		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: 0051375

Facility Name: Parkshore Estates Nrsg Rehab

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

County: Cook

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

HFS ID Number:

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

Type of Ownership:

[ ] VOLUNTARY,NON-PROFIT
- [ ] Charitable Corp.
- [ ] Trust

IRS Exemption Code ____

[X] PROPRIETARY
- [ ] Individual
- [ ] Partnership
- [ ] Corporation
- [ ] "Sub-S" Corp.
- [X] Limited Liability Co.
- [ ] Trust
- [ ] Other ____

[ ] GOVERNMENTAL
- [ ] State
- [ ] County
- [ ] 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 Parkshore Estates Nrsg Rehab # 0051375 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	128	Skilled (SNF)	128	46,720	1
2		Skilled Pediatric (SNF/PED)			2
3	190	Intermediate (ICF)	190	69,350	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	318	TOTALS	318	116,070	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	30,279	11	4,429	34,719	8
9	SNF/PED					9
10	ICF	44,945	16	538	45,499	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	75,224	27	4,967	80,218	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.11%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 4/1/11

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/1/11 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 64 and days of care provided 4,067

Medicare Intermediary Wisconsin Physician 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.

STATE OF ILLINOIS

Facility Name & ID Number Parkshore Estates Nrsg Rehab # 0051375 **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	519,462	62,421	14,200	596,083		596,083	(1)	596,082			1
2	Food Purchase		490,702		490,702		490,702		490,702			2
3	Housekeeping	475,929	96,107		572,036		572,036		572,036			3
4	Laundry	149,628	48,877		198,505		198,505		198,505			4
5	Heat and Other Utilities			483,902	483,902		483,902	3,187	487,089			5
6	Maintenance	137,318	119,900	116,998	374,216		374,216	(4,384)	369,832			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,282,337	818,007	615,100	2,715,444		2,715,444	(1,198)	2,714,246			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	4,298,854	357,734	144,608	4,801,196		4,801,196	(200,707)	4,600,489			10
10a	Therapy			698,910	698,910		698,910	(28)	698,882			10a
11	Activities	310,516	63,943		374,459		374,459		374,459			11
12	Social Services	234,715		3,098	237,813		237,813		237,813			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			23,598	23,598		23,598	(569)	23,029			15
16	**TOTAL Health Care and Programs**	4,844,085	421,677	900,214	6,165,976		6,165,976	(201,304)	5,964,672			16
	C. General Administration											
17	Administrative	90,860		3,383	94,243		94,243	92,246	186,489			17
18	Directors Fees											18
19	Professional Services			1,003,779	1,003,779		1,003,779	196,347	1,200,126			19
20	Dues, Fees, Subscriptions & Promotions			2,050	2,050		2,050	241	2,291			20
21	Clerical & General Office Expenses	256,900	46,213	550,750	853,863		853,863	174,659	1,028,522			21
22	Employee Benefits & Payroll Taxes			811,904	811,904		811,904	67,453	879,357			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,880	11,880		11,880	17,416	29,296			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			769,015	769,015		769,015	131,840	900,855			26
27	Other (specify):*											27
28	**TOTAL General Administration**	347,760	46,213	3,152,761	3,546,734		3,546,734	680,203	4,226,937			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,474,182	1,285,897	4,668,075	12,428,154		12,428,154	477,701	12,905,855			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.

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			118,704	118,704		118,704	809,305	928,009			30
31	Amortization of Pre-Op. & Org.			13,638	13,638		13,638		13,638			31
32	Interest			13,919	13,919		13,919	673,047	686,966			32
33	Real Estate Taxes			718,256	718,256		718,256		718,256			33
34	Rent-Facility & Grounds			2,487,978	2,487,978		2,487,978	(2,479,814)	8,164			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			3,352,495	3,352,495		3,352,495	(997,461)	2,355,034			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			6,686	6,686		6,686		6,686			38
39	Ancillary Service Centers		266,424		266,424		266,424	(3,242)	263,182			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			635,446	635,446		635,446		635,446			42
43	Other (specify):*			289,701	289,701		289,701	(289,701)				43
44	TOTAL Special Cost Centers		266,424	931,833	1,198,257		1,198,257	(292,943)	905,314			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,474,182	1,552,321	8,952,403	16,978,906		16,978,906	(812,704)	16,166,202			45

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

Facility Name & ID Number Parkshore Estates Nrsg Rehab # 0051375 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	(32,716)	30		9
10	Interest and Other Investment Income	(8,529)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1)	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	(180)	21		18
19	Entertainment				19
20	Contributions	(3,180)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(289,701)	43		24
25	Fund Raising, Advertising and Promotional	(3,586)	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	(10,826)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (348,719)		$	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	(463,985)	Various	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (463,985)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (812,704)		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

STATE OF ILLINOIS

Parkshore Estates Nrsg Rehab

ID# 0051375

Report Period Beginning: 1/1/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	RP Profits	$ (51)	10	1
2	RP Profits	(569)	15	2
3	RP Profits	(3,242)	39	3
4	Misc Income - Refund	(191)	5	4
5	Misc Income - Rebate	(6,305)	6	5
6	Misc Income - Med records	(440)	10	6
7	Misc Income - Therapy Refund	(28)	10a	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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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**	(10,826)		49

Facility Name & ID Number Parkshore Estates Nrsg Rehab # 0051375 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	(1)	0	0	0	0	0	0	0	0	0	0	(1)	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	(191)	3,377	0	0	0	0	0	0	0	0	0	3,187	5
6	Maintenance	(6,305)	1,921	0	0	0	0	0	0	0	0	0	(4,384)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,497)	5,299	0	0	0	0	0	0	0	0	0	(1,198)	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	(491)	(200,216)	0	0	0	0	0	0	0	0	0	(200,707)	10
10a	Therapy	(28)	0	0	0	0	0	0	0	0	0	0	(28)	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):*	(569)	0	0	0	0	0	0	0	0	0	0	(569)	15
16	**TOTAL Health Care and Programs**	(1,088)	(200,216)	0	0	0	0	0	0	0	0	0	(201,304)	16
	C. General Administration													
17	Administrative	0	92,246	0	0	0	0	0	0	0	0	0	92,246	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	224,033	(27,686)	0	0	0	0	0	0	0	0	196,347	19
20	Fees, Subscriptions & Promotions	0	241	0	0	0	0	0	0	0	0	0	241	20
21	Clerical & General Office Expenses	(6,946)	181,605	0	0	0	0	0	0	0	0	0	174,659	21
22	Employee Benefits & Payroll Taxes	0	67,453	0	0	0	0	0	0	0	0	0	67,453	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	17,416	0	0	0	0	0	0	0	0	0	17,416	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	3,580	128,260	0	0	0	0	0	0	0	0	131,840	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(6,946)	586,575	100,574	0	0	0	0	0	0	0	0	680,203	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(14,531)	391,658	100,574	0	0	0	0	0	0	0	0	477,701	29

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(32,716)	107	841,914	0	0	0	0	0	0	0	0	809,305	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,529)	8,992	672,584	0	0	0	0	0	0	0	0	673,047	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	8,164	(2,487,978)	0	0	0	0	0	0	0	0	(2,479,814)	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**	(41,245)	17,264	(973,480)	0	0	0	0	0	0	0	0	(997,461)	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	(3,242)	0	0	0	0	0	0	0	0	0	0	(3,242)	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):*	(289,701)	0	0	0	0	0	0	0	0	0	0	(289,701)	43
44	**TOTAL Special Cost Centers**	(292,943)	0	0	0	0	0	0	0	0	0	0	(292,943)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(348,719)	408,921	(872,906)	0	0	0	0	0	0	0	0	(812,704)	45

Facility Name & ID Number Parkshore Estates Nrsg Rehab # 0051375 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	40	Ambassador Nursing & Rehab Center	Chicago	Infinity Healthcare	Hillside	Consulting Co.
GELP	40	Belhaven Nursing & Rehab Center	Chicago	Parkshore Estates		Realty Co.
A & F Realty, LLC	20	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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Heat and Other Utilities	$	Infinity Healthcare Management of IL LLC		$ 3,377	$ 3,377	1
2	V	6	Maintenance	1	Infinity Healthcare Management of IL LLC		1,922	1,921	2
3	V	10	Nursing and Medical Records	298,841	Infinity Healthcare Management of IL LLC		98,625	(200,216)	3
4	V	17	Administrative	1,242	Infinity Healthcare Management of IL LLC		93,488	92,246	4
5	V	19	Professional Services	780,507	Infinity Healthcare Management of IL LLC		1,004,540	224,033	5
6	V	20	Dues, Fees, Subscriptions & Promotions		Infinity Healthcare Management of IL LLC		241	241	6
7	V	21	Clerical & General Office Expenses	163,285	Infinity Healthcare Management of IL LLC		344,890	181,605	7
8	V	22	Employee Benefits & Payroll Taxes	9	Infinity Healthcare Management of IL LLC		67,462	67,453	8
9	V	24	Travel and Seminar	5,740	Infinity Healthcare Management of IL LLC		23,156	17,416	9
10	V	26	Insurance-Prop.Liab.Malpractice		Infinity Healthcare Management of IL LLC		3,580	3,580	10
11	V	30	Depreciation		Infinity Healthcare Management of IL LLC		107	107	11
12	V	32	Interest		Infinity Healthcare Management of IL LLC		8,992	8,992	12
13	V	34	Rent-Facility & Grounds		Infinity Healthcare Management of IL LLC		8,164	8,164	13
14	Total			$ 1,249,625			$ 1,658,546	$ * 408,921	14

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

Facility Name & ID Number Parkshore Estates Nrsg Rehab # 0051375 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	$ 2,487,978	Parkshore Estates Nursing Home		$	$ (2,487,978)	15
16	V	30	Depreciation		Parkshore Estates Nursing Home		841,914	841,914	16
17	V	19	Professional Services		Parkshore Estates Nursing Home		(27,686)	(27,686)	17
18	V	26	Insurance		Parkshore Estates Nursing Home		128,260	128,260	18
19	V	32	Interest		Parkshore Estates Nursing Home		672,584	672,584	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			$ 2,487,978			$ 1,615,072	$ * (872,906)	39

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

Facility Name & ID Number Parkshore Estates Nrsg Rehab # 0051375 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			Parker Nursing & Rehab Center	Streater				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 Parkshore Estates Nrsg Rehab # 0051375 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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Parkshore Estates Nrsg Rehab # 0051375 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 Parkshore Estates Nrsg Rehab # 0051375 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	HUD Loan		X	Mortgage	$85,215.00		$ 20,500,000	$ 19,422,451	6/1/51	3.3900	$ 675,311	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Credit Suisse		X	Working Capital	None	8/31/14	2,630,863	Various	3/14/22	4.5000	32,977	6
7	Infintiy Funding	X		Working Capital	Various	Various	Various		Various	Various		7
8												8
9	TOTAL Facility Related				$85,215.00		$ 23,130,863	$ 19,422,451			$ 708,288	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 23,130,863	$ 19,422,451			$ 708,288	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 128,260 Line # 26

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

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

Facility Name & ID Number Parkshore Estates Nrsg Rehab # 0051375 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Line	Description		Amount	
1	1. Real Estate Tax accrual used on 2019 report.	$	(20,279)	1
2	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.)	$	525,696	2
3	3. Under or (over) accrual (line 2 minus line 1).	$	545,975	3
4	4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	172,282	4
5	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	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	7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	718,256	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

Year	Amount	Line
2015	405,491	8
2016	453,254	9
2017	487,157	10
2018	610,873	11
2019	525,696	12

FOR BHF USE ONLY

Line	Description			Line
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 Parkshore Estates Nrsg Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051375

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)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.	20-14-408-015-0000	Nursing Home	$ 4,063.65	$ 4,063.65
2.	20-14-408-016-0000	Nursing Home	$ 3,968.64	$ 3,968.64
3.	20-14-408-017-0000	Nursing Home	$ 1,966.13	$ 1,966.13
4.	20-14-409-004-0000	Nursing Home	$ 126,166.58	$ 126,166.58
5.	20-14-409-005-0000	Nursing Home	$ 378,680.88	$ 378,680.88
6.	20-14-409-006-0000	Nursing Home	$ 6,156.35	$ 6,156.35
7.	20-14-409-007-0000	Nursing Home	$ 3,060.88	$ 3,060.88
8.	20-14-409-008-0000	Nursing Home	$ 1,632.79	$ 1,632.79
9.			$	$
10.			$	$
		TOTALS	$ 525,695.90	$ 525,695.90

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.

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			2015	$ 500,000	1
2					2
3	TOTALS			$ 500,000	3

Facility Name & ID Number Parkshore Estates Nrsg Rehab # 0051375 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			2015		$ 19,884,200	$ 509,856	39	$ 509,851	$ (5)	$ 2,506,792	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Door Screen			2011	1,875	48	39	48		468	9
10	NEW LIGHT FIXTURES FOR FACILITY			2011	28,695	736	39	736		7,175	10
11	CEILING TILE			2011	1,361	35	39	35		341	11
12	Fence			2011	2,971	76	39	76		741	12
13	CEMENT FOR HANDICAP RAMP			2011	8,000	205	39	205		1,999	13
14	COUNTERTOPS, CEILING TILE, CROWN MOLDING						39				14
15	MINI BLINDS, LED STRIP LIGHT, W.A.C. LIGHTING, TILE										15
16	FLOORING, WOOD PANELING, HAND RAILS, WALL										16
17	COVERING, PARTITION, DOUBLE DOOR, VINYL BASE										17
18	VINYL FLOORING, VINYL WALL BASE, LAMINATE PANELS										18
19	FOR LOBBY, PHYSICAL THERAPY ROOM, AND ELEVATOR			2011	57,107	1,464	39	1,464		14,276	19
20											20
21	PLUMBING AND DRYWALL IN 6TH FLOOR DIALYSIS ROOM			2012	8,246	211	39	211		1,902	21
22	DOOR LOCK SYSTEM ON LOBBY DOOR			2012	2,851	73	39	73		657	22
23	FLOORING & WALLS ON 1ST FLOOR THERAPY ROOMS			2012	11,274	289	39	289		2,601	23
24	FLORING & WALLS IN MAIN LOBBY			2012	11,274	289	39	289		2,601	24
25	INSTALL SPRINKLER SYSTEM			2012	4,775	122	39	122		1,101	25
26											26
27	EIDCO CREDIT??			2012	(57,107)	(1,464)	39	(1,464)		(13,179)	27
28	REMOVE WALLPAPER, PRIME, PAINT ON 1ST FLOOR ADMIN OF			2012	4,500	115	39	115		1,038	28
29	ROOFING REPAIR			2012	1,200	31	39	31		278	29
30	REPAIR FOUNDATIONAL CRACKS			2012	2,600	67	39	67		601	30
31	INSTALLATION OF FIRE ALARM SYSTEM			2012	17,990	461	39	461		4,151	31
32	REMOVE CARPETING AND INSTALL NEW FLOOR ON 1ST FLOOR			2012	1,165	30	39	30		270	32
33	PLUMBING AND ROUGH IN FOR 10 DIALYSIS STATIONS										33
34	INCLUDING NEW DRAINS, BACK FLOW PREVENTOR, AND PIPING										34
35	FOR 6th FLOOR DIALYIS ROOMS			2012	12,000	308	39	308		2,770	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Parkshore Estates Nrsg Rehab # 0051375 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	REPAIR BOILER	2012	$ 2,929	$ 75	39	$ 75	$	$ 675	37
38									38
39	INSTALL SIGN AND MOUNT ON WALL	2012	1,150	29	39	29		264	39
40									40
41	1ST FLOOR LOBBY/RECEPTION - NEW FLOORING, NEW								41
42	COUNTERS, LIGHTING, PAINT AND CROWN MOLDING,								42
43	WALLCOVERINGS & BLINDS								43
44	1ST FLOOR ELEVATOR LOBBY - LIGHTING, TILE								44
45	FLOORING, WALL BASE, RAILINGS, WALLCOVERINGS								45
46	1ST FLOOR NEW PT ROOM - FLOORING, LIGHTING								46
47	GLASS DOOR, VINYL BASE, PAINT	2012	117,214	3,005	39	3,005		27,056	47
48	Toshiba phone s ystem	2013	21,732	557	39	557		4,178	48
49	3rd floor corridor floor & cove base, wall coverings, nurses	2013	116,909	2,998	39	2,998		22,488	49
50	station counter to p & lighting, dining room floor & cove base,								50
51	lighting, common area and resident room signage								51
52	Fire Alarm	2013	2,721	70	39	70		525	52
53	Durolast roofing s ystem	2013	68,800	1,764	39	1,764		13,231	53
54	Storage room & locks	2013	4,716	121	39	121		907	54
55	Sign / logo / Lettering	2013	1,150	29	39	29		219	55
56	Awning support posts	2013	5,100	131	39	131		982	56
57	Awning support posts	2013	1,000	26	39	26		194	57
58	Permits	2013	1,650	42	39	42		316	58
59	Building cooling tower	2013	2,275	58	39	58		436	59
60	Electrical Wiring on 6th floor for WAP at nurses station and kios	2013	17,985	461	39	461		3,458	60
61	Electrical Wiring & lighting - 3rd floor dial ysis & nurses station	2013	4,610	118	39	118		885	61
62	Masonr y on outide of building	2013	114,600		39	2,938	2,938		62
63	Water Heaters	2014	23,900	613	39	613		4,291	63
64	Doors	2014	5,939	152	39	152		1,065	64
65	Paint ever y hallwa y and the dining room on 3rd floor	2014	18,825	483	39	483		3,380	65
66	Fire Doors in laundr y & therapy	2014	4,459	114	39	114		799	66
67	Elevator mainenance	2014	2,575	66	39	66		462	67
68	Remover Adv Medical from 2013	2014	(2,275)	(58)	39	(58)		(407)	68
69	Flat Scan & monitor module	2014	4,047	104	39	104		728	69
70	TOTAL (lines 4 thru 69)		$ 20,546,988	$ 523,912		$ 526,845	$ 2,933	$ 2,622,714	70

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

Facility Name & ID Number Parkshore Estates Nrsg Rehab # 0051375 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	
1	Totals from Page 12A, Carried Forward		$ 20,546,988	$ 523,912		$ 526,845	$ 2,933	$ 2,622,714	1
2	New Passage Lever Door Locks	2015	8,316	213	39	213		1,257	2
3	Re placed A/C Cooling Tower	2015	18,460	473	39	473		2,795	3
4	Add Scale Remover to Cooling Tower	2015	4,190	107	39	107		633	4
5	New walls, tile, and flooring in 4th Floor Shower Room	2015	7,342	188	39	188		1,110	5
6	New walls, tile, & flooring 2nd & 4th Floor Shower Room	2015	6,253	160	39	160		947	6
7	Re placed Exhaust Fan Motors	2015	5,006	128	39	128		758	7
8	Re placed Exhaust Fan	2015	8,737	224	39	224		1,321	8
9	Re placed A/C Control Unit	2015	7,210	185	39	185		1,091	9
10	Re place Wall, Floor, Tiles, Shower Base in 5th Fl Shower Rm	2015	6,814	175	39	175		1,032	10
11	Furnish & Install ADA Covers under sinks on Floors 2-5	2015	5,151	132	39	132		780	11
12	New Passage Lever Door Locks	2015	2,626	67	39	67		397	12
13	New Passage Lever Door Locks	2015	5,711	146	39	146		863	13
14	Tuck Pointing and S palled Brick Re pairs to the Building	2015	8,000	205	39	205		1,211	14
15	Clean, Sealcoat, Re pave, and Restri pe Parking Lot	2015	36,815	944	39	944		5,570	15
16	Install New Floor & Door Threshold on 6th Fl in Wings B&C	2015	11,298	290	39	290		1,710	16
17	Install Door Restrictors for Elevators	2015	5,500	141	39	141		832	17
18									18
19	Paint boiler rm, 2 electrical rooms, & elevator frame 1st fl	2016	3,014	77	39	77		386	19
20	Re place fault y h ydronic unit heater in the boiler room	2016	2,975	76	39	76		381	20
21	Re place therapy rm doors 1st floor & raise patio fence b 2ft	2016	8,560	219	39	219		1,099	21
22	Re place forced air convector in 6th fl dining rm & game rm	2016	9,400	241	39	241		1,205	22
23	Remove and re place 16' x 17' concrete pad	2016	3,100	79	39	79		399	23
24	Shower rm 2nd floor - re place walls, floor, & ceiling	2016	8,033	206	39	206		1,030	24
25	Re place 10-h p cooling tower fan motor	2016	9,130	234	39	234		1,170	25
26	Install shunt tri p for 2 passenger & 1 freight elevators	2016	6,500	167	39	167		834	26
27	Window cables allowing residents to o pen windows 2"	2016	5,100	131	39	131		655	27
28	Shower rm B 5th fl - re place walls, floor, & ceiling	2016	8,392	215	39	215		1,075	28
29	Install new fire alarm for elevator recall s ystem	2016	39,384	1,010	39	1,010		5,050	29
30	Shower rm B 4th fl - re place walls, floor, & ceiling	2016	11,326	290	39	290		1,451	30
31	1st fl bathroom re place toilet, sink, mirror, light, floor tiles	2016							31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 20,809,331	$ 530,639		$ 533,572	$ 2,933	$ 2,659,755	34

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

Facility Name & ID Number Parkshore Estates Nrsg Rehab # 0051375 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	
1	Totals from Page 12B, Carried Forward		$ 20,809,331	$ 530,639		$ 533,572	$ 2,933	$ 2,659,755	1
2	Refurbished Bearing Motor on Circulating Pump #1	2017	5,279	135	39	135		474	2
3	Domestic Water Mixing Valve	2017	2,879	74	39	74		259	3
4	Paint 6th Floor C Wing & 1st Floor Lobby	2017	3,700	95	39	95		332	4
5	Refurbished 3rd Floor Show Room on B Wing	2017	8,393	215	39	215		754	5
6	New Awnings at Parkshore East - Chesterfield Awning	2017	4,994	128	39	128		449	6
7	New Underground Line for Parking Lot Lights	2017	2,475	63	39	63		223	7
8	New Air Handler Chilled Hot Water Coils	2017	18,900	485	39	485		1,695	8
9	Seco Refrigeration - Replace Pump & Motor for Dishwasher	2017	4,223	108	39	108		379	9
10	City of Chicago - Crosswalk and Stripping	2017	19,233	493	39	493		1,726	10
11	Cary Supply - Stairway Door Alarms	2017	2,708	69	39	69		243	11
12	Suburban Elevator - 3 Elevator Door Operators	2017	13,200	338	39	338		1,184	12
13	Complete Concrete - Removal of Concrete Steps	2017	5,200	133	39	133		467	13
14	Alliance Construction - New Hot Water Tank	2017	11,348	291	39	291		1,018	14
15									15
16	Replace Power Supply for Fire Alarm System	2018	3,857	99	39	99		248	16
17	New Hot Water Heater	2018	3,323	85	39	85		213	17
18	New elevator System (down payment)	2018	52,200	1,444	39	1,338	(106)	3,559	18
19	New Jockey pump for sprinkler system	2018	3,371	86	39	86		216	19
20	2 New Doors for Facility	2018	3,720	95	39	95		238	20
21	New Facility Toilets	2018	4,410	113	39	113		282	21
22	Rebuilt Cooling Tower	2018	24,500	628	39	628		1,570	22
23	Replace Garage Roof	2018	3,289	84	39	84		211	23
24									24
25	Elevator Materials - (new microprocessor, tape selector, surface m	2019	52,200	338	39	1,338	1,000	677	25
26	GAL MOVFR Door Operator, infrared door edge, Etc)								26
27	Vacuum Breakers & Various Plumbing Fixtures for Bathrooms	2019	3,525	90	39	90		181	27
28	Completion of Elevator Car #2 Modernization	2019	26,100	169	39	669	500	338	28
29	Remove & Replace Handral & Ramp for Patio Ramp	2019	8,700	89	39	223	134	178	29
30	New Chiller/Hot Water Convectors - consist of blower motor, blo	2019	12,825	279	39	329	50	558	30
31	Elevator (Installation of materials for Elevator #1)	2019	26,100	169	39	669	500	338	31
32	New Chiller/Hot Water Convectors	2019	4,985	78	39	128	50	156	32
33	New Motor for Dish Washer	2019	3,331	85	39	85		171	33
34	TOTAL (lines 1 thru 33)		$ 21,148,300	$ 537,202		$ 542,263	$ 5,061	$ 2,678,091	34

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

Facility Name & ID Number Parkshore Estates Nrsg Rehab # 0051375 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	
1	Totals from Page 12C, Carried Forward		$ 21,148,300	$ 537,202		$ 542,263	$ 5,061	$ 2,678,091	1
2	New Doors for Walk-In Freezer & Cooler	2019	2,950	76	39	76		76	2
3	Two Passenger Car Modifications in elevator Pit Room	2019	13,950	58	39	58		58	3
4	Scratch & Dent Refrigerator Door	2019	2,646	68	39	68		68	4
5	Remodel Shower Room on 6th Floor A & B Wings	2019	18,156	166	39	166		166	5
6	Remove All Wall, Floor Tiles, Repair Framing								6
7	Install Durock and Retile Entire Shower								7
8	Remove Shower Base and Install a custom made one out of tile								8
9									9
10									10
11	New Blower Motor for HVAC System	2019	3,686	95	39	95		189	11
12	New Cabling for IT	2019	7,310	187	39	187		375	12
13	Elevator Modernization	2019	17,400	146	39	146		292	13
14	Install Volt Feeders for Passenger Cars 1 & 2 for Elevators	2019	7,500	192	39	192		385	14
15	Restoration of 6th Floor Nurse Call Station	2019	2,794	72	39	72		143	15
16	Install Ground Wire form Main Electrical Switch Gear to Main E	2019	8,950	229	39	229		459	16
17	Rebuilt Bearing Assembly for Right Hand Building Circulating Pu	2019	2,417	62	39	62		124	17
18	Fabricate Dish Table Extension & Rework Existing Duct	2019	2,289	59	39	59		117	18
19	New Motor for Right Hand Building Circulating Pump #2	2019	1,896	49	39	49		97	19
20	New Motor for Left Hand Building Circulating Pump #1	2019	2,246	58	39	58		115	20
21	Install RPZ on Kitchen Dishwasher; Install RPZ for Janitor Soup	2019	6,380	164	39	164		314	21
22	Install 5 Hand Wash Sinks & Plumbing to Each	2019	7,270	186	39	186		357	22
23	Elevator Modernization	2019	5,464	140	39	140		269	23
24	New Amp Feeder for Controlling Water Pumps	2019	4,950	127	39	127		222	24
25	New Key Pads for Doors at Stairs for Each Building Floor	2019	11,155	286	39	286		501	25
26	Coolong Tower Cleaning	2019	7,820	201	39	201		334	26
27	Repair Heating/Cooling Coil in Kitchen Air Handler	2019	2,024	52	39	52		86	27
28	Repair Multiple Leaks in Heating/Cooling Coil in Kitchen Air Ha	2019	1,962	50	39	50		84	28
29	Patch & Repair Existing Concrete Wall & stelps	2019	2,573	66	39	66		104	29
30	Sealcoat Parking Lot + Striping & Patch Work	2019	4,099	105	39	105		166	30
31	New Concrete Driveway Apron	2019	2,635	68	39	68		101	31
32	Replace Boiler Flue Pipes for the DHWTR Boiler	2019	2,648	68	39	68		85	32
33									33
34	TOTAL (lines 1 thru 33)		$ 21,301,468	$ 540,229		$ 545,291	$ 5,061	$ 2,683,378	34

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

Facility Name & ID Number Parkshore Estates Nrsg Rehab # 0051375 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	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 21,301,468	$ 540,229		$ 545,291	$ 5,061	$ 2,683,378	1
2	Replace Water Pump, 2 Hour Loadbank, Diagnose Generator	2019	2,292	59	39	59		73	2
3	Remove Wall & Floor Tile & Install New Tile & Dry Wall in Show	2019	9,425	242	39	242		282	3
4	Drain Sprinkler System & Replace Broken Valve Stem on Sprinkl	2019	3,157	81	39	81		94	4
5	Install New 3 Phase MO Panel & Refeed & Separated All Outlets	2019	2,400	62	39	62		72	5
6	Replace Faulty EXF On Roof	2019	2,337	60	39	60		70	6
7	Repair, Paint & Patch 6th Floor Hallway	2019	2,995	77	39	77		83	7
8									8
9	Install Stainless Steel Trim Around Laundry Shoot 6th through 2	2018	3,720	95	39	95		80	9
10	Toilet Wall Mounted	2018	312	8	39	8		125	10
11	Ceiling and Floor Tile	2020	3,114	80	39	80		75	11
12	Install New Mixing Valve on 6th Floor Water Pipes Feeding Mach	2020	4,870	125	39	125		85	12
13	Flooring	2020	2,906	75	39	75		388	13
14	Install New 2 Compartment Wash Sink With Faucet in dialysis Ba	2020	3,320	85	39	85		23	14
15	New Grinder Ejection Pump for Basement Sewere Pit	2020	15,120	388	39	388		38	15
16	Rod Out Laundry Pit in Basement for New Grinder Ejection Pum	2020	890	23	39	23		56	16
17	Piping for Ejection Pump	2020	1,464	38	39	38		15	17
18	New 85 Gallon Water Heater for Basement	2020	2,178	56	39	56		73	18
19	Remove Cloth Piece from Ejector Pump from Pit & Reinstall	2020	585	15	39	15		300	19
20	New Door Edge for Elevator 3	2020	2,850	73	39	73		85	20
21	Replace 2nd Water Heater	2020	11,690	300	39	275	(25)	72	21
22	Install Back Flows by Janitor Closet Sink, Dish Washer in Kitche	2020	3,315	85	39	64	(21)	86	22
23	Medical Shoer filters, Overhead Shower Startsets and Faucet Aer	2020	2,827	72	39	54	(18)	73	23
24	Clean Cooling Tower	2020	3,356	86	39	57	(29)	124	24
25	Repair and Replace Tub Mixing Valves on all Floors	2020	2,846	73	39	49	(24)	287	25
26	Repair Mixing Valves on 2nd thru 6th Floor Bathrooms	2020	4,850	124	39	52	(73)	86	26
27	Remove Wood doors and Replace with Fire Rated Doors througho	2020	11,179	287	39	96	(191)	128	27
28	Inspect and Repair Sprinkler System	2020	3,336	86	39	21	(64)	204	28
29	Furnish & Install New Car Sill for Freight Elevator	2020	4,980	128	39	32	(96)	742	29
30	Replace Fire System Check Valve	2020	7,950	204	39	51	(153)	2,174	30
31	Retube & Engineer Leaking Boilers	2020	28,950	742	39	124	(619)		31
32	Replace LH Heating Boiler	2020	84,782	2,174	39	181	(1,993)		32
33									33
34	TOTAL (lines 1 thru 33)		$ 21,535,463	$ 546,229		$ 547,985	$ 1,756	$ 2,689,369	34

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

Facility Name & ID Number Parkshore Estates Nrsg Rehab # 0051375 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	$ 2,467,471	$ 376,194	$ 376,194	$	5	$ 2,000,110	71
72	Current Year Purchases	38,303	38,303	3,830	(34,473)	5	38,303	72
73	Fully Depreciated Assets	580,571				5	580,571	73
74								74
75	TOTALS	$ 3,086,345	$ 414,497	$ 380,024	$ (34,473)		$ 2,618,984	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)	$ 25,121,808	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 960,726	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 928,009	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (32,717)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,308,353	85	

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								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 Parkshore Estates Nrsg Rehab # 0051375 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.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$	4,770	$ 299,326	$	4,770	$ 299,326	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,719	135,520		1,719	135,520	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		3,391	264,063		3,391	264,063	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				134,428		134,428	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-2					3,115		3,115	12
13	Other (specify): Lab	39-2					128,881		128,881	13
14	TOTAL			$	9,880	$ 698,910	$ 266,424	9,880	$ 965,334	14

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

Facility Name & ID Number Parkshore Estates Nrsg Rehab # 0051375 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	$ (151,629)	$ (150,556)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	521,757	521,757	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	434,996	434,996	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		783,024	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 805,124	$ 1,589,221	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		500,000	13
14	Buildings, at Historical Cost		19,884,200	14
15	Leasehold Improvements, at Historical Cost	1,540,763	1,540,763	15
16	Equipment, at Historical Cost	820,071	3,077,871	16
17	Accumulated Depreciation (book methods)	(869,906)	(5,821,811)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	85,411	559,970	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(25,003)	(67,821)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	1,052,029	1,052,029	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,603,365	$ 20,725,201	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,408,489	$ 22,314,422	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,488,894	$ 2,246,530	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,682	24,682	28
29	Short-Term Notes Payable	1,374,400	1,744,271	29
30	Accrued Salaries Payable	188,738	188,738	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,434	21,434	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)**	$ 3,098,148	$ 4,225,655	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		19,052,580	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)**	$	$ 19,052,580	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,098,148	$ 23,278,235	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 310,341	$ (963,813)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,408,489	$ 22,314,422	48

*(See instructions.)

Facility Name & ID Number Parkshore Estates Nrsg Rehab # 0051375 Report Period Beginning: 1/1/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (745,919)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (745,919)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,056,257	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	5	15
16	Other (describe) Rounding Error	(2)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,056,260	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)**	$ 310,341	24 *

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

Facility Name & ID Number Parkshore Estates Nrsg Rehab # 0051375 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$ 15,823,575	1
2	Discounts and Allowances for all Levels	20,295	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 15,843,870	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	287,201	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 287,201	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	1,852,738	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	2,505	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	18,667	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,873,910	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,529	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,529	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a	Misc Income	21,653	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 21,653	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 18,035,163	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,715,444	31
32	Health Care	6,165,976	32
33	General Administration	3,546,734	33
	B. Capital Expense		
34	Ownership	3,352,495	34
	C. Ancillary Expense		
35	Special Cost Centers	1,198,257	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)***	$ 16,978,906	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,056,257	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,056,257	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 13,093,658	44
45	Private Pay - Net Inpatient Revenue	6,660	45
46	Medicare - Net Inpatient Revenue	2,408,187	46
47	Other-(specify) NET PATIENT REVENUE	335,365	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 15,843,870	49

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

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

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

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

Facility Name & ID Number Parkshore Estates Nrsg Rehab # 0051375 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,799	2,053	$ 99,502	$ 48.47	1
2	Assistant Director of Nursing	6,534	7,080	299,147	42.25	2
3	Registered Nurses	13,318	19,497	877,593	45.01	3
4	Licensed Practical Nurses	34,160	41,012	1,325,811	32.33	4
5	CNAs & Orderlies	81,245	97,207	1,643,912	16.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	12,979	16,140	310,516	19.24	10
11	Social Service Workers	10,835	12,113	234,715	19.38	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,668	31,708	519,462	16.38	15
16	Dishwashers					16
17	Maintenance Workers	6,459	7,168	137,318	19.16	17
18	Housekeepers	23,073	25,954	414,895	15.99	18
19	Laundry	9,242	10,102	149,628	14.81	19
20	Administrator	1,912	1,968	90,860	46.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,506	12,501	256,900	20.55	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	3,286	3,476	113,923	32.77	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	243,016	287,979	$ 6,474,182 *	$ 22.48	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	296	$ 14,200	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	1,085	57,945	10-3	38
39	Pharmacist Consultant	472	23,598	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	48	3,088	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,901	$ 98,830		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses			10-2	51
52	Certified Nurse Assistants/Aides	5,490	86,663	10-2	52
53	TOTAL (lines 50 - 52)	5,490	$ 86,663		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gautam, Shubam	Administrators	0	$ 72,043
Ishola, Hamed A	Administrators	0	18,816
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 90,860

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	$ 807,612
Associated Consultants	PROFESSIONAL FEES	15,907
Abbey Road Tax Consultants	PROFESSIONAL FEES	8,114
Empire Risk Management Services, I	PROFESSIONAL FEES	12,000
Genex Services, LLC.	PROFESSIONAL FEES	3
Global Fiscal Midwest LLC	PROFESSIONAL FEES	26,903
Global Healthcare Apex	PROFESSIONAL FEES	2,609
Infinity Healthcare Management of I	PROFESSIONAL FEES	1,238
MTS Consulting	PROFESSIONAL FEES	711
USA Risk Management Inc	PROFESSIONAL FEES	1,234
See Attached Professional Fees		127,449
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 1,003,779

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 117,367
Unemployment Compensation Insurance	32,022
FICA Taxes	551,628
Employee Health Insurance	163,493
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniforms	6,879
Employee backround checks	993
Other employee benefits	6,975
TOTAL (agree to Schedule V, line 22, col.8)	$ 879,357

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,327
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
Clia Laboratory	180
Collaborative healthcare urgency	425
Other licenses and dues	359
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,291

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Travel Reimbursement	5
In-State Travel	
Travel Reimbursement	17,416
Travel Reimbursement	9,198
Seminar Expense	
Education and Seminars	2,677
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 29,296

**See instructions.

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

C. Professional Services

Vendor/Payee	Type	Amount
Premier Destine Inc	COVID-19 PROFESSIONAL FEES	704
Infinity H Funding	COVID-19 PROFESSIONAL FEES	423
Ashman & Stein	LEGAL SERVICE	12,303
Infinity Funding / Sedgwick	LEGAL SERVICE	102,501
Infinity Healthcare Management of Il	LEGAL SERVICE	392
Klauke Law Group LLC	LEGAL SERVICE	26
McGuire Woods - 10/12/20	LEGAL SERVICE	2,099
Ggm	Accounting fees	6,000
Johnson and goldburg	Accounting fees	3,000
See Attached Professional Fees		
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 127,449

Facility Name & ID Number Parkshore Estates Nrsg Rehab # 0051375 Report Period Beginning: 1/1/20 Ending: 12/31/20

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. $ **52,825** 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. $ **635,446**
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.