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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0050880

Facility Name: Parker Nursing and Rehab Ctr

Address: 516 West Frech St (Number) Streater (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:

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: Aaron Mauer **Telephone Number:** 773-747-4506
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 1/1/20 to 12/31/20 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) 3/5/2021 (Date)
(Print Name and Title) Aaron Mauer, President
(Firm Name & Address) GGM Associates, Inc., 6101 Nimtz Parkway South Bend IN 46628
(Telephone) 773-747-4506 Fax # 773-747-4725

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

Facility Name & ID Number Parker Nursing and Rehab Ctr # 0050880 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 NA

	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	9,940	1,171	5,261	16,372	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,940	1,171	5,261	16,372	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 43.98%

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 3,495

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number Parker Nursing and Rehab Ctr # 0050880 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	207,443	17,635	5,300	230,378		230,378	(37)	230,341			1
2	Food Purchase		105,109		105,109		105,109		105,109			2
3	Housekeeping	292,380	21,089		313,469		313,469		313,469			3
4	Laundry	50,691	14,398		65,089		65,089		65,089			4
5	Heat and Other Utilities			131,418	131,418		131,418	689	132,107			5
6	Maintenance	51,675	12,655	37,799	102,129		102,129	(60)	102,069			6
7	Other (specify):*											7
8	TOTAL General Services	602,189	170,886	174,517	947,592		947,592	592	948,184			8
	B. Health Care and Programs											
9	Medical Director			5,485	5,485		5,485		5,485			9
10	Nursing and Medical Records	1,466,376	175,882	39,178	1,681,436		1,681,436	(67,538)	1,613,898			10
10a	Therapy			301,450	301,450		301,450		301,450			10a
11	Activities	109,927	11,156		121,083		121,083		121,083			11
12	Social Services	51,136		6,357	57,493		57,493		57,493			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultants			4,887	4,887		4,887	(118)	4,769			15
16	TOTAL Health Care and Programs	1,627,439	187,038	357,357	2,171,834		2,171,834	(67,656)	2,104,178			16
	C. General Administration											
17	Administrative	100,631		2,500	103,131		103,131	17,898	121,029			17
18	Directors Fees											18
19	Professional Services			292,904	292,904		292,904	7,964	300,868			19
20	Dues, Fees, Subscriptions & Promotions			2,605	2,605		2,605	(28)	2,577			20
21	Clerical & General Office Expenses	66,438	30,716	455,471	552,625		552,625	(13,403)	539,222			21
22	Employee Benefits & Payroll Taxes			440,989	440,989		440,989	13,760	454,749			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,824	11,824		11,824	(414)	11,410			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			209,007	209,007		209,007	731	209,738			26
27	Other (specify):*											27
28	TOTAL General Administration	167,069	30,716	1,415,300	1,613,085		1,613,085	26,507	1,639,592			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,396,697	388,640	1,947,174	4,732,511		4,732,511	(40,556)	4,691,955			29

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

Facility Name & ID Number Parker Nursing and Rehab Ctr #0050880 Report Period Beginning: 1/1/20 Ending: 12/31/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			50,670	50,670		50,670	(10,612)	40,058			30
31	Amortization of Pre-Op. & Org.			5,510	5,510		5,510	66,666	72,176			31
32	Interest			1,182,110	1,182,110		1,182,110	828	1,182,938			32
33	Real Estate Taxes			101,727	101,727		101,727		101,727			33
34	Rent-Facility & Grounds			513,000	513,000		513,000	(511,334)	1,666			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,853,017	1,853,017		1,853,017	(454,452)	1,398,565			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			105	105		105		105			38
39	Ancillary Service Centers		145,687		145,687		145,687	(1,324)	144,363			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			132,911	132,911		132,911		132,911			42
43	Other (specify):*			81,945	81,945		81,945	(81,945)				43
44	TOTAL Special Cost Centers		145,687	214,961	360,648		360,648	(83,269)	277,379			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,396,697	534,327	4,015,152	6,946,176		6,946,176	(578,276)	6,367,900			45

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

Facility Name & ID Number Parker Nursing and Rehab Ctr # 0050880 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	(31,142)	30		9
10	Interest and Other Investment Income	(1,007)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(37)	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	(81,945)	43		24
25	Fund Raising, Advertising and Promotional	(8,736)	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	(2,108)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (124,975)		$	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)			34
35	Other- Attach Schedule	(453,301)	Various	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (453,301)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (578,276)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Parker Nursing and Rehab Ctr

ID# 0050880

Report Period Beginning: 1/1/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	RP Profit	$ (35)	10	1
2	RP Profit	(118)	15	2
3	RP Profit	(1,324)	39	3
4	Misc Income - Vendor Refund	(451)	6	4
5	Misc Income - Med Records	(179)	10	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(2,108)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Parker Nursing and Rehab Ctr # 0050880 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	(37)	0	0	0	0	0	0	0	0	0	0	(37)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	689	0	0	0	0	0	0	0	0	0	689	5
6	Maintenance	(451)	391	0	0	0	0	0	0	0	0	0	(60)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(488)	1,081	0	0	0	0	0	0	0	0	0	592	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	(214)	(67,323)	0	0	0	0	0	0	0	0	0	(67,538)	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):*	(118)	0	0	0	0	0	0	0	0	0	0	(118)	15
16	TOTAL Health Care and Programs	(332)	(67,323)	0	0	0	0	0	0	0	0	0	(67,656)	16
	C. General Administration													
17	Administrative	0	17,898	0	0	0	0	0	0	0	0	0	17,898	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,886	5,078	0	0	0	0	0	0	0	0	7,964	19
20	Fees, Subscriptions & Promotions	0	(28)	0	0	0	0	0	0	0	0	0	(28)	20
21	Clerical & General Office Expenses	(8,736)	(4,667)	0	0	0	0	0	0	0	0	0	(13,403)	21
22	Employee Benefits & Payroll Taxes	0	13,760	0	0	0	0	0	0	0	0	0	13,760	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(414)	0	0	0	0	0	0	0	0	0	(414)	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	731	0	0	0	0	0	0	0	0	0	731	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(8,736)	30,165	5,078	0	0	0	0	0	0	0	0	26,507	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(9,557)	(36,077)	5,078	0	0	0	0	0	0	0	0	(40,556)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Parker Nursing and Rehab Ctr # 0050880 **Report Period Beginning:** 1/1/20 **Ending:** 12/31/20

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	(31,142)	22	20,508	0	0	0	0	0	0	0	0	(10,612)	30
31	Amortization of Pre-Op. & Org.	0	0	66,666	0	0	0	0	0	0	0	0	66,666	31
32	Interest	(1,007)	1,835	0	0	0	0	0	0	0	0	0	828	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	1,666	(513,000)	0	0	0	0	0	0	0	0	(511,334)	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**	(32,149)	3,523	(425,826)	0	0	0	0	0	0	0	0	(454,452)	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	(1,324)	0	0	0	0	0	0	0	0	0	0	(1,324)	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):*	(81,945)	0	0	0	0	0	0	0	0	0	0	(81,945)	43
44	**TOTAL Special Cost Centers**	(83,269)	0	0	0	0	0	0	0	0	0	0	(83,269)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(124,975)	(32,554)	(420,748)	0	0	0	0	0	0	0	0	(578,276)	45

Facility Name & ID Number Parker Nursing and Rehab Ctr # 0050880 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	50	Ambassador Nursing & Rehab Center	Chicago	Infinity Healthcare	Hillside	Consulting Co.
GELP	50	Belhaven Nursing & Rehab Center	Chicago	516 W Frech Realty		Realty Co.
		Citi View Multicare Center	Cicero	United rx		Pharmacy Co.
		Continental Nursing & Rehab Center	Chicago			
		Forest View Nursing & Rehab 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	5	Heat and Other Utilities	$	Infinity Healthcare Management of IL LLC		$ 689	$ 689	1
2	V	6	Maintenance	1	Infinity Healthcare Management of IL LLC		392	391	2
3	V	10	Nursing and Medical Records	87,452	Infinity Healthcare Management of IL LLC		20,129	(67,323)	3
4	V	17	Administrative	1,182	Infinity Healthcare Management of IL LLC		19,080	17,898	4
5	V	19	Professional Services	202,135	Infinity Healthcare Management of IL LLC		205,021	2,886	5
6	V	20	Dues, Fees, Subscriptions & Promotion	77	Infinity Healthcare Management of IL LLC		49	(28)	6
7	V	21	Clerical & General Office Expenses	75,057	Infinity Healthcare Management of IL LLC		70,390	(4,667)	7
8	V	22	Employee Benefits & Payroll Taxes	9	Infinity Healthcare Management of IL LLC		13,769	13,760	8
9	V	24	Travel and Seminar	5,140	Infinity Healthcare Management of IL LLC		4,726	(414)	9
10	V	26	Insurance-Prop.Liab.Malpractice		Infinity Healthcare Management of IL LLC		731	731	10
11	V	30	Depreciation		Infinity Healthcare Management of IL LLC		22	22	11
12	V	32	Interest		Infinity Healthcare Management of IL LLC		1,835	1,835	12
13	V	34	Rent-Facility & Grounds		Infinity Healthcare Management of IL LLC		1,666	1,666	13
14	Total			$ 371,053			$ 338,499	$ * (32,554)	14

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

Facility Name & ID Number Parker Nursing and Rehab Ctr # 0050880 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	34	Rent	$ 513,000	516 West Frech Street LLD		$	$ (513,000)	15
16	V	31	Amortization		516 West Frech Street LLD		66,666	66,666	16
17	V	30	Depreciation		516 West Frech Street LLD		20,508	20,508	17
18	V	19	Professional Services		516 West Frech Street LLD		5,078	5,078	18
19	V	26	Insurance		516 West Frech Street LLD				19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 513,000			$ 92,252	$ * (420,748)	39

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

Facility Name & ID Number Parker Nursing and Rehab Ctr # 0050880 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

Facility Name & ID Number Parker Nursing and Rehab Ctr # 0050880 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 and Rehab Ctr # 0050880 Report Period Beginning: 1/1/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Parker Nursing and Rehab Ctr # 0050880 Report Period Beginning: 1/1/20 Ending: 12/31/20

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Infinity Funding	X		Working Capital	None	Various	Various	6,825,340	None	Various	1,182,110	6
7												7
8												8
9	TOTAL Facility Related						$	$ 6,825,340			$ 1,182,110	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 6,825,340			$ 1,182,110	15

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

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

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

Facility Name & ID Number Parker Nursing and Rehab Ctr # 0050880 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 73,234	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 34,525	2
3. Under or (over) accrual (line 2 minus line 1).		$ (38,709)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 140,436	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.		$ 101,727	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	37,401	8
	2016	34,265	9
	2017	35,884	10
	2018	36,111	11
	2019	34,525	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Parker Nursing and Rehab Ctr COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0050880

CONTACT PERSON REGARDING THIS REPORT Aaron Mauer

TELEPHONE 773-747-4506 FAX #: 773-747-4725

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	33-23-401-004	Nursing Home	$ 34,525.12	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 34,525.12	$

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

Facility Name & ID Number Parker Nursing and Rehab Ctr # 0050880 Report Period Beginning: 1/1/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Parker Nursing and Rehab Ctr # 0050880 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$ 184,582	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Signs			2010	680	17	39	17		183	9
10	Roof			2010	30,000	769	39	769		8,130	10
11	Shower Tiles			2010	1,000	26	39	26		272	11
12	Signs			2010	684	18	39	18		187	12
13	EXHAUST FAN AND HOOD			2010	1,253	32	39	32		339	13
14	DRYWALL, WINDOWS, INSULATION, CEILING TILES			2010	6,300	162	39	162		1,709	14
15	PAINTING, VINYL COVE BASE, REMOVE WALL COVERING			2010	3,868	99	39	99		1,047	15
16	INSTALL BATHROOM ACCESSORIES, PATIO, AND WALL			2010	127,000	3,256	39	3,256		34,421	16
17	INSTALLATION OF DATA LINES AND PHONES			2010	1,750	45	39	45		475	17
18	BACKFLOW REPAIR			2012	6,249	160	39	160		1,440	18
19											19
20	Paint walls / ceiling - 1st wing			2013	3,135	80	39	80		602	20
21	wallpaper - 2nd wing			2013	2,626	67	39	67		504	21
22	paint - bathroom			2013	1,986	51	39	51		382	22
23	Fire alarm system			2013	26,980	692	39	692		5,189	23
24											24
25	Repair leak in hydronic heating system			2014	1,808	46	39	46		323	25
26	Install new gas hot water boiler			2014	4,422	113	39	113		792	26
27	Cubicle curtains			2014	1,582	41	39	41		286	27
28	Vinyl planking replaced in every resident rm in "C" Hallway			2014	2,020	52	39	52		364	28
29	Vinyl planking replaced in every resident rm in "C" Hallway			2014	2,116	54	39	54		379	29
30	Replace outside patio			2014	5,530	142	39	142		994	30
31	Supply and install cabling for office			2014	6,484	166	39	166		1,163	31
32											32
33	Replace flooring in building			2015	3,786	97	39	97		582	33
34											34
35	Replace kitchen floor and cove base			2016	8,369	215	39	215		1,074	35
36				2016	5,581	143	39	143		715	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Parker Nursing and Rehab Ctr # 0050880 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$	$ 671	37
38	Cummins Gaseous Engine Generator	2017	42,636	1,093	39	1,093		3,825	38
39	New Concrete Ramp	2017	2,060	53	39	53		185	39
40	Replace Gutters & Downspout	2017	2,952	76	39	76		265	40
41	New Natural Gas Water Heater for Commercial Kitchen	2017	4,277	110	39	110		385	41
42	New Natural Gas Water Heater for Commercial Kitchen	2017							42
43									43
44	Fix Short in nurse call system	2018	8,951	230	39	230		574	44
45	Fix Sewer Line and replace cast iron piping	2018	6,480	166	39	166		415	45
46									46
47	New Compressor & motor for RTU	2018	4,581	117	39	117		294	47
48	New building cabling for computers	2018	7,860	202	39	202		504	48
49	Wander Guard System	2018	7,473	192	39	192		478	49
50									50
51	New Roof Top HVAC	2019	9,393	241	39	241		82	51
52	Trouble Shoot Nurse Call Station on D Wing	2019	2,554	65	39	65		121	52
53	Replace Section of Kitchen Floor	2019	2,659	68	39	68		136	53
54	Bring Elevator Fire Wall into NFPA Compliance	2019	4,108	105	39	105		202	54
55	Replace Nurse Call Station & Wiring on B Wing	2019	10,501	269	39	269		471	55
56	Replace Nurse Call Station & Wiring on D Wing	2019	8,758	225	39	225		393	56
57	Replace Nurse Call Station & Wiring on C Wing	2019	10,680	274	39	274		411	57
58	Wander Guard System	2019	27,678	710	39	710		1,005	58
59	Replace Kitchen Dry Heads, Replace Defective Astra Accelerator,	2019	4,617	118	39	118		128	59
60	Piped in New Dry HSW to Oxygen Room & a Low Point Drain for	2019	2,240	57	39	57		62	60
61	Repair Faucet in Kitchen, Install New Shut Offs for Toilet & Sink	2019	1,560	40	39	40		43	61
62								66	62
63	Installation of York 5 Ton Gas/Electric Roof Top Unit	2020	2,586	66	39	66		282	63
64	Installation of York 5 Ton Gas/Electric Roof Top Unit	2020	11,000	282	39	282		181	64
65	Natural Gas Boiler	2020	7,050	181	39	136	(45)	186	65
66	Pave, Patch, Seal Coat and Apply Parking Strips to Parking Lot	2020	7,250	186	39	108	(77)	62	66
67	Repairs to Drywall & Cabinetry from Water Line Leak	2020	2,427	62	39	5	(57)	(473)	67
68	Wander Guard System	2020	(18,452)	(473)	39	(473)			68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,246,567	$ 31,958		$ 31,784	$ (175)	$ 257,089	70

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

Facility Name & ID Number Parker Nursing and Rehab Ctr # 0050880 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$ 48,724	$ 4,812	$ 4,812	$	5	$	71
72	Current Year Purchases	34,408	34,408	3,463	(30,945)	5		72
73	Fully Depreciated Assets	379,673				5	379,673	73
74								74
75	TOTALS	$ 462,805	$ 39,220	$ 8,275	$ (30,945)		$ 379,673	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)	$ 1,734,372	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 71,178	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 40,058	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (31,120)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 636,762	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Parker Nursing and Rehab Ctr # 0050880 Report Period Beginning: 1/1/20 Ending: 12/31/20

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.	/2021	$
13.	/2022	$
14.	/2023	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description: (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Parker Nursing and Rehab Ctr # 0050880 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$	1,729	$ 97,254	$	1,729	$ 97,254	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		15	37,095		15	37,095	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		3,586	167,101		3,586	167,101	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				54,877		54,877	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-2					975		975	12
13	Other (specify): Lab	39-2					89,834		89,834	13
14	TOTAL			$	5,330	$ 301,450	$ 145,687	5,330	$ 447,137	14

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

Facility Name & ID Number Parker Nursing and Rehab Ctr # 0050880 Report Period Beginning: 1/1/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (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	$ (77,596)	$ (76,507)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,355,075	1,355,075	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	135,852	135,852	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)**	$ 1,413,331	$ 1,414,420	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	446,565	446,565	15
16	Equipment, at Historical Cost	237,805	237,805	16
17	Accumulated Depreciation (book methods)	(292,630)	(497,720)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	16,531	1,016,531	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(10,561)	(677,226)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		(2,670)	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 397,710	$ 1,348,285	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,811,041	$ 2,762,705	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,401,706	$ 3,549,978	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,344	18,344	28
29	Short-Term Notes Payable	4,642,090	4,642,090	29
30	Accrued Salaries Payable	90,077	90,077	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,848	8,848	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 8,161,065	$ 8,309,337	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)**	$ 8,161,065	$ 8,309,337	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (6,350,024)	$ (5,546,632)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,811,041	$ 2,762,705	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (4,559,717)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,559,717)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,790,306)	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) **Rounding Error**	(3)	15
16	Other (describe) **Rounding**	2	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,790,307)	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)**	$ (6,350,024)	24 *

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

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,433,305	1
2	Discounts and Allowances for all Levels	(11,390)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,421,915	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	60,272	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 60,272	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	642,347	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	540	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	29,130	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 672,017	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,007	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,007	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Misc Income	659	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 659	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,155,870	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	947,592	31
32	Health Care	2,171,834	32
33	General Administration	1,613,085	33
	B. Capital Expense		
34	Ownership	1,853,017	34
	C. Ancillary Expense		
35	Special Cost Centers	360,648	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,946,176	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,790,306)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,790,306)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,005,202	44
45	Private Pay - Net Inpatient Revenue	304,205	45
46	Medicare - Net Inpatient Revenue	1,845,955	46
47	Other-(specify) NET PATIENT REVENUE	266,553	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,421,915	49

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

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

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

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

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,012	2,063	$ 104,628	$ 50.72	1
2	Assistant Director of Nursing	1,976	2,151	54,441	25.31	2
3	Registered Nurses	4,022	4,679	134,738	28.80	3
4	Licensed Practical Nurses	9,831	11,025	354,517	32.16	4
5	CNAs & Orderlies	36,017	41,856	800,691	19.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,151	5,989	109,927	18.35	10
11	Social Service Workers	1,921	2,033	51,136	25.15	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,792	13,515	207,443	15.35	15
16	Dishwashers					16
17	Maintenance Workers	1,950	2,051	51,675	25.20	17
18	Housekeepers	10,335	11,718	171,588	14.64	18
19	Laundry	3,093	3,832	50,691	13.23	19
20	Administrator	2,008	2,104	100,631	47.83	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,501	4,092	66,438	16.24	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	3,078	3,202	138,153	43.15	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	96,687	110,310	$ 2,396,697 *	$ 21.73	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	110	$ 5,300	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	436	23,269	10-3	38
39	Pharmacist Consultant	98	4,887	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	92	5,957	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	736	$ 39,413		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			10-2	51
52	Certified Nurse Assistants/Aides	333	15,909	10-2	52
53	TOTAL (lines 50 - 52)	333	$ 15,909		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Redd, Kimberly J	Administrator	0	$ 100,631
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 100,631

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
Infinity Healthcare Management of I	Management fees	$ 225,593
Empire Risk Management Services, L	Professional fees	12,000
Genex Services, LLC.	Professional fees	21
Global Fiscal Midwest LLC	Professional fees	21,762
Infinity Healthcare Management of I	Professional fees	1,080
MTS CONSULTING, INC	Professional fees	480
Precise Healthcare Management	Professional fees	12,206
USA Risk Management Inc	Professional fees	468
Klauke Law Group LLC - KLG No 1	Professional fees	1,280
See attached schedule		18,014
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 292,904

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,241
Unemployment Compensation Insurance	10,736
FICA Taxes	190,395
Employee Health Insurance	182,663
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniforms	(118)
Pension	24,457
Employee backround checks	195
Other employee benefits	7,180
TOTAL (agree to Schedule V, line 22, col.8)	$ 454,749

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	$ 1,327
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Clia Laboratory	180
Lasalle county	195
Illinois state fire marshal	210
Streato area chamber of commerce	575
Other license and dues	90
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,577

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Travel Reimbursement	843
In-State Travel	
Travel Reimbursement	(414)
Travel Reimbursement	7,756
Seminar Expense	
Education and Seminars	3,225
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,410

* Attach copy of IMRF notifications

**See instructions.

C. Professional Services

Vendor/Payee	Type	Amount
Premier Destine Inc	**Professional fees**	**704**
People Powered LLC	**Professional fees**	**2,000**
Infinity H Funding	**Professional fees**	**423**
Infinity Funding / Sedgwick	**Legal fees**	**2,500**
Infinity Healthcare Management of I	**Legal fees**	**46**
Klauke Law Group LLC	**Legal fees**	**1,241**
McGuire Woods	**Legal fees**	**2,099**
GGM	**Accounting fees**	**6,000**
Johnson and Goldburg	**Accounting fees**	**3,000**
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)	**$**	**18,014**

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount. **N/A**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **30,302** Line **10**

(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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **132,911**
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 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.