FOR BHF USE

LL1

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

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0046565

Facility Name: Paris Health Care Center

Address: 1011 North Main St (Number) Paris (City) 61944 (Zip Code)

County: Edgar

Telephone Number: 217-465-5376 **Fax #** 217-465-8106

HFS ID Number:

Date of Initial License for Current Owners: 1/1/04

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: Paul Traczek **Telephone Number:** 715-858-6619
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Mike Sorells
(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Paul Traczek, Partner
(Firm Name & Address) Wipfli LLP, 3703 Oakwood Hills Parkway, Eau Claire, WI 54702
(Telephone) 715-858-6619 Fax # 715-832-2345

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 Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	128	Skilled (SNF)	128	46,720	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	128	TOTALS	128	46,720	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,691	7,494	6,942	25,127	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,691	7,494	6,942	25,127	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.78%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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 1/1/2004

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1/1/2004 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 2,579

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	158,362	18,117	9,639	186,118		186,118		186,118			1
2	Food Purchase		173,844		173,844		173,844	(876)	172,968			2
3	Housekeeping	99,776	19,332	123	119,231		119,231		119,231			3
4	Laundry	33,226	4,885	2,402	40,513		40,513		40,513			4
5	Heat and Other Utilities			209,012	209,012		209,012		209,012			5
6	Maintenance	54,205	15,438	48,554	118,197		118,197	2,213	120,410			6
7	Other (specify):*											7
8	**TOTAL General Services**	345,569	231,616	269,730	846,915		846,915	1,337	848,252			8
	B. Health Care and Programs											
9	Medical Director			22,800	22,800		22,800		22,800			9
10	Nursing and Medical Records	1,506,452	96,673	28,381	1,631,506		1,631,506	22,527	1,654,033			10
10a	Therapy		1,483	414,782	416,265		416,265	(46,468)	369,797			10a
11	Activities	65,504	1,725	972	68,201		68,201		68,201			11
12	Social Services	40,202	62		40,264		40,264		40,264			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,612,158	99,943	466,935	2,179,036		2,179,036	(23,941)	2,155,095			16
	C. General Administration											
17	Administrative	92,998			92,998		92,998		92,998			17
18	Directors Fees											18
19	Professional Services			150,983	150,983		150,983	4,624	155,607			19
20	Dues, Fees, Subscriptions & Promotions			18,649	18,649		18,649		18,649			20
21	Clerical & General Office Expenses	156,085	10,708	76,316	243,109		243,109	(8,040)	235,069			21
22	Employee Benefits & Payroll Taxes			409,635	409,635		409,635	27,462	437,097			22
23	Inservice Training & Education			425	425		425		425			23
24	Travel and Seminar			17,588	17,588		17,588	15,321	32,909			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			91,623	91,623		91,623	(493)	91,130			26
27	Other (specify):* **Bad Debt**			21,699	21,699		21,699	(21,699)				27
28	**TOTAL General Administration**	249,083	10,708	786,918	1,046,709		1,046,709	17,175	1,063,884			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,206,810	342,267	1,523,583	4,072,660		4,072,660	(5,429)	4,067,231			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 Paris Health Care Center #0046565 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			52,797	52,797		52,797	6,822	59,619			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							28,951	28,951			32
33	Real Estate Taxes			60,043	60,043		60,043		60,043			33
34	Rent-Facility & Grounds			240,000	240,000		240,000	20,532	260,532			34
35	Rent-Equipment & Vehicles			37,761	37,761		37,761		37,761			35
36	Other (specify):*											36
37	**TOTAL Ownership**			390,601	390,601		390,601	56,305	446,906			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		96,141	11,896	108,037		108,037		108,037			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			229,683	229,683		229,683		229,683			42
43	Other (specify):* **Residential**		592	52	644		644		644			43
44	**TOTAL Special Cost Centers**		96,733	241,631	338,364		338,364		338,364			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,206,810	439,000	2,155,815	4,801,625		4,801,625	50,876	4,852,501			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 Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 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	(876)	2		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	4,890	30		9
10	Interest and Other Investment Income	(4,967)	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	(50)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(21,699)	27		24
25	Fund Raising, Advertising and Promotional	(10,538)	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	(61,710)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (94,950)		$	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)	145,826	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 145,826		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 50,876		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

Paris Health Care Center

ID# 0046565

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salary	$ (51,375)	21	1
2	Physician Fees	(1,462)	10	2
3	Vending Machine Income	(673)	21	3
4	Marketing Supplies	(4,924)	21	4
5	Bank Charges	(2,248)	21	5
6	Finance Charges and Late Fees	(733)	21	6
7	Gifts/Flowers	(295)	21	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(61,710)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Paris Health Care Center # 0046565 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(876)	0	0	0	0	0	0	0	0	0	0	(876)	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	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	2,213	0	0	0	0	0	0	0	0	2,213	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(876)	0	2,213	0	0	0	0	0	0	0	0	1,337	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	(1,462)	0	23,989	0	0	0	0	0	0	0	0	22,527	10
10a	Therapy	0	(46,468)	0	0	0	0	0	0	0	0	0	(46,468)	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**	(1,462)	(46,468)	23,989	0	0	0	0	0	0	0	0	(23,941)	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	0	4,624	0	0	0	0	0	0	0	0	4,624	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(70,836)	1,380	61,416	0	0	0	0	0	0	0	0	(8,040)	21
22	Employee Benefits & Payroll Taxes	0	0	27,462	0	0	0	0	0	0	0	0	27,462	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	15,321	0	0	0	0	0	0	0	0	15,321	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	0	(493)	0	0	0	0	0	0	0	0	(493)	26
27	Other (specify):*	(21,699)	0	0	0	0	0	0	0	0	0	0	(21,699)	27
28	**TOTAL General Administration**	(92,535)	1,380	108,330	0	0	0	0	0	0	0	0	17,175	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(94,873)	(45,088)	134,532	0	0	0	0	0	0	0	0	(5,429)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Paris Health Care Center # 0046565 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

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	4,890	0	1,932	0	0	0	0	0	0	0	0	6,822	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,967)	29,122	4,796	0	0	0	0	0	0	0	0	28,951	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	20,532	0	0	0	0	0	0	0	0	0	20,532	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**	(77)	49,654	6,728	0	0	0	0	0	0	0	0	56,305	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(94,950)	4,566	141,260	0	0	0	0	0	0	0	0	50,876	45

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Pg6 - Supplemental		See Pg6 - Supplemental		See Pg6 - 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. ☐ 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	10a	Physical Therapy	$ 164,854	TruRehab, LLC	100.00%	$ 146,737	$ (18,117)	1
2	V	10a	Occupational Therapy	136,573	TruRehab, LLC	100.00%	121,564	(15,009)	2
3	V	10a	Speech Therapy	77,215	TruRehab, LLC	100.00%	67,829	(9,386)	3
4	V	10a	Therapy Management	36,000	TruRehab, LLC	100.00%	32,044	(3,956)	4
5	V								5
6	V	21	Clerical and General		Davis Ide HCP		1,380	1,380	6
7	V	32	Interest		Davis Ide HCP		29,122	29,122	7
8	V	34	Rent	240,000	Davis Ide HCP		260,532	20,532	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 654,642			$ 659,208	$ * 4,566	14

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

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Maintenance	$	Ide Management Group, LLC	100.00%	$ 2,213	$ 2,213	15
16	V	10	Nursing		Ide Management Group, LLC	100.00%	23,989	23,989	16
17	V	19	Professional Fees		Ide Management Group, LLC	100.00%	4,624	4,624	17
18	V	20	Dues, Fees, Subscriptions		Ide Management Group, LLC	100.00%			18
19	V	21	Clerical and General		Ide Management Group, LLC	100.00%	121,416	121,416	19
20	V	22	Employee Benefits		Ide Management Group, LLC	100.00%	27,462	27,462	20
21	V	24	Travel and Seminar		Ide Management Group, LLC	100.00%	15,321	15,321	21
22	V	26	Insurance		Ide Management Group, LLC	100.00%	(493)	(493)	22
23	V	30	Depreciation		Ide Management Group, LLC	100.00%	1,932	1,932	23
24	V	32	Interest		Ide Management Group, LLC	100.00%	4,796	4,796	24
25	V								25
26	V	21	Management Fees	60,000	Ide Management Group, LLC	100.00%		(60,000)	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			$ 60,000			$ 201,260	$ * 141,260	39

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

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Mark Ide	50	Cathedral Health Care Center	Jasper IN	Ide Mgmt Group	Indianapolis IN	Management	1
2	Michael Sorrells	25	Chesterton Manor	Chesterton IN	TruRehab LLC	Vincennes IN	Rehab Therapies	2
3	Ashok Moran	25	Cloverleaf Healthcare	Knightsville IN	Davis-Ide HC Prop	Indianapolis IN	Property Mgmt	3
4			Colonial Nursing & Rehab	Crown Point IN				4
5			Kendallville Manor	Kendallville IN				5
6			Madison Health Care Center	Indianapolis IN				6
7			Oak Village	Oakton IN				7
8			River Terrace Retirement Community	Bluffton IN				8
9			Silver Memories Health Care	Versailles IN				9
10			Warsaw Meadows	Warsaw IN				10
11			Woodland Manor	Elkhart IN				11
12			Yorkton Manor	Yorktown IN				12
13			Edwardsville Nursing and Rehabilitation	Edwardsville IL				13
14			Newton Care Center	Newton IL				14
15			North Logan Health Care Center	Danville IL				15
16			Paris Healthcare Center	Paris IL				16
17			University Nursing and Rehab	Edwardsville IL				17
18			Countryside Health Care Center	Sioux City IA				18
19			Eagle Point Health Care Center	Clinton IA				19
20			Keosauqua Health Care Center	Keosauqua IA				20
21			Keota Health Care Center	Keota IA				21
22			Newton Health Care Center	Newton IA				22
23			Sigourney Health Care	Sigourney IA				23
24			Urbandale Health Care Center	Urbandale IA				24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Ide	Shareholder	Administrative	100.00	See Attached	1.82	4.54	Alloc Salary	$ 15,897	21-7	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	$ 15,897		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 Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2017 Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Ide Management Group, LLC
Street Address: 4521 Independence Square
City / State / Zip Code: Indianapolis, IN 46203
Phone Number: (317-744-9148
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	6	Maintenance	Inpatient Days	553,224	22	$ 48,729	$	25,127	$ 2,213	1
2	10	Nursing	Inpatient Days	553,224	22	528,158	528,158	25,127	23,989	2
3	19	Professional Fees	Inpatient Days	553,224	22	101,802		25,127	4,624	3
4	20	Dues, Fees, Subscriptions	Inpatient Days	553,224	22	0		25,127	0	4
5	21	Clerical and General	Inpatient Days	553,224	22	2,673,220	2,656,119	25,127	121,416	5
6	22	Employee Benefits	Inpatient Days	553,224	22	604,640		25,127	27,462	6
7	24	Travel and Seminar	Inpatient Days	553,224	22	337,331		25,127	15,321	7
8	26	Insurance	Inpatient Days	553,224	22	(10,862)		25,127	(493)	8
9	30	Depreciation	Inpatient Days	553,224	22	42,543		25,127	1,932	9
10	32	Interest	Inpatient Days	553,224	22	105,593		25,127	4,796	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					$ 4,431,154	$ 3,184,277		$ 201,260	25

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

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

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	85,729	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.)	$	61,519	2
3. Under or (over) accrual (line 2 minus line 1).	$	(24,210)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	84,253	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.	$	60,043	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2012	68,862	8
2013	70,275	9
2014	60,044	10
2015	58,121	11
2016	61,519	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** This denial must be no more than four years old at the time the cost report is filed.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Paris Health Care Center COUNTY Edgar

FACILITY IDPH LICENSE NUMBER 0046565

CONTACT PERSON REGARDING THIS REPORT Paul Traczek

TELEPHONE 715-858-6619 FAX #: 715-832-2345

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

Enter the tax index number and real estate tax assessed for 2016 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-13-36-100-021	Nursing Home	$ 61,518.56	$ 61,518.56
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 61,518.56	$ 61,518.56

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,377 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (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 [ ] (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				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			2004	12,329	27	27	457	(430)	2,768	9
10	Water Line EQ & Boiler			2004	1,039	2	27	38	36	465	10
11	Life Safety Crossroads			2005	272	1	15	18	17	216	11
12	Code Alert Model 70 Wand			2006	1,017	2	27	38	36	406	12
13	Access control System			2006	1,218	4	15	81	77	904	13
14	Code Alert Model 70 Wand			2006	1,028	2	27	38	36	394	14
15	Security Keypads (5)			2006	665	1	27	25	24	255	15
16	Double Door in Hallway			2006	2,700	6	27	100	94	1,028	16
17	Wandering Alert Monitor			2006	1,410	5	15	94	89	1,034	17
18	Install Code Alert			2006	1,250	4	15	83	79	916	18
19	System Sensor Alarm			2006	229	1	15	15	14	168	19
20	Door Frame			2007	498	1	27	18	17	179	20
21	Rheem A/C 2 Ton			2007	495		7	71	71	495	21
22	A/C Unit Roof Top			2007	1,155		7	165	165	1,155	22
23	Awnings (22)			2007	2,200	8	15	147	139	1,454	23
24	Panel Lights/Control Unit			2007	5,516	19	15	368	349	3,637	24
25	Fire System			2007	7,445	19	20	372	353	3,847	25
26	Wooden Shadow Boxes (22)			2008	605		10	61	61	303	26
27	Wiring			2008	775		10	77	77	387	27
28	Flooring			2009	14,098	28	15	940	912	3,552	28
29	Paint			2009	1,154	2	15	77	75	290	29
30	Parking Lot Improvements			2010	7,375		15	492	492	3,688	30
31	Lights			2010	1,318		7	188	188	659	31
32	Painting			2010	1,284		15	86	86	642	32
33	Building Improvements			2011	10,340	23	27	383	360	2,277	33
34	Water Line EQ & Boiler			2011	874	2	27	32	30	192	34
35	Life Safety Crossroads			2011	153	1	15	10	9	68	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 Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Code Alert Model 70 Wand	2011	$ 890	$ 1	39	$ 23	$ 22	$ 137	37
38	Access control System	2011	759	3	15	51	48	336	38
39	Code Alert Model 70 Wand	2011	910	2	27	34	32	200	39
40	Security Keypads (5)	2011	589	1	27	22	21	129	40
41	Double Door in Hallway	2011	2,397	5	27	89	84	528	41
42	Wandering Alert Monitor	2011	879	3	15	59	56	389	42
43	Install Code Alert	2011	779	3	15	52	49	345	43
44	System Sensor Alarm	2011	143	1	15	10	9	64	44
45	Door Frame	2011	449	1	27	17	16	99	45
46	Rheem A/C 2 Ton	2011	148	1	7	21	20	134	46
47	A/C Unit Roof Top	2011	517	2	10	52	50	367	47
48	Awnings (22)	2011	1,584	6	15	106	100	701	48
49	Panel Lights/Control Unit	2011	3,971	15	15	265	250	1,758	49
50	Fire System	2011	5,837	18	20	292	274	2,051	50
51	Wooden Shadow Boxes (22)	2011	174	1	10	17	16	124	51
52	Wiring	2011	223	1	10	22	21	158	52
53	Flooring	2011	6,344	23	15	423	400	2,808	53
54	Paint	2011	519	2	15	35	33	230	54
55	Rheem 7 1/2 Ton Air Handler	2011	11,350	45	15	757	712	4,207	55
56	Chair Rail	2011	8,340	33	15	556	523	3,091	56
57	Renovations	2011	9,257	36	15	617	581	3,430	57
58	Firewall Buildout	2011	8,800	35	15	587	552	3,262	58
59	Adj Per Audit	2012	19,474	115	10	1,947	1,832	7,905	59
60	Water Heater 100 Gallon	2013	8,651	34	15	577	543	2,245	60
61	Water Softner	2013	5,922	23	15	395	372	1,536	61
62	Roofing System New	2013	55,928	110	30	1,864	1,754	7,256	62
63	Shower Room Remodel	2013	8,280	24	20	414	390	1,404	63
64	Paint Misc Rooms	2013	29,021	342	5	5,804	5,462	19,690	64
65	Flooring	2013	5,300	31	10	530	499	1,665	65
66	Shower Room Remodel	2013	8,230	24	20	412	388	1,293	66
67	Cooling and heating P-TAC units (6)	2014	18,000	106	10	1,800	1,694	3,856	67
68	Heat Pump	2014	3,525	21	10	353	332	755	68
69									69
70	TOTAL (lines 4 thru 69)		$ 305,632	$ 1,226		$ 22,677	$ 20,591	$ 103,532	70

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

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 305,632	$ 1,226		$ 22,677	$ 21,451	$ 103,532	1
2									2
3	Thermazone AC Unit	2015	3,156	9	20	158	149	272	3
4	Water Heater/Storage Tank	2015	5,279	16	20	264	248	456	4
5	Nuses Station Laminate	2016	1,250	4	20	63	59	67	5
6	Flooring Therapy Room	2016	4,800	14	20	240	226	254	6
7	Front Entrance	2016	11,950	35	20	598	563	633	7
8	Flooring Base in 4 Rooms	2016	2,900	9	20	145	136	154	8
9	Concrete Pad	2016	1,950	6	20	98	92	104	9
10	Memory Care Unit	2016	209,950	619	20	10,498	9,879	11,117	10
11	Parking Lot / Seal Paving	2016	10,950	43	15	730	687	773	11
12	Replace water heaters	2017	10,670	234	15	234		234	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)		$ 568,487	$ 2,215		$ 35,705	$ 33,490	$ 117,596	34

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

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 218,616	$ 16,809	$ 21,732	$ 4,923	5-15	$ 142,000	71
72	Current Year Purchases	19,937	1,289	1,289		7	1,289	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 238,553	$ 18,098	$ 23,021	$ 4,923		$ 143,289	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		2012 Ford E350	2012	$ 17,280	$	$	$	5	$ 10,094	76
77		Lift for Van	2017	6,819	893	893		5	893	77
78										78
79										79
80	TOTALS			$ 24,099	$ 893	$ 893	$		$ 10,987	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)	$ 831,139	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 21,206	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 59,619	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 38,413	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 271,872	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 Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Omega Healthcare Investors

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:		128	11/1/03	$ 240,000	21	20	3
4	Additions							4
5								5
6								6
7	TOTAL		128		$ 240,000 **			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 11/1/03
Ending 12/31/24

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2018	$ 268,348
13.	12/31/2019	$ 276,399
14.	12/31/2020	$ 284,450

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: $ 25,361 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 Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$	2,328	$ 136,573	$	2,328	$ 136,573	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,027	77,215		1,027	77,215	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		3,762	164,854		3,762	164,854	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				96,141		96,141	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-3					6,107		6,107	12
13	Other (specify): Lab	39-3					5,789		5,789	13
14	TOTAL			$	7,117	$ 378,642	$ 108,037	7,117	$ 486,679	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 Paris Health Care Center **#** 0046565 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2017 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 10,915	$	1
2	Cash-Patient Deposits	35,259		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,023,301		3
4	Supply Inventory (priced at)	8,951		4
5	Short-Term Investments			5
6	Prepaid Insurance	(4,720)		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,073,706	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	21,625		13
14	Buildings, at Historical Cost	313,591		14
15	Leasehold Improvements, at Historical Cost	233,271		15
16	Equipment, at Historical Cost	262,653		16
17	Accumulated Depreciation (book methods)	(303,461)		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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 527,679	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,601,385	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,409,180	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	35,080		28
29	Short-Term Notes Payable	293,300		29
30	Accrued Salaries Payable	5,365		30
31	Accrued Taxes Payable (excluding real estate taxes)	146,839		31
32	Accrued Real Estate Taxes(Sch.IX-B)	60,043		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Legal Contingency	25,000		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,974,807	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,974,807	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,373,422)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,601,385	$	48

***(See instructions.)**

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (896,963)	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(227,267)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,124,230)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(249,192)	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)**	$ (249,192)	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)**	$ (1,373,422)	24 *

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

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,352,120	1
2	Discounts and Allowances for all Levels	448,616	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,800,736	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	671,260	6
7	Oxygen	25,762	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 697,022	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	876	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	59,585	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	(226)	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 60,235	23
	D. Non-Operating Revenue		
24	Contributions	(50)	24
25	Interest and Other Investment Income***	4,967	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,917	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income	673	28
28a	Misc. Revenue	(11,150)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (10,477)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,552,433	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	846,915	31
32	Health Care	2,179,036	32
33	General Administration	1,046,709	33
	B. Capital Expense		
34	Ownership	390,601	34
	C. Ancillary Expense		
35	Special Cost Centers	108,681	35
36	Provider Participation Fee	229,683	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,801,625	40
41	**Income before Income Taxes (line 30 minus line 40)****	(249,192)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (249,192)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,245,905	44
45	Private Pay - Net Inpatient Revenue	839,058	45
46	Medicare - Net Inpatient Revenue	643,497	46
47	Other-(specify) Net Inpatient Revenue	72,276	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,800,736	49

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

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

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

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

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,766	2,847	$ 92,010	$ 32.32	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,287	9,697	272,593	28.11	3
4	Licensed Practical Nurses	15,612	16,765	423,948	25.29	4
5	CNAs & Orderlies	49,449	50,855	714,407	14.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,471	4,566	66,066	14.47	9
10	Activity Assistants					10
11	Social Service Workers	1,923	1,982	38,201	19.27	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,349	14,031	154,607	11.02	15
16	Dishwashers					16
17	Maintenance Workers	3,324	3,518	55,704	15.83	17
18	Housekeepers	8,890	9,414	100,949	10.72	18
19	Laundry	3,301	3,542	33,130	9.35	19
20	Administrator	3,009	3,097	92,998	30.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,093	5,333	126,863	23.79	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) Marketing	1,291	1,313	35,334	26.91	33
34	TOTAL (lines 1 - 33)	120,765	126,960	$ 2,206,810 *	$ 17.38	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	238	$ 8,345	1.3	35
36	Medical Director	Monthly	22,800	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant	25	873	10.3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	3	100	11.3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	266	$ 32,118		49

C. CONTRACT NURSES

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

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Wilson	Administrator		$ 92,998
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 92,998

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
Myers Carden & Sax, LLC	Legal	$ 3,980
Saikley Garrison Colombo & Barney,	Legal	686
Hepler Broom LLC	Legal	1,100
BKD	Accounting	7,330
Parrish Consulting	Professional	9,153
Outcoe Services of IL	Professional	6,552
Integrated Resources Mgmt	Professional	66,278
Various	Legal	528
Ide Mgmt Group	Professional/Mgmt	60,000
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 155,607

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 86,700
Unemployment Compensation Insurance	31,597
FICA Taxes	164,182
Employee Health Insurance	134,120
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	(7,624)
Physicals	462
Human Resources	198
Ide Mgmt Group	27,462
TOTAL (agree to Schedule V, line 22, col.8)	$ 437,097

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	2,507
Health Care Worker Background Check	1,312
(Indicate # of checks performed)	
Patient Background Checks	
Advertising	10,538
License and Permits	4,292
Ide Mgmt Group	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,649

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage	16,729
Seminar Expense	
Education and Seminar	398
Ide Mgmt Group	15,321
Hotel	461
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 32,909

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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? **NO**
If YES, give association name and amount. **N/A**

(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? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **16,082** 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? **X** YES _____ 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **229,683**
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.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **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? **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