		FOR BHF USE					

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

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

I. **IDPH License ID Number:** 0051375

Facility Name: Parkshore Estates Nrsg & Reh

Address: 6125 South Kenwood (Number) | Chicago (City) | 60637 (Zip Code)

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 4/1/11

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 Parkshore Estates Nrsg & Reh # 0051375 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	128	Skilled (SNF)	128	46,720	1
2		Skilled Pediatric (SNF/PED)			2
3	190	Intermediate (ICF)	190	69,350	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	318	TOTALS	318	116,070	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	28,406	153	3,588	32,147	8
9	SNF/PED					9
10	ICF	42,165	227	2,283	44,675	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	70,571	380	5,871	76,822	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.19%

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 4/1/11

J. Was the facility purchased or leased after January 1, 1978?

YES [X] Date 4/1/11 NO [ ]

K. Was the facility certified for Medicare during the reporting year?

YES [X] NO [ ] If YES, enter number of beds certified 64 and days of care provided 2,050

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

Is your fiscal year identical to your tax year? YES [ ] 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 Parkshore Estates Nrsg & Reh # 0051375 **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	383,446	48,515	16,025	447,986		447,986	(927)	447,059			1
2	Food Purchase		430,228		430,228		430,228	1,536	431,764			2
3	Housekeeping	269,939	52,277		322,216		322,216	464	322,680			3
4	Laundry	130,770	41,490		172,260		172,260		172,260			4
5	Heat and Other Utilities			354,765	354,765		354,765	626	355,391			5
6	Maintenance	131,277	59,316	106,569	297,162		297,162	527	297,689			6
7	Other (specify):*											7
8	**TOTAL General Services**	915,432	631,826	477,359	2,024,617		2,024,617	2,226	2,026,843			8
	B. Health Care and Programs											
9	Medical Director			16,500	16,500		16,500		16,500			9
10	Nursing and Medical Records	3,414,086	216,844	51,457	3,682,387		3,682,387	1,348	3,683,735			10
10a	Therapy			870,497	870,497		870,497		870,497			10a
11	Activities	232,923	37,640		270,563		270,563		270,563			11
12	Social Services	230,025		3,384	233,409		233,409		233,409			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* **Pharmacy Consult**			22,770	22,770		22,770	(418)	22,352			15
16	**TOTAL Health Care and Programs**	3,877,034	254,484	964,608	5,096,126		5,096,126	930	5,097,056			16
	C. General Administration											
17	Administrative	122,095			122,095		122,095		122,095			17
18	Directors Fees											18
19	Professional Services			894,471	894,471		894,471	(100,254)	794,217			19
20	Dues, Fees, Subscriptions & Promotions			13,241	13,241		13,241	(241)	13,000			20
21	Clerical & General Office Expenses	271,905	68,952	129,805	470,662		470,662	128,087	598,749			21
22	Employee Benefits & Payroll Taxes			1,183,601	1,183,601		1,183,601	36,801	1,220,402			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,284	4,284		4,284	4,497	8,781			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			509,405	509,405		509,405	755	510,160			26
27	Other (specify):*											27
28	**TOTAL General Administration**	394,000	68,952	2,734,807	3,197,759		3,197,759	69,645	3,267,404			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,186,466	955,262	4,176,774	10,318,502		10,318,502	72,801	10,391,303			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 Parkshore Estates Nrsg & Reh #0051375 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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			76,595	76,595		76,595	941,353	1,017,948			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			88,773	88,773		88,773	663,964	752,737			32
33	Real Estate Taxes			447,054	447,054		447,054		447,054			33
34	Rent-Facility & Grounds			2,273,455	2,273,455		2,273,455	(2,267,486)	5,969			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Replacement Tax			316	316		316		316			36
37	TOTAL Ownership			2,886,193	2,886,193		2,886,193	(662,169)	2,224,024			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,633	2,633		2,633		2,633			38
39	Ancillary Service Centers		84,867		84,867		84,867	(1,475)	83,392			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			625,354	625,354		625,354		625,354			42
43	Other (specify):* Bad Debt			280,527	280,527		280,527	(280,527)				43
44	TOTAL Special Cost Centers		84,867	908,514	993,381		993,381	(282,002)	711,379			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,186,466	1,040,129	7,971,481	14,198,076		14,198,076	(871,370)	13,326,706			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 Parkshore Estates Nrsg & Reh # 0051375 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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	99,272	30		9
10	Interest and Other Investment Income	(55,539)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(10)	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	(505)	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	(280,527)	43		24
25	Fund Raising, Advertising and Promotional	(11,405)	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	(5,157)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (261,013)		$	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)	(610,357)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (610,357)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (871,370)		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

Parkshore Estates Nrsg & Reh

ID# 0051375

Report Period Beginning: 1/1/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (2,128)	21	1
2	Lobbying Dues	(1,052)	20	2
3	Related Party 1	(84)	10	3
4	Related Party 2	(418)	15	4
5	Related Party 3	(1,475)	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
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24				24
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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**	(5,157)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Parkshore Estates Nrsg & Reh # 0051375 **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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(10)	(917)	0	0	0	0	0	0	0	0	0	(927)	1
2	Food Purchase	0	1,536	0	0	0	0	0	0	0	0	0	1,536	2
3	Housekeeping	0	464	0	0	0	0	0	0	0	0	0	464	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	626	0	0	0	0	0	0	0	0	0	626	5
6	Maintenance	0	527	0	0	0	0	0	0	0	0	0	527	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(10)	2,236	0	0	0	0	0	0	0	0	0	2,226	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	(84)	1,432	0	0	0	0	0	0	0	0	0	1,348	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):*	(418)	0	0	0	0	0	0	0	0	0	0	(418)	15
16	**TOTAL Health Care and Programs**	(502)	1,432	0	0	0	0	0	0	0	0	0	930	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	(208,175)	107,921	0	0	0	0	0	0	0	0	(100,254)	19
20	Fees, Subscriptions & Promotions	(1,052)	811	0	0	0	0	0	0	0	0	0	(241)	20
21	Clerical & General Office Expenses	(21,180)	148,960	307	0	0	0	0	0	0	0	0	128,087	21
22	Employee Benefits & Payroll Taxes	0	36,801	0	0	0	0	0	0	0	0	0	36,801	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	4,497	0	0	0	0	0	0	0	0	0	4,497	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	755	0	0	0	0	0	0	0	0	0	755	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(22,232)	(16,351)	108,228	0	0	0	0	0	0	0	0	69,645	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(22,744)	(12,683)	108,228	0	0	0	0	0	0	0	0	72,801	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Parkshore Estates Nrsg & Reh # 0051375 **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 D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	99,272	0	842,081	0	0	0	0	0	0	0	0	941,353	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(55,539)	0	719,503	0	0	0	0	0	0	0	0	663,964	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(2,267,486)	0	0	0	0	0	0	0	0	(2,267,486)	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**	43,733	0	(705,902)	0	0	0	0	0	0	0	0	(662,169)	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	(1,475)	0	0	0	0	0	0	0	0	0	0	(1,475)	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):*	(280,527)	0	0	0	0	0	0	0	0	0	0	(280,527)	43
44	**TOTAL Special Cost Centers**	(282,002)	0	0	0	0	0	0	0	0	0	0	(282,002)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(261,013)	(12,683)	(597,674)	0	0	0	0	0	0	0	0	(871,370)	45

Facility Name & ID Number Parkshore Estates Nrsg & Reh # 0051375 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	Parkshore Estates	Hillside	Property Co.
A & F Realty	20%	City View Multicare Center	Cicero			
		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	$ 3,899	Infinity Healthcare Management of Illinois		$ 2,982	$ (917)	1
2	V	2	Food Purchase		Infinity Healthcare Management of Illinois		1,536	1,536	2
3	V	3	Housekeeping		Infinity Healthcare Management of Illinois		464	464	3
4	V	5	Utilities		Infinity Healthcare Management of Illinois		626	626	4
5	V	6	Maintenance		Infinity Healthcare Management of Illinois		527	527	5
6	V	10	Nursing	51,457	Infinity Healthcare Management of Illinois		52,889	1,432	6
7	V	11	Activities		Infinity Healthcare Management of Illinois				7
8	V	19	Professional Fees	344,231	Infinity Healthcare Management of Illinois		136,056	(208,175)	8
9	V	20	Dues & Fees		Infinity Healthcare Management of Illinois		811	811	9
10	V	21	Office Expense	121,411	Infinity Healthcare Management of Illinois		270,371	148,960	10
11	V	22	Employee Benefits		Infinity Healthcare Management of Illinois		36,801	36,801	11
12	V	24	Travel Expense		Infinity Healthcare Management of Illinois		4,497	4,497	12
13	V	26	Insurance		Infinity Healthcare Management of Illinois		755	755	13
14	Total			$ 520,998			$ 508,315	$ * (12,683)	14

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

Facility Name & ID Number Parkshore Estates Nrsg & Reh # 0051375 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	30	Depreciation	$	Infinity Healthcare Management of Illinois		$ 167	$ 167	15
16	V	32	Interest		Infinity Healthcare Management of Illinois		18	18	16
17	V	34	Rent		Infinity Healthcare Management of Illinois		5,969	5,969	17
18	V								18
19	V	19	Professional Fees		Parkshore Estates Nursing Realty		104,221	104,221	19
20	V	19	Office Expense		Parkshore Estates Nursing Realty		3,700	3,700	20
21	V	21	Filing Fees		Parkshore Estates Nursing Realty		307	307	21
22	V	30	Depreciation		Parkshore Estates Nursing Realty		841,914	841,914	22
23	V	32	Interest		Parkshore Estates Nursing Realty		719,485	719,485	23
24	V	34	Rent	2,273,455	Parkshore Estates Nursing Realty			(2,273,455)	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			$ 2,273,455			$ 1,675,781	$ * (597,674)	39

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

Facility Name & ID Number Parkshore Estates Nrsg & Reh # 0051375 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			Parker Nursing & Rehab Center	Streator				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 Parkshore Estates Nrsg & Reh # 0051375 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Parkshore Estates Nrsg & Reh # 0051375 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 Parkshore Estates Nrsg & Reh # 0051375 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**		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	HUD Loan		X	Property	$86,295.00	Various	$ 20,500,000	$ 20,411,378	6/1/51	3.5000	$ 719,878	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Capital One		X	Working Capital	None	8/31/14	15,000,000	4,041,553	8/31/18	2.9500	88,398	6
7												7
8												8
9	TOTAL Facility Related				$86,295.00		$ 35,500,000	$ 24,452,931			$ 808,276	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 35,500,000	$ 24,452,931			$ 808,276	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 134,152 Line # 26

*** 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 Parkshore Estates Nrsg & Reh # 0051375 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.**	$ 21,070	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.)		$ 453,254	2
3. Under or (over) accrual (line 2 minus line 1).		$ 432,184	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 14,870	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		$ 447,054	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	386,276	8
	2013	366,930	9
	2014	379,646	10
	2015	405,491	11
	2016	453,254	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 Parkshore Estates Nrsg & Reh COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051375

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.	20-14-408-015-0000	Nursing Home	$ 3,407.00	$ 3,407.00
2.	20-14-408-016-0000	Nursing Home	$ 3,319.00	$ 3,319.00
3.	20-14-408-017-0000	Nursing Home	$ 1,648.00	$ 1,648.00
4.	20-14-409-004-0000	Nursing Home	$ 108,668.00	$ 108,668.00
5.	20-14-409-005-0000	Nursing Home	$ 326,163.00	$ 326,163.00
6.	20-14-409-006-0000	Nursing Home	$ 5,748.00	$ 5,748.00
7.	20-14-409-007-0000	Nursing Home	$ 2,885.00	$ 2,885.00
8.	20-14-409-008-0000	Nursing Home	$ 1,416.00	$ 1,416.00
9.			$	$
10.			$	$
		TOTALS	$ 453,254.00	$ 453,254.00

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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 Parkshore Estates Nrsg & Reh # 0051375 Report Period Beginning: 1/1/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 83,520 B. General Construction Type: Exterior Brick Frame Concrete Number of Stories 6

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			2015	$ 500,000	1
2					2
3	TOTALS			$ 500,000	3

Facility Name & ID Number Parkshore Estates Nrsg & Reh # 0051375 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	318		2015		$ 19,884,200	$ 509,856	39	$ 509,851	$ (5)	$ 1,487,080	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	DOOR SCREEN			2011	1,875	48	39	48		324	9
10	NEW LIGHT FIXTURES FOR FACILITY			2011	28,695	736	39	736		4,967	10
11	CEILING TILE			2011	1,361	35	39	35		236	11
12	FENCE			2011	2,971	76	39	76		513	12
13	CEMENT FOR HANDICAP RAMP			2011	8,000	205	39	205		1,384	13
14	COUNTERTOPS, CEILING TILE, CROWN MOLDING,										14
15	MINI BLINDS, LED STRIP LIGHT, W.A.C. LIGHTING, TILE										15
16	FLOORING, WOOD PANELING, HAND RAILS, WALL										16
17	COVERING, PARTITION, DOUBLE DOOR, VINYL BASE										17
18	VINYL FLOORING, VINYL WALL BASE, LAMINATE PANELS										18
19	FOR LOBBY, PHYSICAL THERAPY ROOM, AND ELEVATOR			2011	57,107	1,464	39	1,464		9,883	19
20											20
21	PLUMBING AND DRYWALL IN 6TH FLOOR DIALYSIS ROOM			2012	8,246	211	39	211		1,268	21
22	DOOR LOCK SYSTEM ON LOBBY DOOR			2012	2,851	73	39	73		438	22
23	FLOORING & WALLS ON 1ST FLOOR THERAPY ROOMS			2012	11,274	289	39	289		1,734	23
24	FLORING & WALLS IN MAIN LOBBY			2012	11,274	289	39	289		1,734	24
25	INSTALL SPRINKLER SYSTEM			2012	4,775	122	39	122		734	25
26											26
27	EIDCO CREDIT??			2012	(57,107)	(1,464)	39	(1,464)		(8,786)	27
28	REMOVE WALLPAPER, PRIME, PAINT ON 1ST FLOOR ADMIN OI			2012	4,500	115	39	115		692	28
29	ROOFING REPAIR			2012	1,200	31	39	31		185	29
30	REPAIR FOUNDATIONAL CRACKS			2012	2,600	67	39	67		401	30
31	INSTALLATION OF FIRE ALARM SYSTEM			2012	17,990	461	39	461		2,767	31
32	REMOVE CARPETING AND INSTALL NEW FLOOR ON 1ST FLOO			2012	1,165	30	39	30		180	32
33	PLUMBING AND ROUGH IN FOR 10 DIALYSIS STATIONS										33
34	INCLUDING NEW DRAINS, BACK FLOW PREVENTOR, AND PIPING										34
35	FOR 6th FLOOR DIALYIS ROOMS			2012	12,000	308	39	308		1,847	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 Parkshore Estates Nrsg & Reh # 0051375 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	REPAIR BOILER	2012	$ 2,929	$ 75	39	$ 75	$	$ 450	37
38									38
39	INSTALL SIGN AND MOUNT ON WALL	2012	1,150	29	39	29		176	39
40									40
41	1ST FLOOR LOBBY/RECEPTION - NEW FLOORING, NEW								41
42	COUNTERS, LIGHTING, PAINT AND CROWN MOLDING,								42
43	WALLCOVERINGS & BLINDS								43
44	1ST FLOOR ELEVATOR LOBBY - LIGHTING, TILE								44
45	FLOORING, WALL BASE, RAILINGS, WALLCOVERINGS								45
46	1ST FLOOR NEW PT ROOM - FLOORING, LIGHTING								46
47	GLASS DOOR, VINYL BASE, PAINT	2012	117,214	3,007	39	3,005	(2)	18,038	47
48	Toshiba phone system	2013	21,732	557	39	557		2,507	48
49	3rd floor corridor floor & cove base, wall coverings, nurses	2013	116,909	2,999	39	2,998	(1)	13,494	49
50	station counter top & lighting, dining room floor & cove base,								50
51	lighting, common area and resident room signage								51
52	Fire alarm	2013	2,721	70	39	70		315	52
53	Durolast roofing system	2013	68,800	1,764	39	1,764		7,939	53
54	Storage room & locks	2013	4,716	121	39	121		544	54
55	Sign / logo / Lettering	2013	1,150	29	39	29		131	55
56	Awning support posts	2013	5,100	131	39	131		589	56
57	Awning support posts	2013	1,000	26	39	26		117	57
58	Permits	2013	1,650	42	39	42		189	58
59	Building cooling tower	2013	2,275	58	39	58		261	59
60	Electrical Wiring on 6th floor for WAP at nurses station and kiosks	2013	17,985	461	39	461		2,075	60
61	Electrical Wiring & lighting - 3rd floor dialysis & nurses station	2013	4,610	118	39	118		531	61
62	Masonry on outide of building	2013	114,600		39	2,938	2,938		62
63	Water Heaters	2014	23,900	613	39	613		2,452	63
64	Doors	2014	5,939	152	39	152		608	64
65	Paint every hallway and the dining room on 3rd floor	2014	18,825	483	39	483		1,932	65
66	Fire Doors in laundry & therapy	2014	4,459	114	39	114		456	66
67	Elevator mainenance	2014	2,575	66	39	66		264	67
68	Remover Adv Medical from 2013	2014	(2,275)	(58)	39	(58)		(232)	68
69	Flat Scan & monitor module	2014	4,047	104	39	104		416	69
70	TOTAL (lines 4 thru 69)		$ 20,546,987	$ 523,913		$ 526,843	$ 2,930	$ 1,560,833	70

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

Facility Name & ID Number Parkshore Estates Nrsg & Reh # 0051375 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	
1	Totals from Page 12A, Carried Forward		$ 20,546,987	$ 523,913		$ 526,843	$ 2,930	$ 1,560,833	1
2	New Passage Lever Door Locks	2015	8,316	219	39	213	(6)	612	2
3	Replaced A/C Cooling Tower	2015	18,460	487	39	473	(14)	1,361	3
4	Add Scale Remover to Cooling Tower	2015	4,190	110	39	107	(3)	308	4
5	New walls, tile, and flooring in 4th Floor Shower Room	2015	7,342	193	39	188	(5)	540	5
6	New walls, tile, & flooring 2nd & 4th Floor Shower Room	2015	6,253	165	39	160	(5)	461	6
7	Replaced Exhaust Fan Motors	2015	5,006	132	39	128	(4)	369	7
8	Replaced Exhaust Fan	2015	8,737	230	39	224	(6)	643	8
9	Replaced A/C Control Unit	2015	7,210	190	39	185	(5)	531	9
10	Replace Wall, Floor, Tiles, Shower Base in 5th Fl Shower Rm	2015	6,814	180	39	175	(5)	503	10
11	Furnish & Install ADA Covers under sinks on Floors 2-5	2015	5,151	136	39	132	(4)	380	11
12	New Passage Lever Door Locks	2015	2,626	69	39	67	(2)	193	12
13	New Passage Lever Door Locks	2015	5,711	150	39	146	(4)	420	13
14	Tuck Pointing and Spalled Brick Repairs to the Building	2015	8,000	211	39	205	(6)	590	14
15	Clean, Sealcoat, Repave, and Restripe Parking Lot	2015	36,815	970	39	944	(26)	2,712	15
16	Install New Floor & Door Threshold on 6th Fl in Wings B&C	2015	11,298	298	39	290	(8)	833	16
17	Install Door Restrictors for Elevators	2015	5,500	145	39	141	(4)	405	17
18									18
19	Paint boiler rm, 2 electrical rooms, & elevator frame 1st fl	2016	3,014	77	39	77		154	19
20	Replace faulty hydronic unit heater in the boiler room	2016	2,975	76	39	76		152	20
21	Replace therapy rm doors 1st floor & raise patio fence b 2ft	2016	8,560	220	39	219	(1)	440	21
22	Replace forced air convector in 6th fl dining rm & game rm	2016	9,400	241	39	241		482	22
23	Remove and replace 16' x 17' concrete pad	2016	3,100	80	39	79	(1)	160	23
24	Shower rm 2nd floor - replace walls, floor, & ceiling	2016	8,033	206	39	206		412	24
25	Replace 10-hp cooling tower fan motor	2016	9,130	234	39	234		468	25
26	Install shunt trip for 2 passenger & 1 freight elevators	2016	6,500	167	39	167		334	26
27	Window cables allowing residents to open windows 2"	2016	5,100	131	39	131		262	27
28	Shower rm B 5th fl - replace walls, floor, & ceiling	2016	8,392	215	39	215		430	28
29	Install new fire alarm for elevator recall system	2016	39,384	1,010	39	1,010		2,020	29
30	Shower rm B 4th fl - replace walls, floor, & ceiling	2016	11,326	290	39	290		580	30
31	1st fl bathroom replace toilet, sink, mirror, light, floor tiles								31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 20,809,329	$ 530,745		$ 533,566	$ 2,821	$ 1,577,588	34

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

Facility Name & ID Number Parkshore Estates Nrsg & Reh # 0051375 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	
1	Totals from Page 12B, Carried Forward		$ 20,809,329	$ 530,745		$ 533,566	$ 2,821	$ 1,577,588	1
2	Refurbished Bearing Motor on Circulating Pump #1	2016	5,279	67	39	135	68	67	2
3	Domestic Water Mixing Valve	2017	2,879	37	39	74	37	37	3
4	Paint 6th Floor C Wing & 1st Floor Lobby	2017	3,700	47	39	95	48	47	4
5	Refurbished 3rd Floor Show Room on B Wing	2017	8,393	108	39	215	107	108	5
6	New Awnings at Parkshore East - Chesterfield Awning	2017	4,994	64	39	128	64	64	6
7	New Underground Line for Parking Lot Lights	2017	2,475	32	39	63	31	32	7
8	New Air Handler Chilled Hot Water Coils	2017	18,900	242	39	485	243	242	8
9	Seco Refrigeration - Replace Pump & Motor for Dishwasher	2017	4,223	54	39	108	54	54	9
10	City of Chicago - Crosswalk and Stripping	2017	19,233	247	39	493	246	247	10
11	Cary Supply - Stairway Door Alarms	2017	2,708	35	39	69	34	35	11
12	Suburban Elevator - 3 Elevator Door Operators	2017	13,200	169	39	338	169	169	12
13	Complete Concrete - Removal of Concrete Steps	2017	5,200	67	39	133	66	67	13
14	Alliance Construction - New Hot Water Tank	2017	11,348	146	39	291	145	146	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)		$ 20,911,861	$ 532,060		$ 536,193	$ 4,133	$ 1,578,903	34

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

Facility Name & ID Number Parkshore Estates Nrsg & Reh # 0051375 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	$ 2,377,127	$ 354,965	$ 475,425	$ 120,460	5	$ 1,184,874	71
72	Current Year Purchases	31,651	31,651	6,330	(25,321)	5	31,651	72
73	Fully Depreciated Assets	319,093				5	319,093	73
74								74
75	TOTALS	$ 2,727,871	$ 386,616	$ 481,755	$ 95,139		$ 1,535,618	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)	$ 24,139,732	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 918,676	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 1,017,948	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 99,272	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,114,521	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 Parkshore Estates Nrsg & Reh # 0051375 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

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	$

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: *

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 Parkshore Estates Nrsg & Reh # 0051375 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	$	6,632	$ 406,024	$	6,632	$ 406,024	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,620	96,005		1,620	96,005	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		5,300	368,468		5,300	368,468	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				80,345		80,345	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-ray/Laboratory	39-2					4,523		4,523	12
13	Other (specify):									13
14	TOTAL			$	13,552	$ 870,497	$ 84,868	13,552	$ 955,365	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 Parkshore Estates Nrsg & Reh **#** 0051375 **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	$ (217,760)	$ 1,078,864	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,056,210	4,056,210	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	338,105	338,105	6
7	Other Prepaid Expenses	2,211	2,211	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	388,629	913,772	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,567,395	$ 6,389,162	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		500,000	13
14	Buildings, at Historical Cost		19,884,200	14
15	Leasehold Improvements, at Historical Cos	917,161	917,161	15
16	Equipment, at Historical Cost	580,571	2,838,371	16
17	Accumulated Depreciation (book methods)	(659,813)	(3,114,522)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	44,494	519,057	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(14,273)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	375,248	375,248	22
23	Other(specify):		810,277	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,257,661	$ 22,715,519	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,825,056	$ 29,104,681	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,513,983	$ 2,022,630	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,957	25,957	28
29	Short-Term Notes Payable		748,499	29
30	Accrued Salaries Payable	300,961	300,961	30
31	Accrued Taxes Payable (excluding real estate taxes)	24,819	24,819	31
32	Accrued Real Estate Taxes(Sch.IX-B)	313,911	313,911	32
33	Accrued Interest Payable		59,533	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Settlement Reserve	4,041,553	4,041,553	36
37	Due to Infinity Funding IL	2,615	2,615	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,223,799	$ 7,540,478	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		20,085,033	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)**	$	$ 20,085,033	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,223,799	$ 27,625,511	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (398,743)	$ 1,479,170	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,825,056	$ 29,104,681	48

***(See instructions.)**

Facility Name & ID Number Parkshore Estates Nrsg & Reh **#** 0051375 **Report Period Beginning:** 1/1/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (113,820)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (113,820)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(284,923)	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)**	$ (284,923)	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)**	$ (398,743)	24 *

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

Facility Name & ID Number Parkshore Estates Nrsg & Reh # 0051375 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	$ 12,527,671	1
2	Discounts and Allowances for all Levels	802,609	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,330,280	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	462,729	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 462,729	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	57,859	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,812	19
20	Radiology and X-Ray	676	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 64,347	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	53,672	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 53,672	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Misc. Income	2,128	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,128	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,913,156	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,024,617	31
32	Health Care	5,096,126	32
33	General Administration	3,197,761	33
	B. Capital Expense		
34	Ownership	2,886,194	34
	C. Ancillary Expense		
35	Special Cost Centers	87,500	35
36	Provider Participation Fee	625,354	36
	D. Other Expenses (specify):		
37	Bad Debt	280,527	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,198,079	40
41	**Income before Income Taxes (line 30 minus line 40)****	(284,923)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (284,923)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 11,362,640	44
45	Private Pay - Net Inpatient Revenue	68,400	45
46	Medicare - Net Inpatient Revenue	1,172,074	46
47	Other-(specify)	727,166	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 13,330,280	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.**

Facility Name & ID Number Parkshore Estates Nrsg & Reh # 0051375 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	2,189	2,064	$ 121,287	$ 58.76	1
2	Assistant Director of Nursing	7,845	7,806	289,902	37.14	2
3	Registered Nurses	14,598	15,985	561,654	35.14	3
4	Licensed Practical Nurses	37,610	37,325	1,085,154	29.07	4
5	CNAs & Orderlies	92,975	101,578	1,264,997	12.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	12,426	16,328	232,923	14.27	9
10	Activity Assistants					10
11	Social Service Workers	9,118	12,358	230,025	18.61	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,230	27,165	383,446	14.12	15
16	Dishwashers					16
17	Maintenance Workers	8,465	8,552	131,277	15.35	17
18	Housekeepers	18,621	22,925	269,939	11.77	18
19	Laundry	10,972	10,622	130,770	12.31	19
20	Administrator	1,944	1,959	122,095	62.33	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,445	13,985	271,906	19.44	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,972	1,862	32,812	17.62	31
32	Other Health Care(specify)					32
33	Other(specify) Admissions Cord.	1,712	2,048	58,279	28.46	33
34	TOTAL (lines 1 - 33)	261,122	282,562	$ 5,186,466 *	$ 18.36	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	458	$ 16,025	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	455	22,770	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	54	1,874	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,437	$ 92,126		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 Parkshore Estates Nrsg & Reh # 0051375 Report Period Beginning: 1/1/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Thomeka Brown	Administrator		$ 122,095
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 122,095

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	$ 7,519
Johnson, Goldburg, & Brown	Accounting	2,900
Other	Accounting	5,000
Schiff Hardin, LLP	Legal	167,332
Infinity Funding / Sedgwick	Legal	161,083
Leahy, Eisenberg, & Frankael	Legal	63,531
Law Office of John C Ireland	Legal	30,475
Various Legal	Legal	59,272
MTS Consulting	Professional	35,512
Healthcare Recruiting Specialists	Professional	5,616
Infinity Healthcare	Professional/Mgmt	344,231
Empire Risk	Professional/Mgmt	12,000
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 894,471

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 188,722
Unemployment Compensation Insurance	89,901
FICA Taxes	376,379
Employee Health Insurance	182,000
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniform Expense	3,614
Employee Expense	87,428
Other Employee Benefits	36,801
Employee Background Checks	2,950
Workers' Compensation Settlement	252,607
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,220,402

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	16,850
City of Chicago	415
IHCA PAC	1,052
Various	(5,317)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,000

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage	1,890
Seminar Expense	
Seminars	6,891
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,781

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Parkshore Estates Nrsg & Reh # 0051375 Report Period Beginning: 1/1/17 Ending: 12/31/17

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Healthcare Association $16,850**

(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 expens and the location of this expense on Sch. V. $ **53,542** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedure 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. $ **625,354**
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 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 benefit 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? **Yes**
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 othe times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjustec 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 ou 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