

		FOR BHF USE					

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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: 0050880

Facility Name: Parker Nursing & Rehab Ctr

Address: 516 West Frech St Streator 61364
Number City Zip Code

County: LaSalle

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

HFS ID Number:

Date of Initial License for Current Owners: 5/1/98

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: Daniel S. Gaafar Telephone Number: (317) 237-5500
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/16 to 12/31/16 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) Flora Reznik
(Title) CFO

Paid
Preparer

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

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

Facility Name & ID Number Parker Nursing & Rehab Ctr

0050880 Report Period Beginning: 1/1/16 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>102</u>	Skilled (SNF)	<u>102</u>	<u>37,332</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>102</u>	TOTALS	<u>102</u>	<u>37,332</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>16,556</u>	<u>1,497</u>	<u>2,195</u>	<u>20,248</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>16,556</u>	<u>1,497</u>	<u>2,195</u>	<u>20,248</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.24%

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

0 (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

5/1/98

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

YES

☒

Date

5/1/98

NO

☐

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

YES

☒

NO

☐

If YES, enter number

of beds certified

102

and days of care provided

1,699

Medicare Intermediary

National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☐

NO

☐

Tax Year:

12/31/16

Fiscal Year:

12/31/16

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

Facility Name & ID Number **Parker Nursing & Rehab Ctr** # **0050880** Report Period Beginning: **1/1/16** 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	170,821		33,684	204,505		204,505	(6,765)	197,740			1
2	Food Purchase		119,088		119,088		119,088	399	119,487			2
3	Housekeeping	88,680	27,661		116,341		116,341	253	116,594			3
4	Laundry	20,971	10,337		31,308		31,308		31,308			4
5	Heat and Other Utilities			90,186	90,186		90,186	341	90,527			5
6	Maintenance	33,751	28,482	35,717	97,950		97,950	612	98,562			6
7	Other (specify):*											7
8	TOTAL General Services	314,223	185,568	159,587	659,378		659,378	(5,160)	654,218			8
	B. Health Care and Programs											
9	Medical Director			5,891	5,891		5,891		5,891			9
10	Nursing and Medical Records	1,026,829	88,181	48,677	1,163,687		1,163,687	(38,104)	1,125,583			10
10a	Therapy			375,292	375,292		375,292		375,292			10a
11	Activities	58,118	8,782		66,900		66,900	1,606	68,506			11
12	Social Services			4,228	4,228		4,228		4,228			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharmacy Consult			5,913	5,913		5,913		5,913			15
16	TOTAL Health Care and Programs	1,084,947	96,963	440,001	1,621,911		1,621,911	(36,498)	1,585,413			16
	C. General Administration											
17	Administrative	83,145			83,145		83,145		83,145			17
18	Directors Fees											18
19	Professional Services			248,891	248,891		248,891	(53,253)	195,638			19
20	Dues, Fees, Subscriptions & Promotions			9,484	9,484		9,484	54	9,538			20
21	Clerical & General Office Expenses	147,022	28,423	37,739	213,184		213,184	66,627	279,811			21
22	Employee Benefits & Payroll Taxes			322,751	322,751		322,751	29,600	352,351			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,825	15,825		15,825	630	16,455			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			24,680	24,680		24,680	3,975	28,655			26
27	Other (specify):*											27
28	TOTAL General Administration	230,167	28,423	659,370	917,960		917,960	47,633	965,593			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,629,337	310,954	1,258,958	3,199,249		3,199,249	5,975	3,205,224			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			17,995	17,995		17,995	85,918	103,913			30
31	Amortization of Pre-Op. & Org.							66,666	66,666			31
32	Interest			72,893	72,893		72,893	172,531	245,424			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			453,000	453,000		453,000	(449,513)	3,487			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			543,888	543,888		543,888	(124,398)	419,490			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			764	764		764		764			38
39	Ancillary Service Centers		71,615		71,615		71,615		71,615			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			168,044	168,044		168,044		168,044			42
43	Other (specify):* Bad Debt			419,710	419,710		419,710	(419,710)				43
44	TOTAL Special Cost Centers		71,615	588,518	660,133		660,133	(419,710)	240,423			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,629,337	382,569	2,391,364	4,403,270		4,403,270	(538,133)	3,865,137			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	65,262	30		9
10	Interest and Other Investment Income	(33,720)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(47)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(419,710)	43		24
25	Fund Raising, Advertising and Promotional	(2,314)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,507)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (393,036)		\$	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)	(145,097)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (145,097)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (538,133)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Misc. Income	\$ (2,384)	21	1
2	Lobbying Dues	(123)	20	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
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26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,507)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Parker Nursing & Rehab Ctr # 0050880 Report Period Beginning: 1/1/16 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	(47)	(6,718)	0	0	0	0	0	0	0	0	0	(6,765)	1
2	Food Purchase	0	399	0	0	0	0	0	0	0	0	0	399	2
3	Housekeeping	0	253	0	0	0	0	0	0	0	0	0	253	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	341	0	0	0	0	0	0	0	0	0	341	5
6	Maintenance	0	612	0	0	0	0	0	0	0	0	0	612	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(47)	(5,113)	0	0	0	0	0	0	0	0	0	(5,160)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(38,104)	0	0	0	0	0	0	0	0	0	(38,104)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	1,606	0	0	0	0	0	0	0	0	0	1,606	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	(36,498)	0	0	0	0	0	0	0	0	0	(36,498)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(53,253)	0	0	0	0	0	0	0	0	0	(53,253)	19
20	Fees, Subscriptions & Promotions	(123)	177	0	0	0	0	0	0	0	0	0	54	20
21	Clerical & General Office Expenses	(4,698)	70,775	550	0	0	0	0	0	0	0	0	66,627	21
22	Employee Benefits & Payroll Taxes	0	29,600	0	0	0	0	0	0	0	0	0	29,600	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	630	0	0	0	0	0	0	0	0	0	630	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	208	3,767	0	0	0	0	0	0	0	0	3,975	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(4,821)	48,137	4,317	0	0	0	0	0	0	0	0	47,633	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(4,868)	6,526	4,317	0	0	0	0	0	0	0	0	5,975	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Parker Nursing & Rehab Ctr # 0050880 Report Period Beginning: 1/1/16 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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	65,262	0	20,656	0	0	0	0	0	0	0	0	85,918	30
31	Amortization of Pre-Op. & Org.	0	0	66,666	0	0	0	0	0	0	0	0	66,666	31
32	Interest	(33,720)	0	206,251	0	0	0	0	0	0	0	0	172,531	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(449,513)	0	0	0	0	0	0	0	0	(449,513)	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	31,542	0	(155,940)	0	0	0	0	0	0	0	0	(124,398)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(419,710)	0	0	0	0	0	0	0	0	0	0	(419,710)	43
44	TOTAL Special Cost Centers	(419,710)	0	0	0	0	0	0	0	0	0	0	(419,710)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(393,036)	6,526	(151,623)	0	0	0	0	0	0	0	0	(538,133)	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
Michael Blisko	40%	Ambassador Nursing & Rehab Center	Chicago	Infinity Healthcare	Hillside, IL	Management Co.
GELP	40%	Belhaven Nursing & Rehab Center	Chicago	516 W Frech Realty		Realty Co
Joe Blisko	20%	City View Multicare Center	Cicero			
		Continental Nursing & Rehab Center	Chicago			
		Forest View Rehab & Nursing Center	Itasca			
		Lakeview Nursing & Rehab Center	Chicago			
		Midway Neurological & Rehab Center	Bridgeview			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ 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	1	Dietary	\$ 13,670	Infinity Healthcare Management of Illinois		\$ 6,952	\$ (6,718)	1
2	V	2	Food Purchase		Infinity Healthcare Management of Illinois		399	399	2
3	V	3	Housekeeping		Infinity Healthcare Management of Illinois		253	253	3
4	V	5	Utilities		Infinity Healthcare Management of Illinois		341	341	4
5	V	6	Maintenance		Infinity Healthcare Management of Illinois		612	612	5
6	V	10	Nursing	47,728	Infinity Healthcare Management of Illinois		9,624	(38,104)	6
7	V	11	Activities		Infinity Healthcare Management of Illinois		1,606	1,606	7
8	V	19	Professional Fees	128,221	Infinity Healthcare Management of Illinois		74,968	(53,253)	8
9	V	20	Dues & Fees		Infinity Healthcare Management of Illinois		177	177	9
10	V	21	Office Expense	61,046	Infinity Healthcare Management of Illinois		131,821	70,775	10
11	V	22	Employee Benefits		Infinity Healthcare Management of Illinois		29,600	29,600	11
12	V	24	Travel Expense	260	Infinity Healthcare Management of Illinois		890	630	12
13	V	26	Insurance		Infinity Healthcare Management of Illinois		208	208	13
14	Total			\$ 250,925			\$ 257,451	\$ * 6,526	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	30	Depreciation	\$	Infinity Healthcare Management of Illinois		\$ 148	\$ 148	15
16	V	32	Interest		Infinity Healthcare Management of Illinois		1,918	1,918	16
17	V	34	Rent		Infinity Healthcare Management of Illinois		3,487	3,487	17
18	V								18
19	V	26	Insurance		513 West Frech Street LLC		3,767	3,767	19
20	V	31	Amortization		513 West Frech Street LLC		66,666	66,666	20
21	V	21	Office Expense		513 West Frech Street LLC		550	550	21
22	V	30	Depreciation		513 West Frech Street LLC		20,508	20,508	22
23	V	32	Interest		513 West Frech Street LLC		204,333	204,333	23
24	V	34	Rent	453,000	513 West Frech Street LLC			(453,000)	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			\$ 453,000			\$ 301,377	\$ * (151,623)	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			Momence Meadows Nursing & Rehab Ctr	Momence				1
2			Niles Nursing & Rehab Center	Niles				2
3			Oak Lawn Respiratory & Rehab Center	Oak Lawn				3
4			Parkshore Estates Nursing & Rehab Center	Chicago				4
5			Southpoint Nursing & Rehab Center	Chicago				5
6			West Suburban Nursing & Rehab Center	Bloomington				6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Parker Nursing & Rehab Ctr # 0050880 Report Period Beginning: 1/1/16 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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Bank Leumi		X	Property	\$25,454.00	10/22/15	\$ 4,420,000	\$ 4,283,183	4/1/17	4.4000	\$ 204,333	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Infinity Funding	X		Working Capital	None	Various	Various	2,939,756	None	Various	74,811	6
7												7
8												8
9	TOTAL Facility Related				\$25,454.00		\$ 4,420,000	\$ 7,222,939			\$ 279,144	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 4,420,000	\$ 7,222,939			\$ 279,144	15

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	216,895	1																			
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	37,401	2																			
3. Under or (over) accrual (line 2 minus line 1).			\$	(179,494)	3																			
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	179,494	4																			
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5																			
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6																			
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$		7																			
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:	2011	35,328	8	<table><tr><td colspan="3">FOR BHF USE ONLY</td></tr><tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2015</td><td>\$</td><td>13</td></tr><tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr><tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr><tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr></table>		FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2015	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR BHF USE ONLY																								
13	FROM R. E. TAX STATEMENT FOR 2015	\$	13																					
14	PLUS APPEAL COST FROM LINE 5	\$	14																					
15	LESS REFUND FROM LINE 6	\$	15																					
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																					
	2012	32,536	9																					
	2013	33,855	10																					
	2014	34,623	11																					
	2015	37,401	12																					

- 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.

FACILITY NAME Parker Nursing & Rehab Ctr COUNTY LaSalle
FACILITY IDPH LICENSE NUMBER 0050880
CONTACT PERSON REGARDING THIS REPORT Daniel S. Gaafar
TELEPHONE (317) 237-5500 FAX #: (317) 237-5503

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.

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

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.

A. Square Feet: 20,000

B. General Construction Type: Exterior Brick Frame Concrete/Steel Number of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (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).

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	Land			\$ 25,000	1
2					2
3	TOTALS			\$ 25,000	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	102				\$ 800,000	\$ 20,508	39	\$ 20,513	\$ 5	\$ 123,058	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SIGNS			2010	680	17	39	17		114	9
10	ROOF			2010	30,000	769	39	769		5,054	10
11	SHOWER TILES			2010	1,000	26	39	26		169	11
12	SIGNS			2010	684	18	39	18		116	12
13	EXHAUST FAN AND HOOD			2010	1,253	32	39	32		211	13
14	DRYWALL, WINDOWS, INSULATION, CEILING TILES			2010	6,300	162	39	162		1,062	14
15	PAINTING, VINYL COVE BASE, REMOVE WALL COVERING			2010	3,868	99	39	99		651	15
16	INSTALL BATHROOM ACCESSORIES, PATIO, AND WALL			2010	127,000	3,256	39	3,256		21,396	16
17	INSTALLATION OF DATA LINES AND PHONES			2010	1,750	45	39	45		295	17
18	BACKFLOW REPAIR			2012	6,249	160	39	160		800	18
19											19
20	Paint walls / ceiling - 1st wing			2013	3,135	80	39	80		281	20
21	wallpaper - 2nd wing			2013	2,626	67	39	67		235	21
22	paint - bathroom			2013	1,986	51	39	51		178	22
23	Fire alarm system			2013	26,980	692	39	692		2,421	23
24											24
25	Repair leak in hydronic heating system			2014	1,808	46	39	46		138	25
26	Install new gas hot water boiler			2014	4,422	113	39	113		339	26
27	Cubicle curtains			2014	1,582	41	39	41		123	27
28	Vinyl planking replaced in every resident rm in "C" Hallway			2014	2,020	52	39	52		156	28
29	Vinyl planking replaced in every resident rm in "C" Hallway			2014	2,116	54	39	54		162	29
30	Replace outside patio			2014	5,530	142	39	142		426	30
31	Supply and install cabling for office			2014	6,484	166	39	166		498	31
32											32
33	Replace flooring in building			2015	3,786	97	39	97		194	33
34											34
35	Replace kitchen floor and cove base			2016	8,369	215	39	215		215	35
36	Replace compressor switch on fire sprinklers			2016	5,581	143	39	143		143	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Parker Nursing & Rehab Ctr

0050880

Report Period Beginning:

1/1/16

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	
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									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,055,209	\$ 27,051		\$ 27,056	\$ 5	\$ 158,435	70

**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	\$375,671	\$9,877	\$75,134	\$65,257	5	\$341,671	71
72	Current Year Purchases	8,614	1,723	1,723		5	1,723	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$384,285	\$11,600	\$76,857	\$65,257		\$343,394	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	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)	\$1,464,494	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$38,651	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$103,913	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$65,262	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$501,829	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: *

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

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	10a-3	hrs	\$	1,513	\$ 76,045	\$	1,513	\$ 76,045	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		94	5,221		94	5,221	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		3,398	189,026		3,398	189,026	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				66,456		66,456	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>X-ray/Laboratory</u>	39-2					5,159		5,159	12
13	Other (specify): _____									13
14	TOTAL			\$	5,005	\$ 270,292	\$ 71,615	5,005	\$ 341,907	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	\$ 49,920	\$ 138,069	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,140,969	1,490,969	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	37,701	37,701	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,228,590	\$ 1,666,739	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		25,000	13
14	Buildings, at Historical Cost		800,000	14
15	Leasehold Improvements, at Historical Cost	255,205	255,208	15
16	Equipment, at Historical Cost	159,284	384,284	16
17	Accumulated Depreciation (book methods)	(153,772)	(501,830)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		1,000,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(400,000)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 260,717	\$ 1,562,662	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,489,307	\$ 3,229,401	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 404,240	\$ 584,873	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,435	14,435	28
29	Short-Term Notes Payable		115,996	29
30	Accrued Salaries Payable	81,012	81,012	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		15,798	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
36	Other Current Liabilities(specify):			36
37	Working Capital	2,939,756	2,939,756	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,439,443	\$ 3,751,870	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		4,167,187	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
43	Other Long-Term Liabilities(specify):			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 4,167,187	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,439,443	\$ 7,919,057	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,950,136)	\$ (4,689,656)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,489,307	\$ 3,229,401	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,414,063)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,414,063)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(536,073)	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)	\$ (536,073)	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)	\$ (1,950,136)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Parker Nursing & Rehab Ctr

0050880

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12/31/16

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	\$ 3,235,799	1
2	Discounts and Allowances for all Levels	3,256	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,239,055	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	572,233	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 572,233	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	42,529	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,089	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 45,618	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,907	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,907	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Miscellaneous Income	2,384	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,384	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,867,197	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	659,378	31
32	Health Care	1,621,910	32
33	General Administration	917,960	33
	B. Capital Expense		
34	Ownership	543,889	34
	C. Ancillary Expense		
35	Special Cost Centers	72,379	35
36	Provider Participation Fee	168,044	36
	D. Other Expenses (specify):		
37	<u>Bad Debt</u>	419,710	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,403,270	40
41	Income before Income Taxes (line 30 minus line 40)**	(536,073)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (536,073)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,385,385	44
45	Private Pay - Net Inpatient Revenue	236,483	45
46	Medicare - Net Inpatient Revenue	312,156	46
47	Other-(specify)	305,031	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,239,055	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.

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	2,010	2,094	\$ 98,578	\$ 47.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,765	7,345	200,495	27.30	3
4	Licensed Practical Nurses	8,710	9,343	215,310	23.05	4
5	CNAs & Orderlies	38,558	40,931	504,911	12.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,074	5,333	58,118	10.90	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,045	15,128	170,821	11.29	15
16	Dishwashers					16
17	Maintenance Workers	1,888	2,099	33,751	16.08	17
18	Housekeepers	8,189	8,772	88,680	10.11	18
19	Laundry	1,775	2,006	20,971	10.45	19
20	Administrator	2,749	2,985	83,145	27.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,330	11,070	154,557	13.96	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	100,093	107,106	\$ 1,629,337 *	\$ 15.21	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	391	\$ 13,670	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	1,391	48,677	10-3	38
39	Pharmacist Consultant	118	5,913	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2,100	105,000	10a-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	95	3,308	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	4,095	\$ 176,568		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

STATE OF ILLINOIS

Facility Name & ID Number

Parker Nursing & Rehab Ctr

0050880

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bradley Fierce	Administrator		\$ 58,300
Kelsia Phillips	Administrator		24,845
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 83,145

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Bradley Associates	Accounting	\$ 7,948
Johnson, Goldburg & Brown	Accounting	2,900
MTS Consulting	Professional	1,627
Heyl Royster	Legal	3,012
Starstone Specialty Co.	Legal	2,500
Donahue, Brown, Mathewson	Legal	9,701
Infinity	Mgmt/Professional	221,203
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 248,891

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 31,161
Unemployment Compensation Insurance	71,552
FICA Taxes	127,601
Employee Health Insurance	95,970
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	10,349
Uniforms	2,618
Employee Expense	13,100
TOTAL (agree to Schedule V, line 22, col.8)	\$ 352,351

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
IHCA	3,451
NGS	541
Department of Public Health	3,980
Clia Lab	150
Other Dues & Fees	1,416
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 9,538

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Mileage	13,622
Seminar Expense	
Seminars	2,833
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 16,455

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number Parker Nursing & Rehab Ctr	STATE OF ILLINOIS # 0050880	Report Period Beginning: 1/1/16	Ending: 12/31/16
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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? Yes
 If YES, give association name and amount. Illinois Council - \$3,574

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 28,294 Line 10-2

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 419,710
 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 benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A

(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? No
 If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 c. What percent of all travel expense relates to transportation of nurses and patients? 0
 d. Have vehicle usage logs been maintained? N/A
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

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

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

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