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: 0050880

Facility Name: Parker Nursing and Rehab Ctr

Address: 516 West French St (Number) Streator (City) 61364 (Zip Code)

County: LaSalle

Telephone Number: (708) 449-1900 **Fax #** (708) 449-1500

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: Daniel S. Gaafar **Telephone Number:** (317) 237-5500
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 1/1/17 to 12/31/17 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) Paresh Vipani
(Title) CFO

Paid Preparer

(Signed) (Date)
(Print Name and Title) Daniel S. Gaafar, Partner
(Firm Name & Address) Bradley Associates, 201 S. Capitol Ave, Suite 700, Indianapolis, IN 46225
(Telephone) (317) 237-5500 Fax # (317) 237-5503

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 and Rehab Ctr # 0050880 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	17,060	1,539	2,718	21,317	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,060	1,539	2,718	21,317	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.26%

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 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 1,737

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 Parker Nursing and Rehab Ctr # 0050880 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	181,698	13,786	6,971	202,455		202,455	(2,370)	200,085			1
2	Food Purchase		135,530		135,530		135,530	651	136,181			2
3	Housekeeping	105,960	23,895		129,855		129,855	197	130,052			3
4	Laundry	23,372	10,119		33,491		33,491		33,491			4
5	Heat and Other Utilities			106,968	106,968		106,968	265	107,233			5
6	Maintenance	33,657	25,241	33,223	92,121		92,121	224	92,345			6
7	Other (specify):*											7
8	TOTAL General Services	344,687	208,571	147,162	700,420		700,420	(1,033)	699,387			8
	B. Health Care and Programs											
9	Medical Director			8,388	8,388		8,388		8,388			9
10	Nursing and Medical Records	1,097,220	83,331	51,457	1,232,008		1,232,008	(29,123)	1,202,885			10
10a	Therapy			302,001	302,001		302,001		302,001			10a
11	Activities	58,477	7,959		66,436		66,436		66,436			11
12	Social Services	33,143		4,445	37,588		37,588		37,588			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharmacy Consult			6,318	6,318		6,318	(116)	6,202			15
16	TOTAL Health Care and Programs	1,188,840	91,290	372,609	1,652,739		1,652,739	(29,239)	1,623,500			16
	C. General Administration											
17	Administrative	64,648			64,648		64,648		64,648			17
18	Directors Fees											18
19	Professional Services			208,536	208,536		208,536	(88,211)	120,325			19
20	Dues, Fees, Subscriptions & Promotions			6,843	6,843		6,843	5	6,848			20
21	Clerical & General Office Expenses	160,611	33,799	74,296	268,706		268,706	250	268,956			21
22	Employee Benefits & Payroll Taxes			310,381	310,381		310,381	15,594	325,975			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,336	10,336		10,336	1,906	12,242			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			21,931	21,931		21,931	(1,741)	20,190			26
27	Other (specify):*											27
28	TOTAL General Administration	225,259	33,799	632,323	891,381		891,381	(72,197)	819,184			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,758,786	333,660	1,152,094	3,244,540		3,244,540	(102,469)	3,142,071			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 and Rehab Ctr #0050880 Report Period Beginning: 1/1/17 Ending: 12/31/17

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			53,051	53,051		53,051	8,059	61,110			30
31	Amortization of Pre-Op. & Org.							66,666	66,666			31
32	Interest			175,336	175,336		175,336	213,193	388,529			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			465,000	465,000		465,000	(462,471)	2,529			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			693,387	693,387		693,387	(174,553)	518,834			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			8	8		8		8			38
39	Ancillary Service Centers		82,820		82,820		82,820	(1,511)	81,309			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			173,518	173,518		173,518		173,518			42
43	Other (specify):* **Bad Debt Exp**			84,796	84,796		84,796	(84,796)				43
44	**TOTAL Special Cost Centers**		82,820	258,322	341,142		341,142	(86,307)	254,835			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,758,786	416,480	2,103,803	4,279,069		4,279,069	(363,329)	3,915,740			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 and Rehab Ctr # 0050880 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	(12,520)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(47)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,124)	21		18
19	Entertainment				19
20	Contributions	(7,142)	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	(84,796)	43		24
25	Fund Raising, Advertising and Promotional	(4,988)	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	(2,042)	various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (113,659)		$	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)	(249,670)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (249,670)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (363,329)		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 and Rehab Ctr

ID# 0050880

Report Period Beginning: 1/1/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Medical Records Income	$ (54)	10	1
2	Lobbying Dues	(339)	20	2
3	RP Profit	(22)	10	3
4	RP Profit	(116)	15	4
5	RP Profit	(1,511)	39	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(2,042)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Parker Nursing and Rehab Ctr # 0050880 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	(47)	(2,323)	0	0	0	0	0	0	0	0	0	(2,370)	1
2	Food Purchase	0	651	0	0	0	0	0	0	0	0	0	651	2
3	Housekeeping	0	197	0	0	0	0	0	0	0	0	0	197	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	265	0	0	0	0	0	0	0	0	0	265	5
6	Maintenance	0	224	0	0	0	0	0	0	0	0	0	224	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(47)	(986)	0	0	0	0	0	0	0	0	0	(1,033)	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	(76)	(29,047)	0	0	0	0	0	0	0	0	0	(29,123)	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):*	(116)	0	0	0	0	0	0	0	0	0	0	(116)	15
16	**TOTAL Health Care and Programs**	(192)	(29,047)	0	0	0	0	0	0	0	0	0	(29,239)	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	(88,211)	0	0	0	0	0	0	0	0	0	(88,211)	19
20	Fees, Subscriptions & Promotions	(339)	344	0	0	0	0	0	0	0	0	0	5	20
21	Clerical & General Office Expenses	(14,254)	14,197	307	0	0	0	0	0	0	0	0	250	21
22	Employee Benefits & Payroll Taxes	0	15,594	0	0	0	0	0	0	0	0	0	15,594	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,906	0	0	0	0	0	0	0	0	0	1,906	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	320	(2,061)	0	0	0	0	0	0	0	0	(1,741)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(14,593)	(55,850)	(1,754)	0	0	0	0	0	0	0	0	(72,197)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(14,832)	(85,883)	(1,754)	0	0	0	0	0	0	0	0	(102,469)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Parker Nursing and Rehab Ctr # 0050880 **Report Period Beginning:** 1/1/17 **Ending:** 12/31/17

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	(12,520)	71	20,508	0	0	0	0	0	0	0	0	8,059	30
31	Amortization of Pre-Op. & Org.	0	0	66,666	0	0	0	0	0	0	0	0	66,666	31
32	Interest	0	0	213,193	0	0	0	0	0	0	0	0	213,193	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(462,471)	0	0	0	0	0	0	0	0	(462,471)	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**	(12,520)	71	(162,104)	0	0	0	0	0	0	0	0	(174,553)	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	(1,511)	0	0	0	0	0	0	0	0	0	0	(1,511)	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):*	(84,796)	0	0	0	0	0	0	0	0	0	0	(84,796)	43
44	**TOTAL Special Cost Centers**	(86,307)	0	0	0	0	0	0	0	0	0	0	(86,307)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(113,659)	(85,812)	(163,858)	0	0	0	0	0	0	0	0	(363,329)	45

Facility Name & ID Number Parker Nursing and Rehab Ctr # 0050880 Report Period Beginning: 1/1/17 Ending: 12/31/17

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
Michael Blisko	40%	Ambassador Nursing & Rehab Center	Chicago	Infinity Healthcare	Hillside	Management Co.
GELP	40%	Belhaven Nursing & Rehab Center	Chicago	516 W Frech Realty		Realty Co.
Joe Blisko	20%	City View Multicare Center	Cicero	United Rx	Hillside	Pharmacy Co.
		Continental Nursing & Rehab Center	Chicago			
		Forest View Rehab & Nursing Center	Itasca			
		Lakeview Nursing & Rehab Center	Chicago			
		Midway Neurological & Rehab Center	Bridgeview			

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	$ 3,587	Infinity Healthcare Management of Illinois		$ 1,264	$ (2,323)	1
2	V	2	Food Purchase		Infinity Healthcare Management of Illinois		651	651	2
3	V	3	Housekeeping		Infinity Healthcare Management of Illinois		197	197	3
4	V	5	Utilities		Infinity Healthcare Management of Illinois		265	265	4
5	V	6	Maintenance		Infinity Healthcare Management of Illinois		224	224	5
6	V	10	Nursing	51,457	Infinity Healthcare Management of Illinois		22,410	(29,047)	6
7	V	19	Professional Fees	145,861	Infinity Healthcare Management of Illinois		57,650	(88,211)	7
8	V	20	Dues & Fees		Infinity Healthcare Management of Illinois		344	344	8
9	V	21	Office Expense	100,366	Infinity Healthcare Management of Illinois		114,563	14,197	9
10	V	22	Employee Benefits		Infinity Healthcare Management of Illinois		15,594	15,594	10
11	V	24	Travel Expense		Infinity Healthcare Management of Illinois		1,906	1,906	11
12	V	26	Insurance		Infinity Healthcare Management of Illinois		320	320	12
13	V	30	Depreciation		Infinity Healthcare Management of Illinois		71	71	13
14	Total			$ 301,271			$ 215,459	$ * (85,812)	14

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

Facility Name & ID Number Parker Nursing and Rehab Ctr # 0050880 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	32	Interest	$	Infinity Healthcare Management of Illinois		$ 8	$ 8	15
16	V	34	Rent		Infinity Healthcare Management of Illinois		2,529	2,529	16
17	V								17
18	V	26	Insurance		516 West French Street LLC		(2,061)	(2,061)	18
19	V	31	Amortization		516 West French Street LLC		66,666	66,666	19
20	V	21	Office Expense		516 West French Street LLC		307	307	20
21	V	30	Depreciation		516 West French Street LLC		20,508	20,508	21
22	V	32	Interest		516 West French Street LLC		213,185	213,185	22
23	V	34	Rent	465,000	516 West French Street LLC			(465,000)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 465,000			$ 301,142	$ * (163,858)	39

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

Facility Name & ID Number Parker Nursing and Rehab Ctr # 0050880 Report Period Beginning: 1/1/17 Ending: 12/31/17

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			Momence Meadows Nursing & Rehab Ctr	Momence				1
2			Niles Nursing & Rehab Center	Niles				2
3			Oak Lawn Respiratory & Rehab Center	Oak Lawn				3
4			Parkshore Estates Nursing & Rehab Center	Chicago				4
5			Southpoint Nursing & Rehab Center	Chicago				5
6			West Suburban Nursing & Rehab Center	Bloomingdale				6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Parker Nursing and Rehab Ctr # 0050880 Report Period Beginning: 1/1/17 Ending: 12/31/17

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 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 and Rehab Ctr # 0050880 Report Period Beginning: 1/1/17 Ending: 12/31/17

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 and Rehab Ctr # 0050880 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	Bank Leumi		X	Property	$25,454.00	10/22/15	$ 4,420,000	$ 4,188,728	1/15/19	4.4000	$ 213,185	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Infinity Funding	X		Working Capital	None	Various	Various	2,780,087	None	Various	175,344	6
7												7
8												8
9	TOTAL Facility Related				$25,454.00		$ 4,420,000	$ 6,968,815			$ 388,529	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,420,000	$ 6,968,815			$ 388,529	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 and Rehab Ctr **#** 0050880 **Report Period Beginning:** 1/1/17 **Ending:** 12/31/17

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.**	$	179,494	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.)	$	34,265	2
3. Under or (over) accrual (line 2 minus line 1).	$	(145,229)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	145,229	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.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2012	32,536	8
2013	33,855	9
2014	34,623	10
2015	37,401	11
2016	34,265	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 Parker Nursing and Rehab Ctr COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0050880

CONTACT PERSON REGARDING THIS REPORT Daniel S. Gaafar

TELEPHONE (317) 237-5500 FAX #: (317) 237-5503

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.	33-23-401-004	Nursing Home	$ 34,265.42	$ 34,265.42
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 34,265.42	$ 34,265.42

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 Parker Nursing and Rehab Ctr # 0050880 Report Period Beginning: 1/1/17 Ending: 12/31/17

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. [ ] (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).

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	Land			$ 25,000	1
2					2
3	TOTALS			$ 25,000	3

Facility Name & ID Number Parker Nursing and Rehab Ctr # 0050880 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	$ 143,566	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SIGNS			2010	680	17	39	17		131	9
10	ROOF			2010	30,000	769	39	769		5,823	10
11	SHOWER TILES			2010	1,000	26	39	26		195	11
12	SIGNS			2010	684	18	39	18		134	12
13	EXHAUST FAN AND HOOD			2010	1,253	32	39	32		243	13
14	DRYWALL, WINDOWS, INSULATION, CEILING TILES			2010	6,300	162	39	162		1,224	14
15	PAINTING, VINYL COVE BASE, REMOVE WALL COVERING			2010	3,868	99	39	99		750	15
16	INSTALL BATHROOM ACCESSORIES, PATIO, AND WALL			2010	127,000	3,256	39	3,256		24,652	16
17	INSTALLATION OF DATA LINES AND PHONES			2010	1,750	45	39	45		340	17
18	BACKFLOW REPAIR			2012	6,249	160	39	160		960	18
19											19
20	Paint walls / ceiling - 1st wing			2013	3,135	80	39	80		361	20
21	wallpaper - 2nd wing			2013	2,626	67	39	67		302	21
22	paint - bathroom			2013	1,986	51	39	51		229	22
23	Fire alarm system			2013	26,980	692	39	692		3,113	23
24											24
25	Repair leak in hydronic heating system			2014	1,808	46	39	46		184	25
26	Install new gas hot water boiler			2014	4,422	113	39	113		452	26
27	Cubicle curtains			2014	1,582	41	39	41		164	27
28	Vinyl planking replaced in every resident rm in "C" Hallway			2014	2,020	52	39	52		208	28
29	Vinyl planking replaced in every resident rm in "C" Hallway			2014	2,116	54	39	54		216	29
30	Replace outside patio			2014	5,530	142	39	142		568	30
31	Supply and install cabling for office			2014	6,484	166	39	166		664	31
32											32
33	Replace flooring in building			2015	3,786	97	39	97		291	33
34											34
35	Replace kitchen floor and cove base			2016	8,369	215	39	215		430	35
36	Replace compressor switch on fire sprinklers			2016	5,581	143	39	143		286	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 and Rehab Ctr # 0050880 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	2 Double Egress Doors for Activity Room	2017	$ 7,478	$ 96	39	$ 96	$	$ 96	37
38	Cummins Gaseous Engine Generator	2017	42,636	546	39	546		546	38
39	New Concrete Ramp	2017	2,060	26	39	26		26	39
40	Replace Gutters & Downspout	2017	2,952	38	39	38		38	40
41	New Natural Gas Water Heater for Commercial Kitchen	2017	4,277	56	39	55	(1)	56	41
42	New Natural Gas Water Heater for Commercial Kitchen								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)		$ 1,114,612	$ 27,813		$ 27,817	$ 4	$ 186,248	70

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

Facility Name & ID Number Parker Nursing and Rehab Ctr # 0050880 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	$ 134,891	$ 14,240	$ 26,978	$ 12,738	5	$ 106,206	71
72	Current Year Purchases	31,577	31,577	6,315	(25,262)	5	31,577	72
73	Fully Depreciated Assets	251,358				5	251,358	73
74								74
75	TOTALS	$ 417,826	$ 45,817	$ 33,293	$ (12,524)		$ 389,141	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)	$ 1,557,438	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 73,630	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 61,110	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (12,520)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 575,389	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 and Rehab Ctr # 0050880 Report Period Beginning: 1/1/17 Ending: 12/31/17

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.	/2018	$
13.	/2019	$
14.	/2020	$

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 and Rehab Ctr # 0050880 Report Period Beginning: 1/1/17 Ending: 12/31/17

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff 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	$	2,306	$	122,270	$	2,306	$ 122,270	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		486		36,343		486	36,343	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10a-3	hrs		2,612		143,388		2,612	143,388	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					82,301		82,301	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify): X-Ray/Lab	39-2						519		519	12
13	Other (specify):										13
14	TOTAL			$	5,404	$	302,001	$ 82,820	5,404	$ 384,821	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 and Rehab Ctr **#** 0050880 **Report Period Beginning:** 1/1/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/17 **(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	$ 51,441	$ 124,629	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,003,978	1,003,978	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	38,908	38,908	6
7	Other Prepaid Expenses	3,815	3,814	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,098,142	$ 1,171,329	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	314,611	314,611	15
16	Equipment, at Historical Cost	192,827	417,827	16
17	Accumulated Depreciation (book methods)	(206,823)	(575,389)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		1,000,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(466,666)	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)**	$ 300,615	$ 1,515,383	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,398,757	$ 2,686,712	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 554,016	$ 700,379	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,813	15,813	28
29	Short-Term Notes Payable		121,289	29
30	Accrued Salaries Payable	95,793	95,793	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,683	8,683	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		17,988	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Working Capital	2,780,087	2,780,087	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,454,392	$ 3,740,032	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		4,067,439	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)**	$	$ 4,067,439	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,454,392	$ 7,807,471	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,055,635)	$ (5,120,759)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,398,757	$ 2,686,712	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,950,136)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,950,136)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(41,499)	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	(64,000)	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)**	$ (105,499)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,055,635)	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	$ 3,286,579	1
2	Discounts and Allowances for all Levels	572,092	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,858,671	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	296,041	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 296,041	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	42,626	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,001	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 44,627	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	38,231	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 38,231	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,237,570	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	700,418	31
32	Health Care	1,652,740	32
33	General Administration	891,382	33
	B. Capital Expense		
34	Ownership	693,387	34
	C. Ancillary Expense		
35	Special Cost Centers	82,828	35
36	Provider Participation Fee	173,518	36
	D. Other Expenses (specify):		
37	Bad Debt Expense	84,796	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,279,069	40
41	**Income before Income Taxes (line 30 minus line 40)****	(41,499)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (41,499)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,645,795	44
45	Private Pay - Net Inpatient Revenue	256,370	45
46	Medicare - Net Inpatient Revenue	868,648	46
47	Other-(specify)	87,858	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,858,671	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	1,827	2,033	$ 93,761	$ 46.12	1
2	Assistant Director of Nursing	1,410	1,459	40,177	27.54	2
3	Registered Nurses	7,150	7,471	212,015	28.38	3
4	Licensed Practical Nurses	7,730	8,418	195,129	23.18	4
5	CNAs & Orderlies	40,551	43,685	553,216	12.66	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,457	4,765	58,477	12.27	9
10	Activity Assistants					10
11	Social Service Workers	1,459	1,558	33,143	21.27	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,181	15,300	181,698	11.88	15
16	Dishwashers					16
17	Maintenance Workers	2,162	2,207	33,657	15.25	17
18	Housekeepers	9,220	9,591	105,960	11.05	18
19	Laundry	1,845	2,086	23,372	11.20	19
20	Administrator	2,080	2,253	64,648	28.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,410	11,082	160,611	14.49	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) Admissions Coord	177	195	2,922	14.98	33
34	TOTAL (lines 1 - 33)	104,659	112,103	$ 1,758,786 *	$ 15.69	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	199	$ 6,971	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	1,470	51,457	10-3	38
39	Pharmacist Consultant	126	6,318	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	76	2,675	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,871	$ 67,421		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
Kelsia Phillips	Administrator		$ 64,648
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 64,648

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
Bradley Associates	Accounting	$ 11,997
Johnson, Goldburg	Accounting	3,900
Heyl, Royster, Voelker & Allen	Legal	1,988
Infinity Funding/Sedgwick	Legal	9,604
MTS Consulting	Professional	22,827
Pinnacle Quality Insight	Professional	360
Empire Risk Management	Professional/Mgmt	12,000
Infinity Healthcare Mgmt	Professional/Mgmt	145,860
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 208,536

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 66,796
Unemployment Compensation Insurance	18,967
FICA Taxes	124,917
Employee Health Insurance	82,079
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	9,570
Uniform Expense	210
Employee Expense	7,842
Other Employee Benefits	15,594
TOTAL (agree to Schedule V, line 22, col.8)	$ 325,975

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	
IHCA	5,797
State Fire Marshall	240
LaSalle County Health Department	170
City of Streator	50
Various	591
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,848

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage	9,841
Travel Allowance	1,906
Seminar Expense	
Education & Seminars	495
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,242

* Attach copy of IMRF notifications

**See instructions.

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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 - 5,797**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **Yes** If YES, have these costs
been properly adjusted out of the cost report? **Yes**

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **38,837** 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 fo
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 Departmen
during this cost report period. $ **173,518**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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 fo
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
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