



Facility Name & ID Number Parc At Joliet, Llc

# 0052571 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>203</u>	Skilled (SNF)	<u>203</u>	<u>74,095</u>	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	<u>203</u>	TOTALS	<u>203</u>	<u>74,095</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>32,805</u>	<u>4,724</u>	<u>10,007</u>	<u>47,536</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>32,805</u>	<u>4,724</u>	<u>10,007</u>	<u>47,536</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.16%

D. How many bed reserve days during this year were paid by the Department?

None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 11/1/2013

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

YES  Date 11/1/2013 NO

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

YES  NO  If YES, enter number of beds certified 203 and days of care provided 8,556

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/18 Fiscal Year: 12/31/18

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

Facility Name & ID Number Parc At Joliet, Llc # 0052571 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	384,880	82,550	12,519	479,949		479,949	184	480,133		1
2	Food Purchase		352,637		352,637		352,637	(16,974)	335,663		2
3	Housekeeping	366,203	60,254		426,457		426,457	1,002	427,459		3
4	Laundry	68,646	27,568		96,214		96,214		96,214		4
5	Heat and Other Utilities			183,070	183,070		183,070	1,498	184,568		5
6	Maintenance	121,638	25,399	200,038	347,075		347,075	12,481	359,556		6
7	Other (specify):*							735	735		7
8	<b>TOTAL General Services</b>	941,367	548,408	395,627	1,885,402		1,885,402	(1,074)	1,884,328		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			51,000	51,000		51,000		51,000		9
10	Nursing and Medical Records	3,412,059	300,063	21,415	3,733,537		3,733,537	(3,932)	3,729,605		10
10a	Therapy	192,574			192,574		192,574		192,574		10a
11	Activities	203,584	21,370		224,954		224,954		224,954		11
12	Social Services	316,155	952	2,064	319,171		319,171		319,171		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	4,124,372	322,385	74,479	4,521,236		4,521,236	(3,932)	4,517,304		16
	<b>C. General Administration</b>										
17	Administrative	140,293			140,293		140,293	17,934	158,227		17
18	Directors Fees										18
19	Professional Services			314,216	314,216	(4,773)	309,443	(137,071)	172,372		19
20	Dues, Fees, Subscriptions & Promotions			74,358	74,358		74,358	(29,369)	44,989		20
21	Clerical & General Office Expenses	134,355	34,245	572,171	740,771		740,771	(385,730)	355,041		21
22	Employee Benefits & Payroll Taxes			955,574	955,574		955,574	(6,801)	948,773		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,237	4,237		4,237	349	4,586		24
25	Other Admin. Staff Transportation			30	30		30	925	955		25
26	Insurance-Prop.Liab.Malpractice			343,666	343,666		343,666	1,683	345,349		26
27	Other (specify):*							31,279	31,279		27
28	<b>TOTAL General Administration</b>	274,648	34,245	2,264,252	2,573,145	(4,773)	2,568,372	(506,801)	2,061,571		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,340,387	905,038	2,734,358	8,979,783	(4,773)	8,975,010	(511,807)	8,463,203		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 &amp; ID Number

Parc At Joliet, Llc

#0052571

Report Period Beginning:

01/01/18

Ending:

12/31/18

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			121,186	121,186		121,186	173,456	294,642			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			65,232	65,232		65,232	302,140	367,372			32
33	Real Estate Taxes			144,067	144,067	4,773	148,840	4,429	153,269			33
34	Rent-Facility & Grounds			1,409,326	1,409,326		1,409,326	(1,408,490)	836			34
35	Rent-Equipment & Vehicles			28,389	28,389		28,389	461	28,850			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,768,200	1,768,200	4,773	1,772,973	(928,004)	844,969			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		415,353	1,230,176	1,645,529		1,645,529	(25,566)	1,619,963			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			342,343	342,343		342,343		342,343			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		415,353	1,572,519	1,987,872		1,987,872	(25,566)	1,962,306			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,340,387	1,320,391	6,075,077	12,735,855		12,735,855	(1,465,377)	11,270,478			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.



Parc At Joliet, Llc

ID# 0052571

Report Period Beginning: 01/01/18

Ending: 12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Patient Clothing	\$ (553)	10	1
2	Collection Expense	(10,822)	21	2
3	Rev - Other Income	(6,952)	21	3
4	Out of Period	(1,315)	21	4
5	Building Company - Management Fee	(15,225)	17	5
6	Building Company - State Replacement Tax	(11,385)	21	6
7	Building Company - Amortization Expense	(10,870)	36	7
8	Building Company - Filing Fee	(172)	21	8
9	Capitalized R & M	(16,999)	02	9
10	Non-Allowable Professional Fees	(4,311)	19	10
11	Chamber of Commerce Due	(550)	20	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	<b>Total</b>	(79,154)		49

Parc At Joliet, Llc

Report Period Beginning: ID# 0052571  
 Ending: 01/01/18  
 12/31/18

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

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Parc At Joliet, Llc# 0052571

Report Period Beginning:

01/01/18

Ending:

12/31/18

## 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)	
<b>1</b>	<b>A. General Services</b>													
1	Dietary			184									184	1
2	Food Purchase	(17,349)		375									(16,974)	2
3	Housekeeping			1,002									1,002	3
4	Laundry													4
5	Heat and Other Utilities			1,498									1,498	5
6	Maintenance			4,010	8,471								12,481	6
7	Other (specify):*				735								735	7
8	<b>TOTAL General Services</b>	<b>(17,349)</b>		<b>7,069</b>	<b>9,206</b>								<b>(1,074)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(553)				(3,379)							(3,932)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>	<b>(553)</b>				<b>(3,379)</b>							<b>(3,932)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(15,225)	15,225	1,437	16,497								17,934	17
18	Directors Fees													18
19	Professional Services	(4,311)		(132,760)									(137,071)	19
20	Fees, Subscriptions & Promotions	(31,211)		1,842									(29,369)	20
21	Clerical & General Office Expenses	(516,150)	11,557	9,452	109,411								(385,730)	21
22	Employee Benefits & Payroll Taxes				(6,801)								(6,801)	22
23	Inservice Training & Education													23
24	Travel and Seminar			349									349	24
25	Other Admin. Staff Transportation			925									925	25
26	Insurance-Prop.Liab.Malpractice			1,683									1,683	26
27	Other (specify):*				31,279								31,279	27
28	<b>TOTAL General Administration</b>	<b>(566,897)</b>	<b>26,782</b>	<b>(117,072)</b>	<b>150,386</b>								<b>(506,801)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(584,799)</b>	<b>26,782</b>	<b>(110,003)</b>	<b>159,592</b>		<b>(3,379)</b>						<b>(511,807)</b>	<b>29</b>



STATE OF ILLINOIS

Facility Name & ID Number Parc At Joliet, Llc

# 0052571

Report Period Beginning:

01/01/18

Ending:

Summary B

12/31/18

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	(75,428)	246,438	2,446									173,456	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(3,366)	284,527	20,979									302,140	32
33	Real Estate Taxes			4,429									4,429	33
34	Rent-Facility & Grounds		(1,408,490)										(1,408,490)	34
35	Rent-Equipment & Vehicles			461									461	35
36	Other (specify):*	(10,870)	10,870											36
37	<b>TOTAL Ownership</b>	<b>(89,664)</b>	<b>(866,655)</b>	<b>28,315</b>									<b>(928,004)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(25,566)							(25,566)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>					<b>(25,566)</b>							<b>(25,566)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(674,463)</b>	<b>(839,873)</b>	<b>(81,688)</b>	<b>159,592</b>	<b>(28,945)</b>							<b>(1,465,377)</b>	<b>45</b>

Facility Name & ID Number

Parc At Joliet, Llc

# 0052571

Report Period Beginning:

01/01/18

Ending:

12/31/18

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rental Income	\$ 1,408,490	Glenwood Real Estate		\$	\$ (1,408,490)	1
2	V	32 Interest		Glenwood Real Estate		284,527	284,527	2
3	V	17 Management Fees		Glenwood Real Estate		15,225	15,225	3
4	V	21 State Replacement Tax		Glenwood Real Estate		11,385	11,385	4
5	V	30 Depreciation		Glenwood Real Estate		246,438	246,438	5
6	V	36 Amortization Expense		Glenwood Real Estate		10,870	10,870	6
7	V	21 Filing Fee		Glenwood Real Estate		172	172	7
8	V	33 Real Estate Tax Expense	144,067	Glenwood Real Estate		144,067		8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,552,557			\$ 712,684	\$ * (839,873)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	<u>01</u> Dietary	\$	Extended Care Consulting, LLC		\$ 184	\$ 184
16	V	<u>02</u> Food		Extended Care Consulting, LLC		375	375
17	V	<u>03</u> Housekeeping		Extended Care Consulting, LLC		1,002	1,002
18	V	<u>05</u> Utilities		Extended Care Consulting, LLC		1,498	1,498
19	V	<u>06</u> Maintenance		Extended Care Consulting, LLC		4,010	4,010
20	V	<u>17</u> Administrative		Extended Care Consulting, LLC		1,437	1,437
21	V	<u>19</u> Professional Fees	138,000	Extended Care Consulting, LLC		5,240	(132,760)
22	V	<u>20</u> Dues and Subscriptions		Extended Care Consulting, LLC		1,842	1,842
23	V	<u>21</u> Office and Clerical		Extended Care Consulting, LLC		9,452	9,452
24	V	<u>24</u> Seminar and Travel		Extended Care Consulting, LLC		349	349
25	V	<u>25</u> Other Staff Admin. Trans.		Extended Care Consulting, LLC		925	925
26	V	<u>26</u> Insurance		Extended Care Consulting, LLC		1,683	1,683
27	V	<u>30</u> Depreciation		Extended Care Consulting, LLC		2,446	2,446
28	V	<u>32</u> Interest		Extended Care Consulting, LLC		20,979	20,979
29	V	<u>33</u> Real Estate Taxes		Extended Care Consulting, LLC		4,429	4,429
30	V	<u>35</u> Rent - Equipment		Extended Care Consulting, LLC		461	461
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 138,000			\$ 56,312	\$ * (81,688)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	06 Maintenance (Pooled)		Extended Care Consulting, LLC		8,471	\$ 8,471
16	V	06 Maintenance (Direct)		Extended Care Consulting, LLC			
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC		735	735
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC			
19	V						
20	V						
21	V	17 Administrative (Pooled)		Extended Care Consulting, LLC		16,497	16,497
22	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC		108,031	108,031
23	V	21 Office and Clerical (Direct)	22,669	Extended Care Consulting, LLC		24,049	1,380
24	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC		24,903	24,903
25	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC		6,376	6,376
26	V	22 Employee Benefits	6,801	Extended Care Consulting, LLC			(6,801)
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 29,470			\$ 189,062	\$ * 159,592

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 Nursing and Medical Records	39,209	MAC Rx, LLC		35,829	(3,379)
16	V	39 Ancillary	296,633	MAC Rx, LLC		271,068	(25,566)
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	<b>Total</b>		\$ 335,842			\$ 306,897	\$ * (28,945)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	22 Employee Health Insurance	\$	CCS Employee Benefits Group		\$ 264,323	\$ 264,323
16	V						
17	V						
18	V						
19	V	22 Employee Health Insurance	264,323	CCS Employee Benefits Group			(264,323)
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 264,323			\$ 264,323	\$ *

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

Facility Name & ID Number **Parc At Joliet, Llc**

# **0052571**

Report Period Beginning: **01/01/18**

Ending: **12/31/18**

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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



**VII. RELATED PARTIES (continued)**

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

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

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

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

Facility Name & ID Number **Parc At Joliet, Llc**

# **0052571**

Report Period Beginning: **01/01/18**

Ending: **12/31/18**

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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





Facility Name & ID Number Parc At Joliet, Llc # 0052571 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	N/A								\$	1	
2										2	
3										3	
4										4	
5										5	
6										6	
7										7	
8										8	
9										9	
10										10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$	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 Parc At Joliet, Llc

# 0052571 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 Parc At Joliet, Llc

# 0052571 Report Period Beginning: 01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Extended Care Consulting, LLC  
 Street Address 2201 West Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 905-3000  
 Fax Number ( 847) 905-3030

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,389,746	40	\$ 5,386	\$ 47,536	\$ 184	1
2	02	Food	Patient Days	1,389,746	40	10,961	47,536	375	2
3	03	Housekeeping	Patient Days	1,389,746	40	29,295	47,536	1,002	3
4	05	Utilities	Patient Days	1,389,746	40	43,781	47,536	1,498	4
5	06	Maintenance	Patient Days	1,389,746	40	117,234	47,536	4,010	5
6	17	Administrative	Patient Days	1,389,746	40	42,000	47,536	1,437	6
7	19	Professional Fees	Patient Days	1,389,746	40	153,207	47,536	5,240	7
8	20	Dues and Subscriptions	Patient Days	1,389,746	40	53,847	47,536	1,842	8
9	21	Office and Clerical	Patient Days	1,389,746	40	276,330	47,536	9,452	9
10	24	Seminar and Travel	Patient Days	1,389,746	40	10,217	47,536	349	10
11	25	Other Staff Admin. Trans.	Patient Days	1,389,746	40	27,054	47,536	925	11
12	26	Insurance	Patient Days	1,389,746	40	49,193	47,536	1,683	12
13	30	Depreciation	Patient Days	1,389,746	40	71,516	47,536	2,446	13
14	32	Interest	Patient Days	1,389,746	40	613,328	47,536	20,979	14
15	33	Real Estate Taxes	Patient Days	1,389,746	40	129,471	47,536	4,429	15
16	35	Rent - Equipment	Patient Days	1,389,746	40	13,470	47,536	461	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,646,291	\$	\$ 56,312	25



Facility Name & ID Number Parc At Joliet, Llc

# 0052571

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

Extended Care Consulting, LLC  
2201 West Main Street  
Evanston, Illinois 60202  
( 847) 905-3000  
( 847) 905-3030

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	06	Maintenance (Pooled)	Patient Days	1,389,746	40	247,664	247,664	47,536	8,471	1
2	06	Maintenance (Direct)	Direct		25	357,298	357,298			2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,389,746	40	21,482		47,536	735	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		25	47,140				4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,389,746	40	482,303	482,303	47,536	16,497	7
8	21	Office and Clerical (Pooled)	Patient Days	1,389,746	40	3,158,355	3,158,355	47,536	108,031	8
9	21	Office and Clerical (Direct)	Direct		28	484,472	484,472		24,049	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,389,746	40	728,044		47,536	24,903	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		28	72,742			6,376	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					\$ 5,599,498	\$ 4,730,091		\$ 189,062	25

Facility Name & ID Number Parc At Joliet, Llc

# 0052571 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization MAC Rx, LLC  
 Street Address 2307 S. Mount Prospect Road  
 City / State / Zip Code Des Plaines, IL 60018  
 Phone Number ( 224)220-2700  
 Fax Number ( 224)220-2730

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	Nursing And Medical Records	Direct Allocation					35,829	1
2	39	Ancillary	Direct Allocation					271,068	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				\$	\$		306,897	25

Facility Name & ID Number Parc At Joliet, Llc

# 0052571

Report Period Beginning:

01/01/18

Ending: 12/31/18

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

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

CCS Employee Benefits Group, Inc.  
2201 Main Street  
Evanston, Illinois 60202  
( 847)905-4000  
( 847)905-4040

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 264,323	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				\$	\$		\$ 264,323	25

Facility Name & ID Number Parc At Joliet, Llc

# 0052571 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 Parc At Joliet, Llc

# 0052571 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 Parc At Joliet, Llc

# 0052571 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 Parc At Joliet, Llc

# 0052571

Report Period Beginning:

01/01/18

Ending: 12/31/18

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Parc At Joliet, Llc

# 0052571 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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

Parc At Joliet, Llc

# 0052571

Report Period Beginning:

01/01/18

Ending:

12/31/18

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	The Private Bank		X	Mortgage			\$	\$ 4,897,900		\$ 284,527	1									
2											2									
3											3									
4											4									
5											5									
<b>Working Capital</b>																				
6	The Private Bank		X	Line of Credit				\$ 1,000,000		\$ 65,232	6									
7											7									
8											8									
9	<b>TOTAL Facility Related</b>						\$	\$ 5,897,900		\$ 349,759	9									
<b>B. Non-Facility Related*</b>																				
10	Interest Income		X							\$ (3,366)	10									
11	Allocated from EC Consulting		X							\$ 20,979	11									
12											12									
13											13									
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$ 17,613	14									
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 5,897,900		\$ 367,372	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ N/A      Line # 36

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

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



**2017 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Parc At Joliet, Llc COUNTY Will  
 FACILITY IDPH LICENSE NUMBER 0052571  
 CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_  
 TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>30-07-07-304-025-0000</u>	<u>Long Term Care Facility</u>	\$ <u>150,465.60</u>	\$ <u>150,465.60</u>
2. <u>See Attached</u>	<u>Allocated from Care Center Building</u>	\$ <u>190,923.89</u>	\$ <u>4,428.52</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>341,389.49</u>	\$ <u>154,894.12</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

**IMPORTANT NOTICE**

**TO: Long Term Care Facilities with Real Estate Tax Rates**  
**RE: 2017 REAL ESTATE TAX COST DOCUMENTATION**

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 real estate tax bill.

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

**2017 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Parc At Joliet, Llc COUNTY Will  
FACILITY IDPH LICENSE NUMBER 0052571  
CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_  
TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

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

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

**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 Parc At Joliet, Llc

# 0052571

Report Period Beginning:

01/01/18 Ending:

12/31/18

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 80,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity?  (a) Own the Facility  (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?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)  
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  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	<u>Facility</u>	<u>75,625</u>		<u>\$ 347,050</u>	<u>1</u>
2	<u>Allocated from Care Center Building</u>			<u>19,020</u>	<u>2</u>
3	<b>TOTALS</b>			<b>\$ 366,070</b>	<b>3</b>

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	203	2013	1970	\$ 6,593,950	\$ 246,438	35	\$ 188,399	\$ (58,039)	\$ 4,943,550	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1993	27,837		20			27,837	9
10	Various		1994	4,980		20			4,980	10
11	Various		1995	20,929		20			20,929	11
12	Various		1996	21,845		20			21,845	12
13	Various		1997	15,491		20			15,491	13
14	Various		1998	28,751		20			28,751	14
15	Various		1999	17,798		20	890	890	17,798	15
16	Various		2000	67,420		20	3,371	3,371	64,049	16
17	Various		2001	37,385		20	1,869	1,869	33,647	17
18	Various		2002	81,564		20	4,078	4,078	69,329	18
19	Various		2003	22,069		20	1,103	1,103	17,809	19
20	Various		2005	43,812		20	2,191	2,191	30,668	20
21	Various		2006	7,414		20	371	371	4,819	21
22	Various		2014	62,448		20	6,027	6,027	25,837	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

\*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 Parc At Joliet, Llc

# 0052571

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9			
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation			
37		\$	\$		\$	\$	\$	37		
38								38		
39								39		
40								40		
41								41		
42								42		
43								43		
44								44		
45								45		
46								46		
47								47		
48								48		
49								49		
50								50		
51								51		
52								52		
53								53		
54								54		
55								55		
56								56		
57								57		
58								58		
59								59		
60								60		
61								61		
62								62		
63								63		
64								64		
65								65		
66								66		
67	Related Building Company (Pages 12F & 12G)							67		
68	Related Party Allocations (Pages 12H & 12I)		95,621		1,492			68		
69	Financial Statement Depreciation				121,186		(121,186)	69		
70	TOTAL (lines 4 thru 69)		\$ 7,149,314		\$ 369,116		\$ 209,791	\$ (159,326)	\$ 5,391,532	70

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

Facility Name &amp; ID Number Parc At Joliet, Llc

# 0052571

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 7,149,314	\$ 369,116		\$ 209,791	\$ (159,326)	\$ 5,391,532	1
2	Plumbing	2015	4,660		20	466	466	1,786	2
3	80 Gallon Water Heater	2015	3,965		20	397	397	1,421	3
4	Resident Rooms-Handrails,Bumper Guards,Lighting,Signs,Curtain	2015	23,515		20	1,176	1,176	4,115	4
5	Readjust Door Closer Panic Bar Outside Trim Lever	2015	2,564		20	128	128	427	5
6	Elevator Mechanical Door Restrictor	2015	2,930		20	147	147	501	6
7	Activity Room - Vinyl Planks/Tiles/Blinds	2015	45,340		20	2,267	2,267	4,534	7
8	Repaired Doors	2015	28,916		20	1,617	1,617	3,234	8
9	2 Water Heaters	2016	6,351		20	318	318	820	9
10	Water Heater	2016	3,958		20	198	198	462	10
11	Installed Magnetic Locks With Extra Push Bars & Door Handles	2016	3,042		20	152	152	368	11
12	Installed Led Lighting	2016	3,167		20	158	158	330	12
13	Installed Ceiling Tiles	2016	3,170		20	159	159	370	13
14	Ptac Air Conditioner	2016	21,208		20	1,060	1,060	2,121	14
15	Patient Shower Room Covering	2017	55,301		20	5,530	5,530	11,060	15
16	Wall Covering - 200 Wing	2017	8,414		20	841	841	1,613	16
17	Water Heater	2017	4,177		20	418	418	766	17
18	7 Quartz Window Ledges	2017	4,928		20	493	493	780	18
19	Installation Of New Call Light Switch For Bath & Bedrooms	2017	2,526		20	126	126	232	19
20	New Fire Rated Door	2017	7,243		20	362	362	392	20
21	Plumbing Wall Boxes For Drain Lines	2017	8,316		20	566	566	1,132	21
22	2Nd Floor - Flooring	2017	45,848		20	3,712	3,712	7,424	22
23	Nurse Stations -Dialysis Room	2017	37,850		20	1,985	1,985	3,970	23
24	Repaired Dialysis Stations/Electrical Workin Rms/Architect Fees	2017	62,625		20	3,576	3,576	7,153	24
25	Installed New Doors	2017	25,788		20	1,289	1,289	2,579	25
26	Installed Vinly Planks - Resident Rooms	2017	6,700		20	335	335	670	26
27	Repaired Façade And Related Architect Fees	2017	151,850		20	7,593	7,593	15,185	27
28	Sprinkler System	2017	6,725		20	336	336	673	28
29	Wallcovering In 200 Hallway	2017	3,256		20	163	163	326	29
30	Installed Light Fixtures	2017	5,739		20	287	287	574	30
31	200 Wing - Electrical/Tile/Demo/Drvwall/Plumbing/Framing/Hvac	2017	107,960		20	7,583	7,583	15,167	31
32	New Ptac Air Conditioner	2018	8,006		20	200	200	200	32
33	Walk-In Refrigerator	2018	5,175		20	86	86	86	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,860,527	\$ 369,116		\$ 253,515	\$ (115,601)	\$ 5,482,002	34

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



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		\$ 7,860,527	\$ 369,116		\$ 253,515	\$ (115,601)	\$ 5,482,002	1
2	100 Gallon Water Heater	2018	4,391		20	18	18	18	2
3	Install Pendent Sprinklers On 1St And 2Nd Floors	2018	2,900		20	145	145	145	3
4	Install Rooftop Unit To Cover The Dining Room On The 2Nd Floor	2018	11,345		20	567	567	567	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,879,164	\$ 369,116		\$ 254,246	\$ (114,871)	\$ 5,482,732	34

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

Facility Name & ID Number Parc At Joliet, Llc

# 0052571

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,879,164	\$ 369,116		\$ 254,246	\$ (114,871)	\$ 5,482,732	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,879,164	\$ 369,116		\$ 254,246	\$ (114,871)	\$ 5,482,732	34

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

Facility Name & ID Number Parc At Joliet, Llc

# 0052571

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 7,879,164	\$ 369,116		\$ 254,246	\$ (114,871)	\$ 5,482,732	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,879,164	\$ 369,116		\$ 254,246	\$ (114,871)	\$ 5,482,732	34

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

Facility Name & ID Number Parc At Joliet, Llc

# 0052571

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									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	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Parc At Joliet, Llc

# 0052571

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
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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)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting-Care Center Bldg	2002	26,211	672	35	672		10,949	3
4	Allocated from Extended Care Consulting - Dyer Building	2007	8,209	182	35	182		2,091	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting-Care Center Bldg	2002	21,652		20			21,652	9
10	Allocated from Extended Care Consulting-Care Center Bldg	2003	25,516		20			25,516	10
11	Allocated from Extended Care Consulting-Care Center Bldg	2005	1,268		20			1,268	11
12	Allocated from Extended Care Consulting-Care Center Bldg	2009	229	11	20	11		114	12
13	Allocated from Extended Care Consulting-Care Center Bldg	2014	2,196	110	20	110		549	13
14	Allocated from Extended Care Consulting-Care Center Bldg	2015	361	18	20	18		156	14
15	Allocated from Extended Care Consulting-Care Center Bldg	2016	1,425	71	20	71		214	15
16	Allocated from Extended Care Consulting-Care Center Bldg	2017	2,471	124	20	124		247	16
17	Allocated from Extended Care Consulting-Care Center Bldg	2018	1,133	57	20	57		57	17
18	Allocated from Extended Care Consulting	2007	157	8	20	8		94	18
19	Allocated from Extended Care Consulting	2009	94	5	20	5		47	19
20	Allocated from Extended Care Consulting	2010	923	46	20	46		415	20
21	Allocated from Extended Care Consulting	2011	332	17	20	17		133	21
22	Allocated from Extended Care Consulting	2012	109	5	20	5		38	22
23	Allocated from Extended Care Consulting	2014	1,517	76	20	76		379	23
24	Allocated from Extended Care Consulting	2016	1,819	91	20	91		273	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)		\$ 95,621	\$ 1,492		\$ 1,492	\$	\$ 64,193	34

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

Facility Name & ID Number Parc At Joliet, Llc

# 0052571

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 95,621	\$ 1,492		\$ 1,492	\$	\$ 64,193	1
2									2
3									3
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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)		\$ 95,621	\$ 1,492		\$ 1,492	\$	\$ 64,193	34

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

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	\$ 264,578	\$ 780	\$ 37,112	\$ 36,332	10	\$ 110,090	71
72	Current Year Purchases	34,066		3,110	3,110	10	3,110	72
73	Fully Depreciated Assets	399,327				10	399,327	73
74								74
75	TOTALS	\$ 697,972	\$ 780	\$ 40,222	\$ 39,443		\$ 512,528	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		Alloc. Extended Care Consulting	2014	\$ 871	\$ 174	\$ 174	\$ 0	5	\$ 871	76
77										77
78										78
79										79
80	TOTALS			\$ 871	\$ 174	\$ 174	\$ 0		\$ 871	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)	\$ 8,944,076	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 370,070	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 294,642	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (75,428)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,996,131	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.



**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	Storage				836			5
6								6
7	TOTAL				\$ 836			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. \_\_\_\_\_ /2019 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2020 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2021 \$ \_\_\_\_\_

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: \$ 28,850 Description: See Attached Schedule

(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.

**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.)**

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8		
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)							
			Units of Service			Units	Cost										
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	514,898	\$		\$	514,898					1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				108,844									108,844	2
3	Licensed Recreational Therapist		hrs														3
4	Licensed Physical Therapist	39 - 03	hrs				567,240									567,240	4
5	Physician Care		visits														5
6	Dental Care		visits														6
7	Work Related Program		hrs														7
8	Habilitation		hrs														8
9	Pharmacy	39 - 02	# of prescripts								292,712					292,712	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs														10
11	Academic Education		hrs														11
12	Other (specify):																12
13	Other (specify):										39,194	122,641				161,835	13
14	TOTAL			\$				\$	1,230,176	\$	415,353			\$	1,645,529		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 &amp; ID Number Parc At Joliet, Llc

# 0052571

Report Period Beginning: 01/01/18

Ending:

12/31/18

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 7,405	\$ 210,999	1
2	Cash-Patient Deposits	34,309	34,309	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	2,344,365	2,344,365	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	441,269	441,269	6
7	Other Prepaid Expenses	2,379	2,379	7
8	Accounts Receivable (owners or related parties)	475	154,932	8
9	Other(specify): <a href="#">See Attached Schedule</a>	92,284	935,115	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,922,486	\$ 4,123,368	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		747,850	13
14	Buildings, at Historical Cost		6,657,211	14
15	Leasehold Improvements, at Historical Cost	981,424	1,101,346	15
16	Equipment, at Historical Cost	70,247	1,095,264	16
17	Accumulated Depreciation (book methods)	(220,520)	(4,044,729)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <a href="#">See Attached Schedule</a>		34,742	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 831,151	\$ 5,591,684	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,753,637	\$ 9,715,052	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 4,388,615	\$ 4,388,614	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,346	24,346	28
29	Short-Term Notes Payable	1,000,000	1,000,000	29
30	Accrued Salaries Payable	371,360	371,360	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,784	21,784	31
32	Accrued Real Estate Taxes(Sch.IX-B)	183,281	157,989	32
33	Accrued Interest Payable		30,497	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<a href="#">See Attached Schedule</a>	1,228,331	1,228,331	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 7,217,717	\$ 7,222,921	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,897,900	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<a href="#">See Attached Schedule</a>		1,000,000	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 5,897,900	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 7,217,717	\$ 13,120,821	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (3,464,080)	\$ (3,405,769)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,753,637	\$ 9,715,052	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,834,185)	1
2	Restatements (describe):		2
3	Home Office Expense	84,795	3
4	Rounding	(2)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,749,392)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(714,688)	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)	\$ (714,688)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (3,464,080)	24 *

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

Facility Name &amp; ID Number Parc At Joliet, Llc

# 0052571

Report Period Beginning: 01/01/18

Ending: 12/31/18

**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**

1

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 12,020,556	1
2	Discounts and Allowances for all Levels	(5,395,427)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,625,129	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,002,533	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 5,002,533	8
<b>C. Other Operating Revenue</b>			
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	280,767	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	87,144	19
20	Radiology and X-Ray	14,575	20
21	Other Medical Services	701	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 383,187	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	3,366	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,366	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>See Supplemental Schedule</b>	6,952	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 6,952	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 12,021,167	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,885,402	31
32	Health Care	4,521,236	32
33	General Administration	2,573,145	33
<b>B. Capital Expense</b>			
34	Ownership	1,768,200	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,645,529	35
36	Provider Participation Fee	342,343	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 12,735,855	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(714,688)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (714,688)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,855,001	44
45	Private Pay - Net Inpatient Revenue	1,122,452	45
46	Medicare - Net Inpatient Revenue	536,274	46
47	Other-(specify) <u>Hospice</u>	264,385	47
48	Other-(specify) <u>Insurance</u>	(152,983)	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 6,625,129	49

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

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

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

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

Facility Name & ID Number **Parc At Joliet, Llc**

# **0052571**

Report Period Beginning:

**01/01/18**

Ending:

**12/31/18**

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,813	2,050	\$ 114,484	\$ 55.85	1
2	Assistant Director of Nursing	2,237	2,783	115,216	41.40	2
3	Registered Nurses	27,433	29,678	997,334	33.61	3
4	Licensed Practical Nurses	34,018	36,198	1,019,342	28.16	4
5	CNAs & Orderlies	76,991	81,928	1,117,796	13.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,871	9,507	192,574	20.26	8
9	Activity Director	1,894	2,131	49,099	23.04	9
10	Activity Assistants	12,354	13,162	154,485	11.74	10
11	Social Service Workers	9,952	10,858	311,415	28.68	11
12	Dietician					12
13	Food Service Supervisor	3,532	3,943	103,052	26.14	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,558	22,909	281,828	12.30	15
16	Dishwashers					16
17	Maintenance Workers	4,336	4,830	121,638	25.18	17
18	Housekeepers	25,831	29,058	366,203	12.60	18
19	Laundry	4,338	4,769	68,646	14.39	19
20	Administrator	1,933	2,113	101,621	48.09	20
21	Assistant Administrator	1,333	1,447	38,672	26.73	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,401	7,969	134,355	16.86	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	1,827	2,108	47,887	22.72	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	320	420	4,740	11.29	33
34	TOTAL (lines 1 - 33)	247,972	267,861	\$ 5,340,387 *	\$ 19.94	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	266	\$ 12,519	01-03	35
36	Medical Director	Monthly	51,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,694	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	32	2,064	12-03	45
46	Other(specify)				46
47	<u>Psychiatrist</u>	Monthly	6,000	10-03	47
48					48
49	TOTAL (lines 35 - 48)	298	\$ 82,277		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	189	4,721	10-03	52
53	TOTAL (lines 50 - 52)	189	\$ 4,721		53





Facility Name & ID Number Parc At Joliet, Llc# 0052571

Report Period Beginning:

01/01/18Ending: 12/31/18**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 26,759 Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 342,343  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14  
d. Have vehicle usage logs been maintained? No  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees