

		FOR BHF USE					

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0052571 Facility Name: Parc At Joliet, Llc Address: 222 North Hammes Avenue Joliet 60435 County: Will Telephone Number: (815) 725-0443 Fax #: (815) 725-1079 HFS ID Number: Date of Initial License for Current Owners: 11/1/2013 Type of Ownership: ☐ VOLUNTARY,NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code ☒ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☒ Limited Liability Co. ☐ Trust ☐ Other ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other

In the event there are further questions about this report, please contact:

Name: Steven N. Lavenda Telephone Number: (847) 282-6300

Email Address:

Facility Name & ID Number Parc At Joliet, Llc

0052571 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>203</u>	Skilled (SNF)	<u>203</u>	<u>74,298</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>203</u>	TOTALS	<u>203</u>	<u>74,298</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>32,837</u>	<u>3,557</u>	<u>10,043</u>	<u>46,437</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>32,837</u>	<u>3,557</u>	<u>10,043</u>	<u>46,437</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.50%

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

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES ☐ NO ☒

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

YES ☐ NO ☒

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

Date started 11/01/2013

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

YES ☒ Date 11/01/2013 NO ☐

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

YES ☒ NO ☐ If YES, enter number of beds certified 203 and days of care provided 7,461

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Parc At Joliet, Llc # 0052571 Report Period Beginning: 01/01/16 Ending: 12/31/16
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	332,330	77,980	13,536	423,846		423,846	175	424,021			1
2	Food Purchase		312,318		312,318		312,318	138	312,456			2
3	Housekeeping	304,977	85,741		390,718		390,718	969	391,687			3
4	Laundry	66,764	12,988		79,752		79,752		79,752			4
5	Heat and Other Utilities			183,347	183,347		183,347	1,351	184,698			5
6	Maintenance	136,238	23,666	220,930	380,834		380,834	1,900	382,734			6
7	Other (specify):*							793	793			7
8	TOTAL General Services	840,309	512,693	417,813	1,770,815		1,770,815	5,326	1,776,141			8
	B. Health Care and Programs											
9	Medical Director			34,500	34,500		34,500		34,500			9
10	Nursing and Medical Records	2,763,291	324,961	11,499	3,099,751		3,099,751	(4,008)	3,095,743			10
10a	Therapy	188,363		775	189,138		189,138		189,138			10a
11	Activities	159,678	17,698		177,376		177,376		177,376			11
12	Social Services	231,814	163	914	232,891		232,891		232,891			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,343,146	342,822	47,688	3,733,656		3,733,656	(4,008)	3,729,648			16
	C. General Administration											
17	Administrative	212,271			212,271		212,271	18,907	231,178			17
18	Directors Fees											18
19	Professional Services			463,793	463,793	(866)	462,927	(337,110)	125,817			19
20	Dues, Fees, Subscriptions & Promotions			70,121	70,121		70,121	(32,374)	37,747			20
21	Clerical & General Office Expenses	121,406	23,771	462,455	607,632		607,632	(298,055)	309,577			21
22	Employee Benefits & Payroll Taxes			966,159	966,159		966,159	(7,060)	959,099			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,173	2,173		2,173	144	2,317			24
25	Other Admin. Staff Transportation			2,900	2,900		2,900	977	3,877			25
26	Insurance-Prop.Liab.Malpractice			238,211	238,211		238,211	1,691	239,902			26
27	Other (specify):*							27,212	27,212			27
28	TOTAL General Administration	333,677	23,771	2,205,812	2,563,260	(866)	2,562,394	(625,668)	1,936,726			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,517,132	879,286	2,671,313	8,067,731	(866)	8,066,865	(624,350)	7,442,515			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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			33,603	33,603		33,603	307,914	341,517			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			19,716	19,716		19,716	306,889	326,605			32
33	Real Estate Taxes			161,523	161,523	866	162,389	3,943	166,332			33
34	Rent-Facility & Grounds			1,288,998	1,288,998		1,288,998	(1,287,322)	1,676			34
35	Rent-Equipment & Vehicles			26,384	26,384		26,384	923	27,307			35
36	Other (specify):*											36
37	TOTAL Ownership			1,530,224	1,530,224	866	1,531,090	(667,653)	863,437			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		320,497	994,338	1,314,835		1,314,835	(16,059)	1,298,776			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			340,954	340,954		340,954		340,954			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		320,497	1,335,292	1,655,789		1,655,789	(16,059)	1,639,730			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,517,132	1,199,783	5,536,829	11,253,744		11,253,744	(1,308,061)	9,945,683			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	59,221	30		9
10	Interest and Other Investment Income	(940)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(239)	02		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	(310)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(390,109)	21		24
25	Fund Raising, Advertising and Promotional	(31,927)	20		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	(67,160)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (431,464)		\$	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)	(876,597)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (876,597)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,308,061)		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

Parc At Joliet, Llc

	ID#	0052571
Report Period Beginning:		01/01/16
Ending:		12/31/16

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Patient Clothing	\$ (972)	10	1
2	Theft/Loss	(400)	21	2
3	Collection Expense	(7,737)	21	3
4	Capitalized R&M	(9,378)	06	4
5	Building Company - Management Fee	(10,150)	17	5
6	Building Company - State Replacement Tax	(4,964)	21	6
7	Building Company - Bank Charge	(106)	21	7
8	Building Company - Amortization Expense	(27,954)	36	8
9	Building Company - Filing Fee	(250)	21	9
10	PAC Dues	(479)	20	10
11	Non Allowable Legal Fees	(1,242)	19	11
12	Chamber of Commerce Dues	(575)	20	12
13	Lobbying Expense	(2,953)	21	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	(67,160)		49

Parc At Joliet, Llc

	ID#	0052571
Report Period Beginning:		01/01/16
Ending:		12/31/16

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Parc At Joliet, Llc # 0052571 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			175									175	1
2	Food Purchase	(239)		377									138	2
3	Housekeeping			969									969	3
4	Laundry													4
5	Heat and Other Utilities			1,351									1,351	5
6	Maintenance	(9,378)		2,822	8,456								1,900	6
7	Other (specify):*				793								793	7
8	TOTAL General Services	(9,617)		5,694	9,249								5,326	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(972)					(3,036)						(4,008)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(972)					(3,036)						(4,008)	16
	C. General Administration													
17	Administrative	(10,150)	10,150	2,825	16,082								18,907	17
18	Directors Fees													18
19	Professional Services	(1,242)		(335,868)									(337,110)	19
20	Fees, Subscriptions & Promotions	(33,291)		917									(32,374)	20
21	Clerical & General Office Expenses	(406,519)	5,320	5,692	97,452								(298,055)	21
22	Employee Benefits & Payroll Taxes				(7,060)								(7,060)	22
23	Inservice Training & Education													23
24	Travel and Seminar			144									144	24
25	Other Admin. Staff Transportation			977									977	25
26	Insurance-Prop.Liab.Malpractice			1,691									1,691	26
27	Other (specify):*				27,212								27,212	27
28	TOTAL General Administration	(451,202)	15,470	(323,622)	133,686								(625,668)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(461,791)	15,470	(317,928)	142,935		(3,036)						(624,350)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Parc At Joliet, Llc # 0052571 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	59,221	246,438	2,255									307,914	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(940)	299,644	8,185									306,889	32
33	Real Estate Taxes			3,943									3,943	33
34	Rent-Facility & Grounds		(1,287,322)										(1,287,322)	34
35	Rent-Equipment & Vehicles			923									923	35
36	Other (specify):*	(27,954)	27,954											36
37	TOTAL Ownership	30,327	(713,286)	15,306									(667,653)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(16,059)						(16,059)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers						(16,059)						(16,059)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(431,464)	(697,816)	(302,622)	142,935		(19,094)						(1,308,061)	45

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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	34	Rental Income	\$ 1,287,322	Glenwood Real Estate	100.00%	\$	(1,287,322)	1
2	V	32	Interest		Glenwood Real Estate	100.00%	299,644	299,644	2
3	V	17	Management Fees		Glenwood Real Estate	100.00%	10,150	10,150	3
4	V	21	State Replacement Tax		Glenwood Real Estate	100.00%	4,964	4,964	4
5	V	21	Bank Charge		Glenwood Real Estate	100.00%	106	106	5
6	V	30	Depreciation		Glenwood Real Estate	100.00%	246,438	246,438	6
7	V	36	Amortization Expense		Glenwood Real Estate	100.00%	27,954	27,954	7
8	V	21	Filing Fee		Glenwood Real Estate	100.00%	250	250	8
9	V	33	Real Estate Tax Expense	161,523	Glenwood Real Estate	100.00%	161,523		9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,448,845			\$ 751,029	\$ * (697,816)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 175	\$ 175	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	377	377	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	969	969	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,351	1,351	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	2,822	2,822	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	2,825	2,825	20
21	V	19	Professional Fees	341,508	Extended Care Consulting, LLC	100.00%	5,640	(335,868)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	917	917	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	5,692	5,692	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	144	144	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	977	977	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,691	1,691	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	2,255	2,255	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	8,185	8,185	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	3,943	3,943	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	923	923	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			\$ 341,508			\$ 38,886	\$ * (302,622)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ 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)	
15	V	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	8,456	\$	8,456
16	V	06	Maintenance (Direct)		Extended Care Consulting, LLC	100.00%			
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	793		793
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%			
19	V								
20	V								
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	16,082		16,082
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	97,452		97,452
23	V	21	Office and Clerical (Direct)	23,532	Extended Care Consulting, LLC	100.00%	23,532		
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	20,765		20,765
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	6,447		6,447
26	V	22	Employee Benefits	7,060	Extended Care Consulting, LLC	100.00%			(7,060)
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ 30,592			\$ 173,527	\$ *	142,935

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 272,396	\$ 272,396	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	272,396	CCS Employee Benefits Group	100.00%		(272,396)	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			\$ 272,396			\$ 272,396	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	\$ 42,150	MAC Rx, LLC	100.00%	\$ 39,114	\$ (3,036)	15
16	V	21	Clerical & General Office Expenses		MAC Rx, LLC	100.00%			16
17	V	22	Employee Benefits		MAC Rx, LLC	100.00%			17
18	V	39	Ancillary	222,972	MAC Rx, LLC	100.00%	206,913	(16,059)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 265,122			\$ 246,027	\$ * (19,094)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES☐ NO

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

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

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

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

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	Wissati Irrevocable Trust	80.00%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC BEECHER		Extended Care Consulting	Evanston	Mgmt / Bookkeeping	1
2	Charles Slagel	20.00%	BRIAR PLACE LTD.	INDIAN HEAD PARK	Extended Care Clinical	Evanston	Clinical	2
3			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	Care Centers Building	Evanston	Building Company	3
4			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	Vent Lease LLC	Evanston	Ventilator Equipment	4
5			GRASMERE PLACE, LLC	CHICAGO	C.C.S. Veba	Evanston	Health Insurance	5
6			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	MAC RX	Des Plaines	Pharmacy	6
7			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	Reliable Medical Supply	Des Plaines	Medical Supplies	7
8			MAJOR HOSPITAL DYER	DYER, IN	Glenwood Real Estate	Joliet	Building Company	8
9			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				9
10			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				10
11			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				11
12			MAJOR HOSPITAL SEBOS	HOBART, IN				12
13			MCKINLEY HEALTH CARE CENTER	CANTON, OH				13
14			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				14
15			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				15
16			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				16
17			RAINBOW BEACH QOC, L.L.C.	CHICAGO				17
18			SHEFFIELD MANOR	DYER, IN				18
19			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				19
20			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				20
21			SPRING CREEK NURSING & REHAB CENTER	JOLIET				21
22			ST. JAMES WELLNESS REHAB VILLAS	CRETE				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			THE PARC AT JOLIET	JOLIET				24
25			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				25
26			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				26
27			WHEATON CARE CENTER	WHEATON				27
28								28
29								29
30								30

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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Parc At Joliet, Llc # 0052571 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

Facility Name & ID Number Parc At Joliet, Llc # 0052571 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,380,761	34	\$ 5,206	\$	46,437	\$ 175	1
2	02	Food	Patient Days	1,380,761	34	11,203		46,437	377	2
3	03	Housekeeping	Patient Days	1,380,761	34	28,798		46,437	969	3
4	05	Utilities	Patient Days	1,380,761	34	40,168		46,437	1,351	4
5	06	Maintenance	Patient Days	1,380,761	34	83,922		46,437	2,822	5
6	17	Administrative	Patient Days	1,380,761	34	84,000		46,437	2,825	6
7	19	Professional Fees	Patient Days	1,380,761	34	167,697		46,437	5,640	7
8	20	Dues and Subscriptions	Patient Days	1,380,761	34	27,266		46,437	917	8
9	21	Office and Clerical	Patient Days	1,380,761	34	169,235		46,437	5,692	9
10	24	Seminar and Travel	Patient Days	1,380,761	34	4,279		46,437	144	10
11	25	Other Staff Admin. Trans.	Patient Days	1,380,761	34	29,053		46,437	977	11
12	26	Insurance	Patient Days	1,380,761	34	50,289		46,437	1,691	12
13	30	Depreciation	Patient Days	1,380,761	34	67,038		46,437	2,255	13
14	32	Interest	Patient Days	1,380,761	34	243,379		46,437	8,185	14
15	33	Real Estate Taxes	Patient Days	1,380,761	34	117,233		46,437	3,943	15
16	35	Rent - Equipment & Auto	Patient Days	1,380,761	34	27,451		46,437	923	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,156,218	\$		\$ 38,886	25

Facility Name & ID Number Parc At Joliet, Llc # 0052571 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	06	Maintenance (Pooled)	Patient Days	1,380,761	34	251,431	251,431	46,437	8,456	1
2	06	Maintenance (Direct)	Direct		20	373,682	373,682			2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,380,761	34	23,565		46,437	793	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		20	46,748				4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,380,761	34	478,172	478,172	46,437	16,082	7
8	21	Office and Clerical (Pooled)	Patient Days	1,380,761	34	2,897,656	2,897,656	46,437	97,452	8
9	21	Office and Clerical (Direct)	Direct		24	460,382	460,382		23,532	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,380,761	34	617,434		46,437	20,765	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		24	73,413			6,447	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 5,222,483	\$ 4,461,323		\$ 173,527	25

Facility Name & ID Number Parc At Joliet, Llc # 0052571 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 CCS Employee Benefits Group, Inc.
Street Address 2201 Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847)905-4000
Fax Number (847)905-4040

	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	22	Employee Health Insurance	Direct Allocation					\$ 272,396	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				\$	\$		\$ 272,396	25

Facility Name & ID Number Parc At Joliet, Llc # 0052571 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1 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	10	Nursing And Medical Records	Direct Allocation		\$	\$		\$ 39,114	1
	2	21	Clerical & General Office Expense	Direct Allocation						2
	3	22	Employee Benefits	Direct Allocation						3
	4	39	Ancillary	Direct Allocation					206,913	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				\$	\$		\$ 246,027	25

Facility Name & ID Number Parc At Joliet, Llc # 0052571 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number

Fax Number

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

Facility Name & ID Number Parc At Joliet, Llc # 0052571 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

()

()

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

Facility Name & ID Number Parc At Joliet, Llc # 0052571 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

Facility Name & ID Number Parc At Joliet, Llc # 0052571 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

()

()

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

Facility Name & ID Number Parc At Joliet, Llc # 0052571 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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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

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	The Private Bank		X	Mortgage			\$	5,641,900			\$	299,644	1
2													2
3													3
4													4
5					-								5
	Working Capital												
6	The Private Bank		X	Line of Credit				790,000				19,716	6
7													7
8					-								8
9	TOTAL Facility Related						\$	6,431,900			\$	319,360	9
	B. Non-Facility Related*												
10	Interest		X									(940)	10
11	Alloc Extended Care Consulting	X										8,185	11
12													12
13					-								13
14	TOTAL Non-Facility Related						\$				\$	7,245	14
15	TOTALS (line 9+line14)						\$	6,431,900			\$	326,605	15

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

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

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

B. Real Estate Taxes

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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Parc At Joliet, Llc

COUNTY

Will

FACILITY IDPH LICENSE NUMBER

0052571

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-6300

FAX #:

(847) 236-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. <u>30-07-07-304-025-0000</u>	<u>Long Term Care Facility</u>	\$ <u>161,648.36</u>	\$ <u>161,648.36</u>
2. <u>See Attached</u>	<u>Allocated from Extended Care Consul</u>	\$ <u>117,233.57</u>	\$ <u>3,942.74</u>
3. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u>278,881.93</u>	\$ <u>165,591.10</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

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

FACILITY NAME	<u>Parc At Joliet, Llc</u>	COUNTY	<u>Will</u>
FACILITY IDPH LICENSE NUMBER	<u>0052571</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Steve Lavenda</u>		
TELEPHONE	<u>(847) 236-6300</u>	FAX #:	<u>(847) 236-6301</u>

Enter the tax index number and real estate tax assessed for 2015 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 2015.

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

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

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	75,625		\$ 747,850	1
2	Allocated form Care Centers Building			19,300	2
3	TOTALS	75,625		\$ 767,150	3

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	203		2013	1970	\$ 6,657,211	\$ 246,438	35	\$ 190,206	\$ (56,232)	\$ 4,564,945	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Various			1993	27,837		20			27,837	9	
10	Various			1994	4,980		20			4,980	10	
11	Various			1995	20,929		20			20,929	11	
12	Various			1996	21,845		20			21,845	12	
13	Various			1997	15,491		20	775	775	15,491	13	
14	Various			1998	28,751		20	1,438	1,438	27,313	14	
15	Various			1999	17,798		20	890	890	16,018	15	
16	Various			2000	67,420		20	3,371	3,371	57,307	16	
17	Various			2001	37,385		20	1,869	1,869	29,908	17	
18	Various			2002	81,564		20	4,078	4,078	61,173	18	
19	Various			2003	22,069		20	1,103	1,103	15,602	19	
20	Various			2005	43,812		20	2,191	2,191	26,287	20	
21	Various			2006	7,414		20	371	371	4,078	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	

*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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12F & 12G)							67
68	Related Party Allocations (Pages 12H & 12I)	92,887	1,316		1,316		61,987	68
69	Financial Statement Depreciation		33,603			(33,603)		69
70	TOTAL (lines 4 thru 69)	\$ 7,147,393	\$ 281,357		\$ 207,607	\$ (73,750)	\$ 4,955,700	70

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

Facility Name & ID Number Parc At Joliet, Llc

0052571

Report Period Beginning:

01/01/16

Ending:

12/31/16

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		\$ 7,147,393	\$ 281,357		\$ 207,607	\$ (73,750)	\$ 4,955,700	1
2	Tile & Thinset For 1St Floor Bathrooms	2014	8,193		20	819	819	2,321	2
3	Signage	2014	6,550		20	437	437	1,164	3
4	Cut Open Concrete & Repipe Underground Sewer, Reconcrete Fl	2014	43,136		20	4,314	4,314	9,346	4
5	Water Heater	2014	4,569		20	457	457	952	5
6	Plumbing	2015	4,660		20	466	466	854	6
7	80 Gallon Water Heater	2015	3,965		20	397	397	628	7
8	Resident Rooms-Handrails,Bumper Guards,Lighting,Signs,Curtai	2015	23,515		20	1,176	1,176	1,764	8
9	Readjust Door Closer Panic Bar Outside Trim Lever	2015	2,564		20	128	128	171	9
10	Elevator Mechanical Door Restrictor	2015	2,930		20	147	147	208	10
11	2 Water Heaters	2016	6,351		20	185	185	185	11
12	Water Heater	2016	3,958		20	66	66	66	12
13	Installed Magnetic Locks With Extra Push Bars And Door Handle	2016	3,042		20	152	152	152	13
14	Installed Led Lighting	2016	3,167		20	158	158	158	14
15	Installed Ceiling Tiles	2016	3,170		20	159	159	159	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,267,163	\$ 281,357		\$ 216,667	\$ (64,690)	\$ 4,973,829	34

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

XI. OWNERSHIP COSTS (continued)

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

1		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 12B, Carried Forward		\$ 7,267,163	\$ 281,357		\$ 216,667	\$ (64,690)	\$ 4,973,829	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,267,163	\$ 281,357		\$ 216,667	\$ (64,690)	\$ 4,973,829	34

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

XI. OWNERSHIP COSTS (continued)

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

1		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 12C, Carried Forward		\$ 7,267,163	\$ 281,357		\$ 216,667	\$ (64,690)	\$ 4,973,829	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,267,163	\$ 281,357		\$ 216,667	\$ (64,690)	\$ 4,973,829	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 7,267,163	\$ 281,357		\$ 216,667	\$ (64,690)	\$ 4,973,829	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
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,267,163	\$ 281,357		\$ 216,667	\$ (64,690)	\$ 4,973,829	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Parc At Joliet, Llc

0052571

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4	Allocated from Extended Care Consulting LLC - BLDG	2002	26,596	682	39	682		9,746	4
5	Allocated from Extended Care Consulting, LLC - Dyer Bldg	2007	8,072	179	20	179		1,698	5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting, LLC	2007	155	8	20	8		77	9
10	Allocated from Extended Care Consulting, LLC	2009	92	5	20	5		37	10
11	Allocated from Extended Care Consulting, LLC	2010	907	45	20	45		318	11
12	Allocated from Extended Care Consulting, LLC	2011	327	16	20	16		98	12
13	Allocated from Extended Care Consulting, LLC	2012	108	5	20	5		27	13
14	Allocated from Extended Care Consulting, LLC	2014	1,492	75	20	75		224	14
15	Allocated from Extended Care Consulting, LLC	2016	1,788	89	20	89		89	15
16									16
17	Allocated from Extended Care Consulting LLC - BLDG	2002	21,970		20			21,970	17
18	Allocated from Extended Care Consulting LLC - BLDG	2003	25,891		20			25,891	18
19	Allocated from Extended Care Consulting LLC - BLDG	2005	1,286	2	20	2		1,286	19
20	Allocated from Extended Care Consulting LLC - BLDG	2009	232	12	20	12		93	20
21	Allocated from Extended Care Consulting LLC - BLDG	2014	2,159	108	20	108		324	21
22	Allocated from Extended Care Consulting LLC - BLDG	2015	366	18	20	18		37	22
23	Allocated from Extended Care Consulting LLC - BLDG	2016	1,446	72	20	72		72	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 92,887	\$ 1,316		\$ 1,316	\$	\$ 61,987	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 92,887	\$ 1,316		\$ 1,316	\$	\$ 61,987	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 92,887	\$ 1,316		\$ 1,316	\$	\$ 61,987	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,180,271	\$ 767	\$ 124,330	\$ 123,563	10	\$ 248,839	71
72	Current Year Purchases	5,220		348	348	10	348	72
73	Fully Depreciated Assets	395,164				10	395,164	73
74								74
75	TOTALS	\$ 1,580,654	\$ 767	\$ 124,678	\$ 123,911		\$ 644,351	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Alloc. Extended Care Consulting,	2016	\$ 6,069	\$ 171	\$ 171		5	\$ 5,727	76
77										77
78										78
79										79
80	TOTALS			\$ 6,069	\$ 171	\$ 171			\$ 5,727	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 9,621,036	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 282,295	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 341,516	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 59,221	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,623,907	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	Renovation	\$ 578,709	92
93			93
94			94
95		\$ 578,709	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?

YES

NO
- If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Storage Unit				1,676			5
6								6
7	TOTAL				\$1,676			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:

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: \$27,306
- Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ 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		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 383,355	\$		\$ 383,355	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			111,986			111,986	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			475,503			475,503	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				259,581		259,581	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					23,494	60,916		84,410	13
14	TOTAL			\$		\$ 994,338	\$ 320,497		\$ 1,314,835	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 43,003	\$ 424,799	1
2	Cash-Patient Deposits	40,527	40,527	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,097,907	1,097,907	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	351,851	351,851	6
7	Other Prepaid Expenses	12,448	12,448	7
8	Accounts Receivable (owners or related parties)	475	254,932	8
9	Other(specify): <u>See Attached Schedule</u>	95,431	95,431	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,641,642	\$ 2,277,895	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		747,850	13
14	Buildings, at Historical Cost		6,657,211	14
15	Leasehold Improvements, at Historical Cost	192,991	312,913	15
16	Equipment, at Historical Cost	21,188	1,046,205	16
17	Accumulated Depreciation (book methods)	(55,426)	(3,386,759)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	578,709	635,190	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 737,462	\$ 6,012,610	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,379,104	\$ 8,290,505	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,190,843	\$ 2,190,843	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,577	33,577	28
29	Short-Term Notes Payable	790,000	790,000	29
30	Accrued Salaries Payable	306,598	306,598	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,493	14,493	31
32	Accrued Real Estate Taxes(Sch.IX-B)	195,023	169,731	32
33	Accrued Interest Payable		24,184	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	1,028,390	1,380,145	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,558,924	\$ 4,909,571	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,641,900	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43			500,000	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 6,141,900	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,558,924	\$ 11,051,471	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,179,820)	\$ (2,760,966)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,379,104	\$ 8,290,505	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,774,561)	1
2	Restatements (describe):		2
3			3
4	Rounding Adjustment	6	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,774,555)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(405,265)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (405,265)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,179,820)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 10,763,361	1
2	Discounts and Allowances for all Levels	(4,370,413)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,392,948	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,175,995	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,175,995	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	276,025	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,685	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 278,710	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	940	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 940	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	(114)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (114)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,848,479	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,770,815	31
32	Health Care	3,733,656	32
33	General Administration	2,563,260	33
	B. Capital Expense		
34	Ownership	1,530,224	34
	C. Ancillary Expense		
35	Special Cost Centers	1,314,835	35
36	Provider Participation Fee	340,954	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,253,744	40
41	Income before Income Taxes (line 30 minus line 40)**	(405,265)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (405,265)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,866,507	44
45	Private Pay - Net Inpatient Revenue	821,450	45
46	Medicare - Net Inpatient Revenue	506,261	46
47	Other-(specify) Hospice	228,684	47
48	Other-(specify) Insurance	(29,954)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,392,948	49

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.
*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.
****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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	2,091	2,217	\$ 121,958	\$ 55.01	1
2	Assistant Director of Nursing	2,091	2,264	92,568	40.89	2
3	Registered Nurses	16,108	18,473	555,417	30.07	3
4	Licensed Practical Nurses	34,223	36,953	986,589	26.70	4
5	CNAs & Orderlies	77,850	83,741	960,923	11.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,796	11,313	188,363	16.65	8
9	Activity Director	2,622	3,073	57,672	18.77	9
10	Activity Assistants	10,090	10,808	102,006	9.44	10
11	Social Service Workers	7,989	8,765	231,814	26.45	11
12	Dietician					12
13	Food Service Supervisor	4,946	5,414	108,417	20.03	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,749	6,171	81,545	13.21	15
16	Dishwashers	14,696	16,022	142,368	8.89	16
17	Maintenance Workers	5,914	6,653	136,238	20.48	17
18	Housekeepers	26,065	30,292	304,977	10.07	18
19	Laundry	4,833	5,617	66,764	11.89	19
20	Administrator	2,091	2,254	102,092	45.29	20
21	Assistant Administrator	4,081	4,536	110,179	24.29	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,204	9,163	121,406	13.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,797	2,214	45,836	20.70	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	241,236	265,943	\$ 4,517,132 *	\$ 16.99	34

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	288	\$ 13,536	01-03	35
36	Medical Director	Monthly	34,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,499	10-03	39
40	Physical Therapy Consultant	3	226	10a-03	40
41	Occupational Therapy Consultant	2	163	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	6	386	10a-03	43
44	Activity Consultant				44
45	Social Service Consultant	13	914	12-03	45
46	Other(specify)				46
47					47
48	Psychiatrist	Monthly	6,000		48
49	TOTAL (lines 35 - 48)	312	\$ 61,224		49

C. CONTRACT NURSES

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

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

** See instructions.

Facility Name & ID Number		Parc At Joliet, Llc		STATE OF ILLINOIS	#	0052571	Report Period Beginning:	01/01/16	Ending:	12/31/16	Page 22
XX. GENERAL INFORMATION:											
(1)	Are nursing employees (RN,LPN,NA) represented by a union?			<u>Yes</u>							
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.			<u>Yes</u> <u>ICLTC \$1,451</u>							
(3)	Did the nursing home make political contributions or payments to a political action organization? If YES, have these costs been properly adjusted out of the cost report?			<u>Yes</u> <u>Yes</u>							
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?			<u>No</u> <u>N/A</u>							
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?			<u>Yes</u> <u>10 Years</u>							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$ <u>N/A</u> Line <u>N/A</u>							
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.			<u>Yes</u>							
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.			<u>No</u> <u>N/A</u>							
(9)	Are you presently operating under a sublease agreement?			YES <u>X</u> NO							
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>NO</u> <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.			<u>N/A</u>							
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. This amount is to be recorded on line 42 of Schedule V.			\$ <u>340,954</u>							
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.			<u>No</u>							
(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?			<u>Yes</u>							
(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? 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.			<u>No</u>							
(15)	Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. Has any meal income been offset against related costs?			\$ <u>N/A</u> Indicate the amount. \$ <u>N/A</u>							
(16)	Travel and Transportation										
	a. Are there costs included for out-of-state travel? If YES, attach a complete explanation.			<u>No</u>							
	b. Do you have a separate contract with the Department to provide medical transportation for residents? If YES, please indicate the amount of income earned from such a program during this reporting period.			<u>No</u> \$ <u>N/A</u>							
	c. What percent of all travel expense relates to transportation of nurses and patients?			<u>100% in 14</u>							
	d. Have vehicle usage logs been maintained?			<u>No</u>							
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?			<u>No</u>							
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?			<u>N/A</u>							
	g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.			<u>No</u> \$ <u>N/A</u>							
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name:			<u>No</u> <u>N/A</u>							
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?			<u>Yes</u>							
(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. Attach invoices and a summary of services for all architect and appraisal fees			<u>Yes</u>							