FOR BHF USE

LL1

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

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0046565

Facility Name: Paris Health Care Center

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

County: Edgar

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

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: **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 1/1/2018 to 12/31/18 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) Debbie Baynes
(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 Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2018 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	128	Skilled (SNF)	128	46,720	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	128	TOTALS	128	46,720	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,028	8,698	3,809	23,535	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,028	8,698	3,809	23,535	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 50.37%

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

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

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1/1/2004

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1/1/2004 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 128 and days of care provided 2,773

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

Is your fiscal year identical to your tax year? YES [X] 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 Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2018 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	158,854	12,904	9,402	181,160		181,160	(333)	180,827			1
2	Food Purchase		174,151		174,151		174,151	(724)	173,427			2
3	Housekeeping	107,102	16,505		123,607		123,607		123,607			3
4	Laundry	32,080	8,988	910	41,978		41,978		41,978			4
5	Heat and Other Utilities			197,584	197,584		197,584	2,104	199,688			5
6	Maintenance	43,760	14,696	39,636	98,092		98,092	466	98,558			6
7	Other (specify):*											7
8	**TOTAL General Services**	341,796	227,244	247,532	816,572		816,572	1,513	818,085			8
	B. Health Care and Programs											
9	Medical Director			23,605	23,605		23,605		23,605			9
10	Nursing and Medical Records	1,507,770	99,538	26,939	1,634,247		1,634,247	16,082	1,650,329			10
10a	Therapy		817	481,872	482,689		482,689	41,080	523,769			10a
11	Activities	74,489	2,498	4,410	81,397		81,397		81,397			11
12	Social Services	50,488	171	5,196	55,855		55,855		55,855			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharm Consultant			1,050	1,050		1,050		1,050			15
16	**TOTAL Health Care and Programs**	1,632,747	103,024	543,072	2,278,843		2,278,843	57,162	2,336,005			16
	C. General Administration											
17	Administrative	87,749			87,749		87,749		87,749			17
18	Directors Fees											18
19	Professional Services			134,536	134,536		134,536	(53,365)	81,171			19
20	Dues, Fees, Subscriptions & Promotions			4,698	4,698		4,698	708	5,406			20
21	Clerical & General Office Expenses	121,584	7,630	65,994	195,208		195,208	50,928	246,136			21
22	Employee Benefits & Payroll Taxes			415,714	415,714		415,714	27,220	442,934			22
23	Inservice Training & Education			2,300	2,300		2,300		2,300			23
24	Travel and Seminar			7,870	7,870		7,870	11,841	19,711			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			27,623	27,623		27,623	2,781	30,404			26
27	Other (specify):*											27
28	**TOTAL General Administration**	209,333	7,630	658,735	875,698		875,698	40,113	915,811			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,183,876	337,898	1,449,339	3,971,113		3,971,113	98,788	4,069,901			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Paris Health Care Center #0046565 Report Period Beginning: 1/1/2018 Ending: 12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			52,748	52,748		52,748	74,930	127,678			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							129,217	129,217			32
33	Real Estate Taxes			60,043	60,043		60,043		60,043			33
34	Rent-Facility & Grounds			240,000	240,000		240,000	(240,000)				34
35	Rent-Equipment & Vehicles			30,823	30,823		30,823		30,823			35
36	Other (specify):*											36
37	**TOTAL Ownership**			383,614	383,614		383,614	(35,853)	347,761			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			633	633		633		633			38
39	Ancillary Service Centers		151,200	18,884	170,084		170,084		170,084			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			247,001	247,001		247,001		247,001			42
43	Other (specify):* **Bad Debt**			551,086	551,086		551,086	(551,086)				43
44	**TOTAL Special Cost Centers**		151,200	817,604	968,804		968,804	(551,086)	417,718			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,183,876	489,098	2,650,557	5,323,531		5,323,531	(488,151)	4,835,380			45

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

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2018 Ending: 12/31/18

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(724)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	16,029	30		9
10	Interest and Other Investment Income	(3,325)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(333)	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				18
19	Entertainment				19
20	Contributions	(200)	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	(551,086)	43		24
25	Fund Raising, Advertising and Promotional	(9,379)	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	(52,043)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (601,061)		$	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)	112,910	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 112,910		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (488,151)		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

Paris Health Care Center

ID# 0046565

Report Period Beginning: 1/1/2018

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (59)	21	1
2	Miscellaneous Income	(375)	21	2
3	Marketing Supplies	(7,025)	21	3
4	Marketing Wages	(39,483)	21	4
5	Bank Charges	(1,533)	21	5
6	Finance Charge and Late Fees	(1,784)	21	6
7	Travel Marketing	(1,163)	21	7
8	Finance Charge and Late Fees (Related Party)	(621)	21	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(52,043)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2018 Ending: 12/31/18

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	(333)	0	0	0	0	0	0	0	0	0	0	(333)	1
2	Food Purchase	(724)	0	0	0	0	0	0	0	0	0	0	(724)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,104	0	0	0	0	0	0	0	0	2,104	5
6	Maintenance	0	0	466	0	0	0	0	0	0	0	0	466	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,057)	0	2,570	0	0	0	0	0	0	0	0	1,513	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	16,082	0	0	0	0	0	0	0	0	16,082	10
10a	Therapy	0	41,080	0	0	0	0	0	0	0	0	0	41,080	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	41,080	16,082	0	0	0	0	0	0	0	0	57,162	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(53,365)	0	0	0	0	0	0	0	0	(53,365)	19
20	Fees, Subscriptions & Promotions	0	0	708	0	0	0	0	0	0	0	0	708	20
21	Clerical & General Office Expenses	(61,622)	621	111,929	0	0	0	0	0	0	0	0	50,928	21
22	Employee Benefits & Payroll Taxes	0	0	27,220	0	0	0	0	0	0	0	0	27,220	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	11,841	0	0	0	0	0	0	0	0	11,841	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,781	0	0	0	0	0	0	0	0	2,781	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(61,622)	621	101,114	0	0	0	0	0	0	0	0	40,113	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(62,679)	41,701	119,766	0	0	0	0	0	0	0	0	98,788	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2018 Ending: 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	16,029	56,108	2,793	0	0	0	0	0	0	0	0	74,930	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,325)	116,977	15,565	0	0	0	0	0	0	0	0	129,217	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(240,000)	0	0	0	0	0	0	0	0	0	(240,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	12,704	(66,915)	18,358	0	0	0	0	0	0	0	0	(35,853)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(551,086)	0	0	0	0	0	0	0	0	0	0	(551,086)	43
44	TOTAL Special Cost Centers	(551,086)	0	0	0	0	0	0	0	0	0	0	(551,086)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(601,061)	(25,214)	138,124	0	0	0	0	0	0	0	0	(488,151)	45

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2018 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10a	Therapy	$ 481,870	TruRehab, LLC		$ 522,950	$ 41,080	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V	21	Clerical and General		IMG Healthcare Properties Illinois, LLC		621	621	6
7	V	30	Depreciation		IMG Healthcare Properties Illinois, LLC		56,108	56,108	7
8	V	32	Interest		IMG Healthcare Properties Illinois, LLC		116,977	116,977	8
9	V	34	Rent	240,000				(240,000)	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 721,870			$ 696,656	$ * (25,214)	14

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

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2018 Ending: 12/31/18

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Mark Ide	100%	Cathedral Health Care Center	Jasper, IN	Ide Mgmt. Group	Indianapolis, IN	Management	1
2			Chesterton Manor	Chesterton, IN	TruRehab, LLC	Vincennes, IN	Rehab Therapies	2
3			Cloverleaf Healthcare	Knightsville, IN	IMG HCP IL, LLC	Indianapolis, IN	Property Mgmt.	3
4			Colonial Nursing & Rehab	Crown Point, IN				4
5			Kendallville Manor	Kendallville, IN				5
6			Madison Health Care Center	Indianapolis, IN				6
7			Oak Village	Oaktown, IN				7
8			River Terrace Retirement Community	Bluffton, IN				8
9			Silver Memories Health Care	Versailles, IN				9
10			Warsaw Meadows	Warsaw, IN				10
11			Woodland Manor	Elkhart, IN				11
12			Yorktown Manor	Yorktown, IN				12
13			Newton Care Center	Newton, IL				13
14			North Logan Health Care Center	Danville, IL				14
15			Paris Healthcare Center	Paris, IL				15
16			Countryside Health Care Center	Sioux City, IA				16
17			Eagle Point Health Care Center	Clinton, IA				17
18			Keosauqua Health Care Center	Keosauqua, IA				18
19			Keota Health Care Center	Keota, IA				19
20			Newton Health Care Center	Newton, IA				20
21			Sigourney Health Care	Sigourney, IA				21
22			Urbandale Health Care Center	Urbandale, IA				22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2018 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. [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	5	Utilities	$	Ide Management Group, LLC		$ 2,104	$ 2,104	15
16	V	6	Maintenance		Ide Management Group, LLC		466	466	16
17	V	10	Nursing		Ide Management Group, LLC		16,082	16,082	17
18	V	19	Professional Fees		Ide Management Group, LLC		6,635	6,635	18
19	V	20	Dues, Fees, Subscriptions		Ide Management Group, LLC		708	708	19
20	V	21	Clerical and General		Ide Management Group, LLC		111,929	111,929	20
21	V	22	Employee Benefits		Ide Management Group, LLC		27,220	27,220	21
22	V	24	Travel and Seminar		Ide Management Group, LLC		11,841	11,841	22
23	V	26	Insurance		Ide Management Group, LLC		2,781	2,781	23
24	V	30	Depreciation		Ide Management Group, LLC		2,793	2,793	24
25	V	32	Interest		Ide Management Group, LLC		15,565	15,565	25
26	V								26
27	V	19	Management Fees	60,000	Ide Management Group, LLC			(60,000)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 60,000			$ 198,124	$ * 138,124	39

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

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2018 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Ide	Shareholder	Administrative	100.00	See Attached	1.95	4.87	Alloc Salary	$ 17,035	21-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 17,035		13

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

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

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2018 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 [X] NO [ ]

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

Name of Related Organization: Ide Management Group, LLC
Street Address: 4521 Indepence Square
City / State / Zip Code: Indianapolis, IN 46203
Phone Number: ((317) 744-9184
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	5	Utilities	Inpatient Days	483,703	24	$ 43,224	$	23,543	$ 2,104	1
2	6	Maintenance	Inpatient Days	483,703	24	9,566		23,543	466	2
3	10	Nursing	Inpatient Days	483,703	24	330,413	330,413	23,543	16,082	3
4	19	Professional Services	Inpatient Days	483,703	24	136,325		23,543	6,635	4
5	20	Dues and Subscriptions	Inpatient Days	483,703	24	14,545		23,543	708	5
6	21	Clerical & General	Inpatient Days	483,703	24	2,299,646	1,819,582	23,543	111,929	6
7	22	Employee Benefits	Inpatient Days	483,703	24	559,236		23,543	27,219	7
8	24	Travel and Seminar	Inpatient Days	483,703	24	243,272		23,543	11,841	8
9	26	Insurance	Inpatient Days	483,703	24	57,161		23,543	2,782	9
10	30	Depreciation	Inpatient Days	483,703	24	57,393		23,543	2,793	10
11	32	Interest	Inpatient Days	483,703	24	319,783		23,543	15,565	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,070,564	$ 2,149,995		$ 198,124	25

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2018 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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	First Financial Bank		X	Mortgage	$28,149.03	12/28/17	$ 4,000,000	$ 2,112,555	12/28/20	0.0570	$ 116,977	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$28,149.03		$ 4,000,000	$ 2,112,555			$ 116,977	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,000,000	$ 2,112,555			$ 116,977	15

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

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

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

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2018 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 84,253	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 61,346	2
3. Under or (over) accrual (line 2 minus line 1).		$ (22,907)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 82,950	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 60,043	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	70,275	8
	2014	60,044	9
	2015	58,121	10
	2016	61,519	11
	2017	61,346	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Paris Health Care Center COUNTY Edgar

FACILITY IDPH LICENSE NUMBER 0046565

CONTACT PERSON REGARDING THIS REPORT 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 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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-13-36-100-021	Nursing Home	$ 61,346.42	$ 61,346.42
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 61,346.42	$ 61,346.42

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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 Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2018 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [X] (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 [ ] (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			2017	$ 150,132	1
2					2
3	TOTALS			$ 150,132	3

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2018 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 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	128		2017		$ 2,690,593	$ 56,108	39	$ 68,990	$ 12,882	$ 69,788	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			2004	12,329	456	27	457	1	3,225	9
10	Water Line EQ & Boiler			2004	1,039	38	27	38		503	10
11	Life Safety Crossroads			2005	272	15	15	18	3	234	11
12	Code Alert Model 70 Wand			2006	1,017	37	27	38	1	444	12
13	Access Control System			2006	1,218	75	15	81	6	985	13
14	Code Alert Model 70 Wand			2006	1,028	38	27	38		432	14
15	Security Keypads (5)			2006	665	24	27	25	1	280	15
16	Double Door in Hallway			2006	2,700	100	27	100		1,128	16
17	Wandering Alert Monitor			2006	1,410	80	15	94	14	1,128	17
18	Install Code Alert			2006	1,250	71	15	83	12	999	18
19	System Sensor Alarm			2006	229	13	15	15	2	183	19
20	Door Frame			2007	498	18	27	18		197	20
21	Rheem A/C 2 Ton			2007	495		7			495	21
22	A/C Unit Roof Top			2007	1,155		7			1,155	22
23	Awnings (22)			2007	2,200	129	15	147	18	1,601	23
24	Panel Lights/Control Unit			2007	5,516	321	15	368	47	4,005	24
25	Fire System			2007	7,445	329	20	372	43	4,219	25
26	Wooden Shadow Boxes (22)			2008	605		10	61	61	364	26
27	Wiring			2008	775		10	77	77	464	27
28	Flooring			2009	14,098	470	15	940	470	4,492	28
29	paint			2009	1,154	38	15	77	39	367	29
30	Parking Lot Improvements			2010	7,375		15	492	492	4,180	30
31	Lights			2010	1,318		7	188	188	847	31
32	painting			2010	1,284		15	86	86	728	32
33	Building Improvements			2011	10,340	383	27	383		2,660	33
34	Water Line EQ & Boiler			2011	874	32	27	32		224	34
35	Life Safety Crossroads			2011	153	10	15	10		78	35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2018 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	
37	code alert model 70	2011	$ 890	$ 23	39	$ 23	$	$ 160	37
38	Access Control System	2011	759	47	15	51	4	387	38
39	code alert model 70	2011	910	34	27	34		234	39
40	Security Keypads (5)	2011	589	22	27	22		151	40
41	Double Door in Hallway	2011	2,397	89	27	89		617	41
42	Wandering Alert Monitor	2011	879	55	15	59	4	448	42
43	Install Code Alert	2011	779	49	15	52	3	397	43
44	System Sensor Alarm	2011	143	9	15	10	1	74	44
45	Door Frame	2011	449	17	27	17		116	45
46	Rheem A/C 2 Ton	2011	148		7	14	14	148	46
47	A/C Unit Roof Top	2011	517	38	10	52	14	419	47
48	Awnings (22)	2011	1,584	99	15	106	7	807	48
49	panel lights	2011	3,971	248	15	265	17	2,023	49
50	Fire System	2011	5,837	271	20	292	21	2,343	50
51	Wooden Shad Boxes (22)	2011	174	13	10	17	4	141	51
52	wiring	2011	223	16	10	22	6	180	52
53	Flooring	2011	6,344	395	15	423	28	3,231	53
54	paint	2011	519	32	15	35	3	265	54
55	Rheem 7 1/2 Ton Air Handler	2011	11,350	757	15	757		4,964	55
56	Chair Rail	2011	8,340	556	15	556		3,647	56
57	Reovations	2011	9,257	617	15	617		4,047	57
58	Firewall Buildout	2011	8,800	587	15	587		3,849	58
59	Adj Per Audit	2012	19,474	1,947	10	1,947		9,852	59
60	Water Heater 100 Gallon	2013	8,651	577	15	577		2,822	60
61	Water Softner	2013	5,922	395	15	395		1,931	61
62	Roofing System New	2013	55,928	1,864	30	1,864		9,120	62
63	Shower Room Remodel	2013	8,280	414	20	414		1,818	63
64	Paint Misc Rooms	2013	29,021	3,869	5	5,804	1,935	25,494	64
65	Flooring	2013	5,300	530	10	530		2,195	65
66	Shower Room Remodel	2013	8,230	412	20	412		1,705	66
67	Cooling and heating P-TAC units (6)	2014	18,000	1,800	10	1,800		5,656	67
68	Heat pump	2014	3,525	353	10	353		1,108	68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,996,221	$ 74,920		$ 91,424	$ 16,504	$ 195,753	70

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

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2018 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 12A, Carried Forward		$ 2,996,221	$ 74,920		$ 91,424	$ 16,504	$ 195,753	1
2									2
3	Thermazone AC Unit	2015	3,156	158	20	158		430	3
4	Water Heater/Storage Tank	2015	5,279	264	20	264		720	4
5	Nuses Station Laminate	2016	1,250	63	20	63		130	5
6	Flooring Therapy Room	2016	4,800	240	20	240		494	6
7	Front Entrance	2016	11,950	597	20	598	1	1,231	7
8	Flooring Base in 4 Rooms	2016	2,900	145	20	145		299	8
9	Concrete Pad	2016	1,950	98	20	98		202	9
10	Memory Care Unit	2016	209,950	10,497	20	10,498	1	21,615	10
11	Parking Lot / Seal Paving	2016	10,950	730	15	730		1,503	11
12	Parking Lot Repair	2017	10,670	712	15	234	(478)	468	12
13									13
14	Awning	2018	1,950	98	15	98		98	14
15	Door Entry	2018	5,950	297	15	298	1	298	15
16	Freight Elevator	2018	41,000	1,025	15	1,025		1,025	16
17	Vinyl In Hallway	2018	86,800	723	15	723		723	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)		$ 3,394,776	$ 90,567		$ 106,596	$ 16,029	$ 224,988	34

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

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2018 Ending: 12/31/18

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	$ 206,508	$ 17,315	$ 20,108	$ 2,793	5	$ 146,867	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	32,045				5	32,045	73
74								74
75	TOTALS	$ 238,553	$ 17,315	$ 20,108	$ 2,793		$ 178,912	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2012 Ford E350	2012	$ 20,188	$	$	$	5	$ 20,188	76
77		Lift for Van	2017	6,819	974	974		5	1,867	77
78										78
79										79
80	TOTALS			$ 27,007	$ 974	$ 974	$		$ 22,055	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)	$ 3,810,468	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 108,856	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 127,678	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 18,822	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 425,955	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2018 Ending: 12/31/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.		$
13.		$
14.		$

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 Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2018 Ending: 12/31/18

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$	2,721	$ 127,189	$	2,721	$ 127,189	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,454	66,800		1,454	66,800	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		3,220	184,160		3,220	184,160	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				151,200		151,200	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray & Phys. Fees	39-3					9,188		9,188	12
13	Other (specify): Lab	39-3					9,697		9,697	13
14	TOTAL			$	7,395	$ 378,149	$ 170,085	7,395	$ 548,234	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2018 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*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 143,234	$ 146,463	1
2	Cash-Patient Deposits	35,259	35,259	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	182,826	271,233	3
4	Supply Inventory (priced at)	9,068	9,068	4
5	Short-Term Investments			5
6	Prepaid Insurance	3,092	3,092	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 373,479	$ 465,115	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		150,132	13
14	Buildings, at Historical Cost	449,291	3,139,884	14
15	Leasehold Improvements, at Historical Cost	254,896	254,896	15
16	Equipment, at Historical Cost	265,560	265,560	16
17	Accumulated Depreciation (book methods)	(397,916)	(467,704)	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): Financing Cost		16,182	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 571,831	$ 3,358,950	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 945,310	$ 3,824,065	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,649,062	$ 2,649,063	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	429,000	1,148,107	29
30	Accrued Salaries Payable	120	120	30
31	Accrued Taxes Payable (excluding real estate taxes)	71,546	71,546	31
32	Accrued Real Estate Taxes(Sch.IX-B)	56,899	56,899	32
33	Accrued Interest Payable		1,259	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Legal Contingency	25,000	25,000	36
37	Resident Trust Fund Liability	35,080	35,080	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,266,707	$ 3,987,074	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,112,555	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)**	$	$ 2,112,555	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,266,707	$ 6,099,629	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,321,397)	$ (2,275,564)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 945,310	$ 3,824,065	48

***(See instructions.)**

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2018 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,373,422)	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(78,387)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,451,809)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(869,588)	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)**	$ (869,588)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,321,397)	24 *

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

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2018 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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,105,497	1
2	Discounts and Allowances for all Levels	489,661	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,595,158	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	745,332	6
7	Oxygen	32,262	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 777,594	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	724	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	76,713	17
18	Sale of Supplies to Non-Patients	(177)	18
19	Laboratory	112	19
20	Radiology and X-Ray	60	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 77,432	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,325	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,325	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income	59	28
28a	Misc Income	375	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 434	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,453,943	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	816,572	31
32	Health Care	2,278,843	32
33	General Administration	875,698	33
	B. Capital Expense		
34	Ownership	383,614	34
	C. Ancillary Expense		
35	Special Cost Centers	721,803	35
36	Provider Participation Fee	247,001	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,323,531	40
41	**Income before Income Taxes (line 30 minus line 40)****	(869,588)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (869,588)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,968,011	44
45	Private Pay - Net Inpatient Revenue	846,086	45
46	Medicare - Net Inpatient Revenue	704,288	46
47	Other-(specify) Net Patient Revenue	99,736	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,618,121	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 Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2018 Ending: 12/31/18

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	2,080	2,176	$ 79,227	$ 36.41	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,430	7,813	243,100	31.11	3
4	Licensed Practical Nurses	14,517	15,631	494,619	31.64	4
5	CNAs & Orderlies	44,728	47,427	646,141	13.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,698	5,835	74,489	12.77	9
10	Activity Assistants					10
11	Social Service Workers	2,096	2,250	50,488	22.44	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,677	17,666	158,854	8.99	15
16	Dishwashers					16
17	Maintenance Workers	2,816	3,005	43,760	14.56	17
18	Housekeepers	6,400	6,956	107,102	15.40	18
19	Laundry	3,165	3,459	32,080	9.27	19
20	Administrator	2,712	2,839	87,749	30.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,692	4,016	90,065	22.43	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	2,220	2,276	36,719	16.13	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing Director			39,483		33
34	TOTAL (lines 1 - 33)	114,231	121,349	$ 2,183,876 *	$ 18.00	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	162	$ 8,424	1-3	35
36	Medical Director	48	23,605	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	4	1,050	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	45	2,698	11-3	44
45	Social Service Consultant	45	2,698	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	304	$ 38,475		49

C. CONTRACT NURSES

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

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2018 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Erika Roberts	Admin	100	$ 87,749
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 87,749

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
Saikley Garrison Colombo	Legal	$ 295
Various	Legal	175
Parrissh Consulting	Professional	14,368
Outcome Service of IL	Professional	2,916
Paris Area Chamber of CO	Professional	220
Ide Management	Management	60,000
Ide Management	Payroll	52,617
Bradley Associates	Accounting	2,045
Somerset	Accounting	1,900
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 134,536

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 81,714
Unemployment Compensation Insurance	26,646
FICA Taxes	163,244
Employee Health Insurance	140,612
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	1,636
Physicals	415
Human Resources	1,447
Ide Management Group	27,220
TOTAL (agree to Schedule V, line 22, col.8)	$ 442,934

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

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	
Dues and Subscriptions	2,348
License and Permits	2,350
Ide Management Group	708
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,406

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Ide Management Group	11,841
Mileage	5,684
Seminar Expense	
Tution and Education	1,805
Hotel	381
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 19,711

**See instructions.

Facility Name & ID Number Paris Health Care Center # 0046565 Report Period Beginning: 1/1/2018 Ending: 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? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **10,909** Line **10.2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **247,001**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees