805,999	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,159,270)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,159,270)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(177,151)	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) **related party property co net income**	(239,837)	15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (416,988)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,576,258)	24	*

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,366,699	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,366,699	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	199,324	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 199,324	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***	97,951	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 97,951	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	related party property co income	429,000	28
28a	vending and misc income	850	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 429,850	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,093,824	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	578,872	31
32	Health Care	1,562,394	32
33	General Administration	676,248	33
	B. Capital Expense		
34	Ownership	868,855	34
	C. Ancillary Expense		
35	Special Cost Centers	123,571	35
36	Provider Participation Fee	161,160	36
	D. Other Expenses (specify):		
37	bad debt	299,875	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,270,975	40
41	**Income before Income Taxes (line 30 minus line 40)****	(177,151)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (177,151)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,883,114	44
45	Private Pay - Net Inpatient Revenue	239,075	45
46	Medicare - Net Inpatient Revenue	1,049,779	46
47	Other-(specify) Commercial	194,731	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,366,699	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES 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	1,840	2,080	$ 81,999	$ 39.42	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,836	8,402	263,382	31.35	3
4	Licensed Practical Nurses	10,799	11,405	274,878	24.10	4
5	CNAs & Orderlies	29,131	32,096	354,109	11.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,726	1,927	19,516	10.13	9
10	Activity Assistants	2,439	2,659	22,283	8.38	10
11	Social Service Workers	1,922	2,004	38,155	19.04	11
12	Dietician					12
13	Food Service Supervisor	1,993	2,242	26,726	11.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,858	14,128	138,026	9.77	15
16	Dishwashers					16
17	Maintenance Workers	1,960	2,127	32,518	15.29	17
18	Housekeepers	7,650	8,291	81,619	9.84	18
19	Laundry	1,498	1,825	17,288	9.47	19
20	Administrator	2,032	2,164	77,993	36.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,493	3,841	73,771	19.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	87,177	95,191	$ 1,502,263 *	$ 15.78	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	98	$ 4,912	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	125	6,267	10-3	38
39	Pharmacist Consultant	107	5,355	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	60	3,013	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	391	$ 19,547		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
Bradley Fierce	Administrator		$ 77,993
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 77,993

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Ironshore Insurance	Legal fees	$ 15,000
Polsinelli	Legal fees	113
Law Offices of Peter Ferracuti	Legal fees	1,500
Bradley & Associtates	Acct fees	4,689
Johnson, Goldburg	Acct fees	3,500
MTS Consulting	Prof fees	1,110
Infinity Healthcare	Mgmt fees	127,882
Brickyard Bank	Appraisal fees	5,200
Loan from SPA	Prof fees	15,636
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 174,630

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 54,695
Unemployment Compensation Insurance	38,195
FICA Taxes	111,210
Employee Health Insurance	30,441
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
employee expense	16,777
uniforms	1,802
TOTAL (agree to Schedule V, line 22, col.8)	$ 253,120

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
illinois council	3,756
license renbewal	6,718
clia	150
lasalle county	170
various	602
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,396

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
auto allowance	4,876
mileage	8,052
continuing education	73
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,001

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PARKER NURSING & REHAB CTR # 0050880 Report Period Beginning: 1/1/14 Ending: 12/31/14

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILLINOIS COUNCIL**

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

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **18,073** Line **10-2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **161,160**
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. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation. N/A
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? **0%**
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 of Schedule V? **N/A**

(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.