FOR BHF USE

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

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

I. IDPH License ID Number: 050880

Facility Name: Parker Nursing & Rehabilitation Center

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

County: LaSalle

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

HFS ID Number:

Date of Initial License for Current Owners: (708) 449-1500

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Daniel S. Gaafar **Telephone Number:** (317) 237-5500
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/18 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) Paresh Vipani
(Title) CFO

Paid Preparer

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

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Parker Nursing & Rehabilitation Center # 050880 Report Period Beginning: 1/1/18 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	102	Skilled (SNF)	102	37,230	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	102	TOTALS	102	37,230	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,988	1,507	2,859	17,354	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,988	1,507	2,859	17,354	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 46.61%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 5/1/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/1/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 102 and days of care provided 2,613

Medicare Intermediary National Governemnt Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Parker Nursing & Rehabilitation Center # 050880 Report Period Beginning: 1/1/18 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	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	175,159	14,258	4,662	194,079		194,079	(49)	194,030			1
2	Food Purchase		111,926		111,926		111,926	531	112,457			2
3	Housekeeping	81,739	14,942		96,681		96,681	6	96,687			3
4	Laundry	26,364	9,531		35,895		35,895		35,895			4
5	Heat and Other Utilities			124,233	124,233		124,233	877	125,110			5
6	Maintenance	57,110	23,056	38,322	118,488		118,488	481	118,969			6
7	Other (specify):*											7
8	**TOTAL General Services**	340,372	173,713	167,217	681,302		681,302	1,846	683,148			8
	B. Health Care and Programs											
9	Medical Director			9,285	9,285		9,285		9,285			9
10	Nursing and Medical Records	1,110,111	70,060	51,457	1,231,628		1,231,628	(35,403)	1,196,225			10
10a	Therapy			337,877	337,877		337,877		337,877			10a
11	Activities	84,228	4,379		88,607		88,607		88,607			11
12	Social Services	39,594		3,754	43,348		43,348		43,348			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			5,121	5,121		5,121	(110)	5,011			15
16	**TOTAL Health Care and Programs**	1,233,933	74,439	407,494	1,715,866		1,715,866	(35,513)	1,680,353			16
	C. General Administration											
17	Administrative	82,299			82,299		82,299		82,299			17
18	Directors Fees											18
19	Professional Services			351,742	351,742		351,742	(222,955)	128,787			19
20	Dues, Fees, Subscriptions & Promotions			5,659	5,659		5,659	(791)	4,868			20
21	Clerical & General Office Expenses	71,802	33,522	155,008	260,332		260,332	(4,000)	256,332			21
22	Employee Benefits & Payroll Taxes			338,384	338,384		338,384	11,608	349,992			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,057	11,057		11,057	(1,324)	9,733			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			75,639	75,639		75,639	1,090	76,729			26
27	Other (specify):*											27
28	**TOTAL General Administration**	154,101	33,522	937,489	1,125,112		1,125,112	(216,372)	908,740			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,728,406	281,674	1,512,200	3,522,280		3,522,280	(250,039)	3,272,241			29

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

Facility Name & ID Number Parker Nursing & Rehabilitation Center #050880 Report Period Beginning: 1/1/18 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			18,400	18,400		18,400	96,821	115,221			30
31	Amortization of Pre-Op. & Org.							66,666	66,666			31
32	Interest			515,377	515,377		515,377	67,921	583,298			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			486,000	486,000		486,000	(484,264)	1,736			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,019,777	1,019,777		1,019,777	(252,856)	766,921			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		82,507		82,507		82,507	(1,745)	80,762			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			143,876	143,876		143,876		143,876			42
43	Other (specify):*			55,996	55,996		55,996	(55,996)				43
44	**TOTAL Special Cost Centers**		82,507	199,872	282,379		282,379	(57,741)	224,638			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,728,406	364,181	2,731,849	4,824,436		4,824,436	(560,636)	4,263,800			45

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

Facility Name & ID Number Parker Nursing & Rehabilitation Center # 050880 Report Period Beginning: 1/1/18 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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	76,313	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(49)	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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(55,996)	43		24
25	Fund Raising, Advertising and Promotional	(6,189)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,101)	various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 11,978		$	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)	(572,614)	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (572,614)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (560,636)		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

STATE OF ILLINOIS

Parker Nursing & Rehabilitation Center

ID# 050880

Report Period Beginning: 1/1/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	RP Profit	$ (33)	10	1
2	RP Profit	(110)	15	2
3	RP Profit	(1,745)	39	3
4	Contributions	(15)	21	4
5	Misc Income	(135)	10	5
6	Misc Income	(1)	21	6
7	PAC Expense	(62)	20	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(2,101)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Parker Nursing & Rehabilitation Center # 050880 Report Period Beginning: 1/1/18 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)	
	A. General Services													
1	Dietary	(49)	0	0	0	0	0	0	0	0	0	0	(49)	1
2	Food Purchase	0	531	0	0	0	0	0	0	0	0	0	531	2
3	Housekeeping	0	6	0	0	0	0	0	0	0	0	0	6	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	877	0	0	0	0	0	0	0	0	0	877	5
6	Maintenance	0	481	0	0	0	0	0	0	0	0	0	481	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(49)	1,895	0	0	0	0	0	0	0	0	0	1,846	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	(168)	(35,235)	0	0	0	0	0	0	0	0	0	(35,403)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(110)	0	0	0	0	0	0	0	0	0	0	(110)	15
16	**TOTAL Health Care and Programs**	(278)	(35,235)	0	0	0	0	0	0	0	0	0	(35,513)	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	(222,955)	0	0	0	0	0	0	0	0	0	(222,955)	19
20	Fees, Subscriptions & Promotions	(62)	(729)	0	0	0	0	0	0	0	0	0	(791)	20
21	Clerical & General Office Expenses	(6,205)	(24,882)	27,087	0	0	0	0	0	0	0	0	(4,000)	21
22	Employee Benefits & Payroll Taxes	0	11,608	0	0	0	0	0	0	0	0	0	11,608	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(1,324)	0	0	0	0	0	0	0	0	0	(1,324)	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	468	622	0	0	0	0	0	0	0	0	1,090	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(6,267)	(237,814)	27,709	0	0	0	0	0	0	0	0	(216,372)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(6,594)	(271,154)	27,709	0	0	0	0	0	0	0	0	(250,039)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Parker Nursing & Rehabilitation Center # 050880 Report Period Beginning: 1/1/18 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	76,313	0	20,508	0	0	0	0	0	0	0	0	96,821	30
31	Amortization of Pre-Op. & Org.	0	0	66,666	0	0	0	0	0	0	0	0	66,666	31
32	Interest	0	0	67,921	0	0	0	0	0	0	0	0	67,921	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(484,264)	0	0	0	0	0	0	0	0	(484,264)	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	76,313	0	(329,169)	0	0	0	0	0	0	0	0	(252,856)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(1,745)	0	0	0	0	0	0	0	0	0	0	(1,745)	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):*	(55,996)	0	0	0	0	0	0	0	0	0	0	(55,996)	43
44	TOTAL Special Cost Centers	(57,741)	0	0	0	0	0	0	0	0	0	0	(57,741)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	11,978	(271,154)	(301,460)	0	0	0	0	0	0	0	0	(560,636)	45

Facility Name & ID Number Parker Nursing & Rehabilitation Center # 050880 Report Period Beginning: 1/1/18 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
Michael Blisko	40%	Ambassador Nursing & Rehabd Center	Chicago	Infinity Healthcare	Hillside	Management Co.
GELP	40%	Belhaven Nursing & Rehab Center	Chicago	516 W Frech Realty		Realty Co.
Joe Blisko	20%	City View Multicare Center	Cicero	United Rx	Hillside	Pharamcy Co.
		Continental Nursing & Rehab Center	Chicao			
		Forest View Rehab & Nursing Center	Itasca			
		Lakeview Nursing & Rehab Center	Chicago			
		Midway Neurological & Rehab Center	Bridgeview			

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Infinity Healthcare Management of Illinois		$	$	1
2	V	2	Food Purchase		Infinity Healthcare Management of Illinois		531	531	2
3	V	3	Housekeeping		Infinity Healthcare Management of Illinois		6	6	3
4	V	5	Utilities		Infinity Healthcare Management of Illinois		877	877	4
5	V	6	Maintenance		Infinity Healthcare Management of Illinois		481	481	5
6	V	10	Nursing	51,526	Infinity Healthcare Management of Illinois		16,291	(35,235)	6
7	V	19	Professional Fees	223,698	Infinity Healthcare Management of Illinois		743	(222,955)	7
8	V	20	Dues & Fees	780	Infinity Healthcare Management of Illinois		51	(729)	8
9	V	21	Office Expense	115,774	Infinity Healthcare Management of Illinois		90,892	(24,882)	9
10	V	22	Employee Benefits	2,228	Infinity Healthcare Management of Illinois		13,836	11,608	10
11	V	24	Travel Expense	2,970	Infinity Healthcare Management of Illinois		1,646	(1,324)	11
12	V	26	Insurance		Infinity Healthcare Management of Illinois		468	468	12
13	V	30	Depreciation		Infinity Healthcare Management of Illinois				13
14	Total			$ 396,976			$ 125,822	$ * (271,154)	14

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

Facility Name & ID Number Parker Nursing & Rehabilitation Center # 050880 Report Period Beginning: 1/1/18 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	32	Interest	$	Infinity Healthcare Management of Illinois		$ 1,517	$ 1,517	15
16	V	34	Rent		Infinity Healthcare Management of Illinois		1,736	1,736	16
17	V								17
18	V	26	Insurance		516 West French Street LLD		622	622	18
19	V	31	Amortization		516 West French Street LLD		66,666	66,666	19
20	V	21	Office Expense		516 West French Street LLD		27,087	27,087	20
21	V	30	Depreciation		516 West French Street LLD		20,508	20,508	21
22	V	32	Interest		516 West French Street LLD		66,404	66,404	22
23	V	34	Rent	486,000	516 West French Street LLD			(486,000)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 486,000			$ 184,540	$ * (301,460)	39

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

Facility Name & ID Number Parker Nursing & Rehabilitation Center # 050880 Report Period Beginning: 1/1/18 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			Momence Meadows Nursing & Rehab Ctr	Momence				1
2			Niles Nursing & Rehab Center	Niles				2
3			Oak Lawn Respiratory & Rehab Center	Oak Lawn				3
4			Parkshore Estates Nursing & Rehab Ctr	Chicago				4
5			Southpoint Nursing & Rehab Center	Chicago				5
6			West Suburban Nuring & Rehab Center	Bloomingdale				6
7			Landmark of Des Plaines Rehab Center	Des Plaines				7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Parker Nursing & Rehabilitation Center # 050880 Report Period Beginning: 1/1/18 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Parker Nursing & Rehabilitation Center # 050880 Report Period Beginning: 1/1/18 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 [X]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Parker Nursing & Rehabilitation Center # 050880 Report Period Beginning: 1/1/18 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				
	A. Directly Facility Related											
	Long-Term											
1	Bank Leumi		X	Property	$25,454.00	10/22/15	$ 4,420,000	$	5/31/18	4.4000	$ 66,404	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Infinity Funding	X		Working Capital	None	Various	Various	3,737,038	None	Various	516,894	6
7												7
8												8
9	TOTAL Facility Related				$25,454.00		$ 4,420,000	$ 3,737,038			$ 583,298	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,420,000	$ 3,737,038			$ 583,298	15

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

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

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

Facility Name & ID Number Parker Nursing & Rehabilitation Center # 050880 Report Period Beginning: 1/1/18 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.**	$ 145,229	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.)		$ 35,884	2
3. Under or (over) accrual (line 2 minus line 1).		$ (109,345)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 109,345	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2013	33,855	8
2014	34,623	9
2015	37,401	10
2016	34,265	11
2017	35,884	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 Parker Nursing & Rehabilitation Center COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 050880

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.	33-23-401-004	Nursing Home	$ 35,883.96	$ 35,883.96
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 35,883.96	$ 35,883.96

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 Parker Nursing & Rehabilitation Center # 050880 Report Period Beginning: 1/1/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,000 B. General Construction Type: Exterior Brick Frame Concrete/Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land			$ 25,000	1
2					2
3	TOTALS			$ 25,000	3

Facility Name & ID Number Parker Nursing & Rehabilitation Center # 050880 Report Period Beginning: 1/1/18 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	102				$ 800,000	$ 20,508	39	$ 20,513	$ 5	$ 164,074	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SIGNS			2010	680	17	39	17		148	9
10	ROOF			2010	30,000	769	39	769		6,592	10
11	SHOWER TILES			2010	1,000	26	39	26		221	11
12	SIGNS			2010	684	18	39	18		152	12
13	EXHAUST FAN AND HOOD			2010	1,253	32	39	32		275	13
14	DRYWALL, WINDOWS, INSULATION, CEILING TILES			2010	6,300	162	39	162		1,386	14
15	PAINTING, VINYL COVE BASE, REMOVE WALL COVERING			2010	3,868	99	39	99		849	15
16	INSTALL BATHROOM ACCESSORIES, PATIO, AND WALL			2010	127,000	3,256	39	3,256		27,908	16
17	INSTALLATION OF DATA LINES AND PHONES			2010	1,750	45	39	45		385	17
18	BACKFLOW REPAIR			2012	6,249	160	39	160		1,120	18
19											19
20	Paint walls / ceiling - 1st wing			2013	3,135	80	39	80		441	20
21	wallpaper - 2nd wing			2013	2,626	67	39	67		369	21
22	paint - bathroom			2013	1,986	51	39	51		280	22
23	Fire alarm system			2013	26,980	692	39	692		3,805	23
24											24
25	Repair leak in hydronic heating system			2014	1,808	46	39	46		230	25
26	Install new gas hot water boiler			2014	4,422	113	39	113		565	26
27	Cubicle curtains			2014	1,582	41	39	41		205	27
28	Vinyl planking replaced in every resident rm in "C" Hallway			2014	2,020	52	39	52		260	28
29	Vinyl planking replaced in every resident rm in "C" Hallway			2014	2,116	54	39	54		270	29
30	Replace outside patio			2014	5,530	142	39	142		710	30
31	Supply and install cabling for office			2014	6,484	166	39	166		830	31
32											32
33	Replace flooring in building			2015	3,786	97	39	97		388	33
34											34
35	Replace kitchen floor and cove base			2016	8,369	215	39	215		645	35
36				2016	5,581	143	39	143		429	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Parker Nursing & Rehabilitation Center # 050880 Report Period Beginning: 1/1/18 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	
37	2 Double Egress Doors for Activity Room	2017	$ 7,478	$ 192	39	$ 192	$	$ 288	37
38	Cummins Gaseous Engine Generator	2017	42,636	1,093	39	1,093		1,639	38
39	New Concrete Ramp	2017	2,060	53	39	53		79	39
40	Replace Gutters & Downspout	2017	2,952	76	39	76		114	40
41	New Natural Gas Water Heater for Commercial Kitchen	2017	4,277	110	39	110		166	41
42	New Natural Gas Water Heater for Commercial Kitchen								42
43									43
44	Fix Short in nurse call system	2018	8,951	115	39	230	115	115	44
45	Fix Sewer Line and replace cast iron piping	2018	6,480	83	39	166	83	83	45
46									46
47	New Compressor & motor for RTU	2018	4,581	59	39	117	58	59	47
48	New building cabling for computers	2018	7,860	101	39	202	101	101	48
49	Wander Guard System	2018	7,473	95	39	192	97	95	49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,149,957	$ 29,028		$ 29,487	$ 459	$ 215,276	70

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

Facility Name & ID Number Parker Nursing & Rehabilitation Center # 050880 Report Period Beginning: 1/1/18 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	$ 134,893	$ 9,881	$ 26,979	$ 17,098	5	$ 116,087	71
72	Current Year Purchases	10,844		2,169	2,169	5		72
73	Fully Depreciated Assets	282,935		56,587	56,587	5	282,935	73
74								74
75	TOTALS	$ 428,672	$ 9,881	$ 85,734	$ 75,853		$ 399,022	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,603,629	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 38,909	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 115,221	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 76,312	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 614,298	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Parker Nursing & Rehabilitation Center # 050880 Report Period Beginning: 1/1/18 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.	/2019	$
13.	/2020	$
14.	/2021	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Parker Nursing & Rehabilitation Center # 050880 Report Period Beginning: 1/1/18 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.

Facility Name & ID Number Parker Nursing & Rehabilitation Center # 050880 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	$	2,575	$ 150,380	$	2,575	$ 150,380	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		520	35,188		520	35,188	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		2,707	152,309		2,707	152,309	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				81,545		81,545	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray/Lab	39-2					962		962	12
13	Other (specify):									13
14	TOTAL			$	5,802	$ 337,877	$ 82,507	5,802	$ 420,384	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.

STATE OF ILLINOIS

Facility Name & ID Number Parker Nursing & Rehabilitation Center # 050880 Report Period Beginning: 1/1/18 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*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (80,481)	$ (79,402)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	870,866	870,867	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	100,073	100,073	6
7	Other Prepaid Expenses	49,813	49,813	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 940,271	$ 941,351	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		25,000	13
14	Buildings, at Historical Cost		800,000	14
15	Leasehold Improvements, at Historical Cost	349,956	349,956	15
16	Equipment, at Historical Cost	203,673	428,673	16
17	Accumulated Depreciation (book methods)	(225,223)	(614,297)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		1,000,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(533,332)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 328,406	$ 1,456,000	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,268,677	$ 2,397,351	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 464,267	$ 592,689	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,528	17,528	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	105,562	105,562	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,223	9,223	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		(17,942)	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Working Capital	3,737,038	3,737,040	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,333,618	$ 4,444,100	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,333,618	$ 4,444,100	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,064,941)	$ (2,046,749)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,268,677	$ 2,397,351	48

*(See instructions.)

Facility Name & ID Number Parker Nursing & Rehabilitation Center # 050880 Report Period Beginning: 1/1/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,055,635)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,055,635)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,009,306)	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)**	$ (1,009,306)	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)**	$ (3,064,941)	24 *

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

Facility Name & ID Number Parker Nursing & Rehabilitation Center # 050880 Report Period Beginning: 1/1/18 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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,269,645	1
2	Discounts and Allowances for all Levels	899,346	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,168,991	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	572,296	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 572,296	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	67,793	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,677	19
20	Radiology and X-Ray	231	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 73,701	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	142	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 142	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,815,130	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	681,302	31
32	Health Care	1,715,866	32
33	General Administration	1,125,112	33
	B. Capital Expense		
34	Ownership	1,019,777	34
	C. Ancillary Expense		
35	Special Cost Centers	82,507	35
36	Provider Participation Fee	143,876	36
	D. Other Expenses (specify):		
37		55,996	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,824,436	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,009,306)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,009,306)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,052,180	44
45	Private Pay - Net Inpatient Revenue	264,686	45
46	Medicare - Net Inpatient Revenue	1,341,315	46
47	Other-(specify)	489,190	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,147,371	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 Parker Nursing & Rehabilitation Center # 050880 Report Period Beginning: 1/1/18 Ending: 12/31/18

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,857	1,992	$ 95,424	$ 47.90	1
2	Assistant Director of Nursing	2,162	2,286	69,275	30.30	2
3	Registered Nurses	7,484	8,020	256,852	32.03	3
4	Licensed Practical Nurses	7,908	8,440	222,707	26.39	4
5	CNAs & Orderlies	32,970	35,554	446,522	12.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	6,222	6,741	84,228	12.49	9
10	Activity Assistants					10
11	Social Service Workers	1,861	1,998	39,594	19.82	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,817	13,951	175,159	12.56	15
16	Dishwashers					16
17	Maintenance Workers	3,862	4,080	57,110	14.00	17
18	Housekeepers	6,836	7,283	81,739	11.22	18
19	Laundry	1,915	2,087	26,364	12.63	19
20	Administrator	1,676	2,036	82,299	40.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,218	5,560	71,802	12.91	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Admissions Coord	885	895	19,331	21.60	33
34	TOTAL (lines 1 - 33)	93,673	100,923	$ 1,728,406 *	$ 17.13	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	133	$ 4,662	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	1,470	51,457	10-3	38
39	Pharmacist Consultant	102	5,121	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	89	3,124	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,794	$ 64,364		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 Parker Nursing & Rehabilitation Center # 050880 Report Period Beginning: 1/1/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bradley Fierce	Administrator		$ 12,447
Kelsia Phillips	Administrator		34,363
Margaux Mdominguez	Administrator		21,982
Wanita Cassani	Administrator		13,507
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 82,299

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Bradley Associates	Accounting	$ 12,000
Infinity Funding Sedgwick	Legal	133,916
Donahue, Brown, Mathewson	Legal	(9,701)
MTS Consulting	Professional	(20,450)
Infinity Healthcare	Professional	53,566
Various	Professional	1,206
Empire Risk	Management	12,000
Infinity Healthcare	Management	169,205
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 351,742

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 72,212
Unemployment Compensation Insurance	8,470
FICA Taxes	132,614
Employee Health Insurance	118,244
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	10,206
Uniform Expense	252
Employee Expense	5,060
Employee Background Checks	2,934
TOTAL (agree to Schedule V, line 22, col.8)	$ 349,992

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
IHCA	847
ILL Department of Public Health	1,990
Infinity Healthcare Management LLC	780
Other	1,189
IHCA PAC	62
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,868

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage	10,055
Travel Allowance	(1,324)
Seminar Expense	
Education & Seminars	1,002
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,733

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Parker Nursing & Rehabilitation Center # 050880 Report Period Beginning: 1/1/18 Ending: 12/31/18

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Healthcare Association $909**

(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? **5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **23,622** Line **10-2**

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

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

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

(10) Was this home previously operated by a related party (as is defined in the instructions 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. $ **143,876**
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? **0%**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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