

		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: 0051375 Facility Name: Parkshore Estates Nrsg & Reh Address: 6125 South Kenwood Chicago 60637 County: Cook Telephone Number: (708) 449-1900 Fax #: (708) 449-1500 HFS ID Number: Date of Initial License for Current Owners: 4/1/11 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. X Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: 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) (Type or Print Name) Flora Reznik (Title) CFO Paid Preparer (Signed) (Print Name and Title) Daniel S. Gaafar Partner (Firm Name & Address) Bradley Associates 201 S. Capitol Ave, Suite 700, Indianapolis, IN 46225 (Telephone) (317) 237-5500 Fax #: (317) 237-5503 MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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Facility Name & ID Number Parkshore Estates Nrsg & Reh

0051375 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 <u>N/A</u>					
	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>128</u>	Skilled (SNF)	<u>128</u>	<u>46,848</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>190</u>	Intermediate (ICF)	<u>190</u>	<u>69,540</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>318</u>	TOTALS	<u>318</u>	<u>116,388</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>28,521</u>	<u>310</u>	<u>3,532</u>	<u>32,363</u>	8
9	SNF/PED					9
10	ICF	<u>42,336</u>	<u>460</u>	<u>2,726</u>	<u>45,522</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>70,857</u>	<u>770</u>	<u>6,258</u>	<u>77,885</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.92%

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 4/1/11

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 64 and days of care provided 1,695

Medicare Intermediary Wisconsin Physician 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 **Parkshore Estates Nrsg & Reh** # **0051375** 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	369,110		53,502	422,612		422,612	(1,843)	420,769			1
2	Food Purchase		387,058		387,058		387,058	741	387,799			2
3	Housekeeping	255,532	55,652		311,184		311,184	469	311,653			3
4	Laundry	110,789	35,742		146,531		146,531		146,531			4
5	Heat and Other Utilities			389,311	389,311		389,311	633	389,944			5
6	Maintenance	123,698	47,300	133,595	304,593		304,593	1,136	305,729			6
7	Other (specify):*											7
8	TOTAL General Services	859,129	525,752	576,408	1,961,289		1,961,289	1,136	1,962,425			8
	B. Health Care and Programs											
9	Medical Director			32,450	32,450		32,450		32,450			9
10	Nursing and Medical Records	3,380,435	243,135	48,989	3,672,559		3,672,559	(31,148)	3,641,411			10
10a	Therapy			937,231	937,231		937,231		937,231			10a
11	Activities	207,378	43,886		251,264		251,264	2,976	254,240			11
12	Social Services	197,464		9,784	207,248		207,248		207,248			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharmacy Consult			22,239	22,239		22,239		22,239			15
16	TOTAL Health Care and Programs	3,785,277	287,021	1,050,693	5,122,991		5,122,991	(28,172)	5,094,819			16
	C. General Administration											
17	Administrative	110,062			110,062		110,062		110,062			17
18	Directors Fees											18
19	Professional Services			506,646	506,646		506,646	(139,086)	367,560			19
20	Dues, Fees, Subscriptions & Promotions			17,255	17,255		17,255	(246)	17,009			20
21	Clerical & General Office Expenses	242,622	61,312	98,899	402,833		402,833	131,368	534,201			21
22	Employee Benefits & Payroll Taxes			775,310	775,310		775,310	54,877	830,187			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,199	3,199		3,199	1,357	4,556			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			535,119	535,119		535,119	84,653	619,772			26
27	Other (specify):*											27
28	TOTAL General Administration	352,684	61,312	1,936,428	2,350,424		2,350,424	132,923	2,483,347			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,997,090	874,085	3,563,529	9,434,704		9,434,704	105,887	9,540,591			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			79,596	79,596		79,596	992,394	1,071,990			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			73,689	73,689		73,689	834,448	908,137			32
33	Real Estate Taxes			405,933	405,933		405,933	(1,395)	404,538			33
34	Rent-Facility & Grounds			2,209,923	2,209,923		2,209,923	(2,203,459)	6,464			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Pers. Prop. Tax			8,285	8,285		8,285		8,285			36
37	TOTAL Ownership			2,777,426	2,777,426		2,777,426	(378,012)	2,399,414			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,662	1,662		1,662		1,662			38
39	Ancillary Service Centers		142,217		142,217		142,217		142,217			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			598,668	598,668		598,668		598,668			42
43	Other (specify):* Bad Debt			668,843	668,843		668,843	(668,843)				43
44	TOTAL Special Cost Centers		142,217	1,269,173	1,411,390		1,411,390	(668,843)	742,547			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,997,090	1,016,302	7,610,128	13,623,520		13,623,520	(940,968)	12,682,552			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	154,962	30		9
10	Interest and Other Investment Income	(60,008)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(20)	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	(6,411)	21		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	(668,843)	43		24
25	Fund Raising, Advertising and Promotional	(5,120)	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	(2,184)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (587,624)		\$	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)	(353,344)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (353,344)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (940,968)		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	Miscellaneous Income	\$ (1,610)	21	1
2	Lobbying Dues	(574)	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
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,184)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Parkshore Estates Nrsg & Reh # 0051375 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	(20)	(1,823)	0	0	0	0	0	0	0	0	0	(1,843)	1
2	Food Purchase	0	741	0	0	0	0	0	0	0	0	0	741	2
3	Housekeeping	0	469	0	0	0	0	0	0	0	0	0	469	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	633	0	0	0	0	0	0	0	0	0	633	5
6	Maintenance	0	1,136	0	0	0	0	0	0	0	0	0	1,136	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(20)	1,156	0	0	0	0	0	0	0	0	0	1,136	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	(31,148)	0	0	0	0	0	0	0	0	0	(31,148)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	2,976	0	0	0	0	0	0	0	0	0	2,976	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	(28,172)	0	0	0	0	0	0	0	0	0	(28,172)	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	(189,348)	50,262	0	0	0	0	0	0	0	0	(139,086)	19
20	Fees, Subscriptions & Promotions	(574)	328	0	0	0	0	0	0	0	0	0	(246)	20
21	Clerical & General Office Expenses	(13,141)	144,309	200	0	0	0	0	0	0	0	0	131,368	21
22	Employee Benefits & Payroll Taxes	0	54,877	0	0	0	0	0	0	0	0	0	54,877	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,333	24	0	0	0	0	0	0	0	0	1,357	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	387	84,266	0	0	0	0	0	0	0	0	84,653	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(13,715)	11,886	134,752	0	0	0	0	0	0	0	0	132,923	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(13,735)	(15,130)	134,752	0	0	0	0	0	0	0	0	105,887	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Parkshore Estates Nrsg & Reh # 0051375 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	154,962	0	837,432	0	0	0	0	0	0	0	0	992,394	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(60,008)	0	894,456	0	0	0	0	0	0	0	0	834,448	32
33	Real Estate Taxes	0	0	(1,395)	0	0	0	0	0	0	0	0	(1,395)	33
34	Rent-Facility & Grounds	0	0	(2,203,459)	0	0	0	0	0	0	0	0	(2,203,459)	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	94,954	0	(472,966)	0	0	0	0	0	0	0	0	(378,012)	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):*	(668,843)	0	0	0	0	0	0	0	0	0	0	(668,843)	43
44	TOTAL Special Cost Centers	(668,843)	0	0	0	0	0	0	0	0	0	0	(668,843)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(587,624)	(15,130)	(338,214)	0	0	0	0	0	0	0	0	(940,968)	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	Management Co.
GELP	40%	Belhaven Nursing & Rehab Center	Chicago			
A & F Realty	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	\$ 14,710	Infinity Healthcare Management of Illinois		\$ 12,887	\$ (1,823)	1
2	V	2	Food Purchase		Infinity Healthcare Management of Illinois		741	741	2
3	V	3	Housekeeping		Infinity Healthcare Management of Illinois		469	469	3
4	V	5	Utilities		Infinity Healthcare Management of Illinois		633	633	4
5	V	6	Maintenance		Infinity Healthcare Management of Illinois		1,136	1,136	5
6	V	10	Nursing	48,989	Infinity Healthcare Management of Illinois		17,841	(31,148)	6
7	V	11	Activities		Infinity Healthcare Management of Illinois		2,976	2,976	7
8	V	19	Professional Fees	328,327	Infinity Healthcare Management of Illinois		138,979	(189,348)	8
9	V	20	Dues & Fees		Infinity Healthcare Management of Illinois		328	328	9
10	V	21	Office Expense	100,066	Infinity Healthcare Management of Illinois		244,375	144,309	10
11	V	22	Employee Benefits		Infinity Healthcare Management of Illinois		54,877	54,877	11
12	V	24	Travel Expense	316	Infinity Healthcare Management of Illinois		1,649	1,333	12
13	V	26	Insurance		Infinity Healthcare Management of Illinois		387	387	13
14	Total			\$ 492,408			\$ 477,278	\$ * (15,130)	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.

☒ 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	30	Depreciation	\$	Infinity Healthcare Management of Illinois		\$ 275	\$ 275	15
16	V	32	Interest		Infinity Healthcare Management of Illinois		3,555	3,555	16
17	V	34	Rent		Infinity Healthcare Management of Illinois		6,464	6,464	17
18	V								18
19	V	33	RE Taxes		Parkshore Estates Nursing Realty		(1,395)	(1,395)	19
20	V	26	Insurance		Parkshore Estates Nursing Realty		84,266	84,266	20
21	V	19	Professional Fees		Parkshore Estates Nursing Realty		50,262	50,262	21
22	V	21	Office Expense		Parkshore Estates Nursing Realty		200	200	22
23	V	30	Depreciation		Parkshore Estates Nursing Realty		837,157	837,157	23
24	V	32	Interest		Parkshore Estates Nursing Realty		890,901	890,901	24
25	V	24	Seminars		Parkshore Estates Nursing Realty		24	24	25
26	V	34	Rent	2,209,923	Parkshore Estates Nursing Realty			(2,209,923)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 2,209,923			\$ 1,871,709	\$ * (338,214)	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			Parker Nursing & Rehab Center	Streator				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 Parkshore Estates Nrsg & Reh # 0051375 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	HUD Loan		X	Property	\$86,295.00	Various	\$ 20,500,000	\$ 20,411,378	6/1/51	3.5000	\$ 890,901	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Capital One		X	Working Capital	None	8/31/14	15,000,000	3,967,462	8/31/18	2.9500	77,244	6	
7												7	
8												8	
9	TOTAL Facility Related				\$86,295.00		\$ 35,500,000	\$ 24,378,840			\$ 968,145	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 35,500,000	\$ 24,378,840			\$ 968,145	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 90,480 Line # 26

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2015 report.			\$	22,023	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.)			\$	405,491	2
3. Under or (over) accrual (line 2 minus line 1).			\$	383,468	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	21,070	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.			\$	404,538	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	306,337	8	
		2012	386,276	9	
		2013	366,930	10	
		2014	379,646	11	
		2015	405,491	12	
				13	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

- 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 Parkshore Estates Nrsg & Reh COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051375

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.

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: 83,520

B. General Construction Type: Exterior Brick Frame Concrete Number of Stories 6

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			2015	\$ 500,000	1
2					2
3	TOTALS			\$ 500,000	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	318		2015		\$ 19,884,200	\$ 509,856	39	\$ 509,851	\$ (5)	\$ 977,224	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	DOOR SCREEN			2011	1,875	48	39	48		276	9
10	NEW LIGHT FIXTURES FOR FACILITY			2011	28,695	736	39	736		4,231	10
11	CEILING TILE			2011	1,361	35	39	35		201	11
12	FENCE			2011	2,971	76	39	76		437	12
13	CEMENT FOR HANDICAP RAMP			2011	8,000	205	39	205		1,179	13
14	COUNTERTOPS, CEILING TILE, CROWN MOLDING,										14
15	MINI BLINDS, LED STRIP LIGHT, W.A.C. LIGHTING, TILE										15
16	FLOORING, WOOD PANELING, HAND RAILS, WALL										16
17	COVERING, PARTITION, DOUBLE DOOR, VINYL BASE										17
18	VINYL FLOORING, VINYL WALL BASE, LAMINATE PANELS										18
19	FOR LOBBY, PHYSICAL THERAPY ROOM, AND ELEVATOR			2011	57,107	1,464	39	1,464		8,419	19
20											20
21	PLUMBING AND DRYWALL IN 6TH FLOOR DIALYSIS ROOM			2012	8,246	211	39	211		1,057	21
22	DOOR LOCK SYSTEM ON LOBBY DOOR			2012	2,851	73	39	73		365	22
23	FLOORING & WALLS ON 1ST FLOOR THERAPY ROOMS			2012	11,274	289	39	289		1,445	23
24	FLORING & WALLS IN MAIN LOBBY			2012	11,274	289	39	289		1,445	24
25	INSTALL SPRINKLER SYSTEM			2012	4,775	122	39	122		612	25
26											26
27	EIDCO CREDIT??			2012	(57,107)	(1,464)	39	(1,464)		(7,322)	27
28	REMOVE WALLPAPER, PRIME, PAINT ON 1ST FLOOR ADMIN OF			2012	4,500	115	39	115		577	28
29	ROOFING REPAIR			2012	1,200	31	39	31		154	29
30	REPAIR FOUNDATIONAL CRACKS			2012	2,600	67	39	67		334	30
31	INSTALLATION OF FIRE ALARM SYSTEM			2012	17,990	461	39	461		2,306	31
32	REMOVE CARPETING AND INSTALL NEW FLOOR ON 1ST FLOOR			2012	1,165	30	39	30		150	32
33	PLUMBING AND ROUGH IN FOR 10 DIALYSIS STATIONS										33
34	INCLUDING NEW DRAINS, BACK FLOW PREVENTOR, AND PIPING										34
35	FOR 6th FLOOR DIALYSIS ROOMS			2012	12,000	308	39	308		1,539	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Parkshore Estates Nrsg & Reh

0051375

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	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 REPAIR BOILER	2012	\$ 2,929	\$ 75	39	\$ 75		\$ 375	37
38								38
39 INSTALL SIGN AND MOUNT ON WALL	2012	1,150	29	39	29		147	39
40								40
41 1ST FLOOR LOBBY/RECEPTION - NEW FLOORING, NEW								41
42 COUNTERS, LIGHTING, PAINT AND CROWN MOLDING,								42
43 WALLCOVERINGS & BLINDS								43
44 1ST FLOOR ELEVATOR LOBBY - LIGHTING, TILE								44
45 FLOORING, WALL BASE, RAILINGS, WALLCOVERINGS								45
46 1ST FLOOR NEW PT ROOM - FLOORING, LIGHTING								46
47 GLASS DOOR, VINYL BASE, PAINT	2012	117,214	3,007	39	3,005	(2)	15,031	47
48 Toshiba phone system	2013	21,732	557	39	557		1,950	48
49 3rd floor corridor floor & cove base, wall coverings, nurses	2013	116,909	2,999	39	2,998	(1)	10,495	49
50 station counter top & lighting, dining room floor & cove base,								50
51 lighting, common area and resident room signage								51
52 Fire alarm	2013	2,721	70	39	70		245	52
53 Durolast roofing system	2013	68,800	1,764	39	1,764		6,175	53
54 Storage room & locks	2013	4,716	121	39	121		423	54
55 Sign / logo / Lettering	2013	1,150	29	39	29		102	55
56 Awning support posts	2013	5,100	131	39	131		458	56
57 Awning support posts	2013	1,000	26	39	26		91	57
58 Permits	2013	1,650	42	39	42		147	58
59 Building cooling tower	2013	2,275	58	39	58		203	59
60 Electrical Wiring on 6th floor for WAP at nurses station and kiosk	2013	17,985	461	39	461		1,614	60
61 Electrical Wiring & lighting - 3rd floor dialysis & nurses station	2013	4,610		39	118	118		61
62 Masonry on outside of building	2013	114,600	118	39	2,938	2,820	413	62
63 Water Heaters	2014	23,900	613	39	613		1,839	63
64 Doors	2014	5,939	152	39	152		456	64
65 Paint every hallway and the dining room on 3rd floor	2014	18,825	483	39	483		1,449	65
66 Fire Doors in laundry & therapy	2014	4,459	114	39	114		342	66
67 Elevator mainenance	2014	2,575	66	39	66		198	67
68 Remover Adv Medical from 2013	2014	(2,275)	(58)	39	(58)		(174)	68
69 Flat Scan & monitor module	2014	4,047	104	39	104		312	69
70 TOTAL (lines 4 thru 69)		\$ 20,546,987	\$ 523,913		\$ 526,843	\$ 2,930	\$ 1,036,920	70

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

Facility Name & ID Number Parkshore Estates Nrsg & Reh

0051375

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	2	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 12A, Carried Forward		\$ 20,546,987	\$ 523,913		\$ 526,843	\$ 2,930	\$ 1,036,920	1
2	New Passage Lever Door Locks	2015	8,316	219	39	213	(6)	393	2
3	Replaced A/C Cooling Tower	2015	18,460	487	39	473	(14)	874	3
4	Add Scale Remover to Cooling Tower	2015	4,190	110	39	107	(3)	198	4
5	New walls, tile, and flooring in 4th Floor Shower Room	2015	7,342	193	39	188	(5)	347	5
6	New walls, tile, & flooring 2nd & 4th Floor Shower Room	2015	6,253	165	39	160	(5)	296	6
7	Replaced Exhaust Fan Motors	2015	5,006	132	39	128	(4)	237	7
8	Replaced Exhaust Fan	2015	8,737	230	39	224	(6)	413	8
9	Replaced A/C Control Unit	2015	7,210	190	39	185	(5)	341	9
10	Replace Wall, Floor, Tiles, Shower Base in 5th Fl Shower Rm	2015	6,814	180	39	175	(5)	323	10
11	Furnish & Install ADA Covers under sinks on Floors 2-5	2015	5,151	136	39	132	(4)	244	11
12	New Passage Lever Door Locks	2015	2,626	69	39	67	(2)	124	12
13	New Passage Lever Door Locks	2015	5,711	150	39	146	(4)	270	13
14	Tuck Pointing and Spalled Brick Repairs to the Building	2015	8,000	211	39	205	(6)	379	14
15	Clean, Sealcoat, Repave, and Restripe Parking Lot	2015	36,815	970	39	944	(26)	1,742	15
16	Install New Floor & Door Threshold on 6th Fl in Wings B&C	2015	11,298	298	39	290	(8)	535	16
17	Install Door Restrictors for Elevators	2015	5,500	145	39	141	(4)	260	17
18									18
19	Paint boiler rm, 2 electrical rooms, & elevator frame 1st fl	2016	3,014	77	39	77		77	19
20	Replace faulty hydronic unit heater in the boiler room	2016	2,975	76	39	76		76	20
21	Replace therapy rm doors 1st floor & raise patio fence b 2ft	2016	8,560	220	39	219	(1)	220	21
22	Replace forced air convector in 6th fl dining rm & game rm	2016	9,400	241	39	241		241	22
23	Remove and replace 16' x 17' concrete pad	2016	3,100	80	39	79	(1)	80	23
24	Shower rm 2nd floor - replace walls, floor, & ceiling	2016	8,033	206	39	206		206	24
25	Replace 10-hp cooling tower fan motor	2016	9,130	234	39	234		234	25
26	Install shunt trip for 2 passenger & 1 freight elevators	2016	6,500	167	39	167		167	26
27	Window cables allowing residents to open windows 2"	2016	5,100	131	39	131		131	27
28	Shower rm B 5th fl - replace walls, floor, & ceiling	2016	8,392	215	39	215		215	28
29	Install new fire alarm for elevator recall system	2016	39,384	1,010	39	1,010		1,010	29
30	Shower rm B 4th fl - replace walls, floor, & ceiling	2016	11,326	290	39	290		290	30
31	1st fl bathroom replace toilet, sink, mirror, light, floor tiles								31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 20,809,329	\$ 530,745		\$ 533,566	\$ 2,821	\$ 1,046,843	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	\$2,656,154	\$379,090	\$531,231	\$152,141	5	\$1,151,491	71
72	Current Year Purchases	35,967	7,193	7,193	0	5	7,193	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$2,692,121	\$386,283	\$538,424	\$152,141		\$1,158,684	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)	\$24,001,450	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$917,028	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$1,071,990	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$154,962	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,205,527	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.
13.
14.

* 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)	\$			

- (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.
- 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	
- (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	\$	5,147	\$ 322,935	\$	5,147	\$ 322,935	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		2,569	164,418		2,569	164,418	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		4,877	314,879		4,877	314,879	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				135,127		135,127	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					7,090		7,090	12
13	Other (specify): <u> </u>									13
14	TOTAL			\$	12,593	\$ 802,232	\$ 142,217	12,593	\$ 944,449	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.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (207,050)	\$ 497,772	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,495,695	4,495,695	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	326,781	326,781	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	32,061	1,162,819	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,647,487	\$ 6,483,067	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		500,000	13
14	Buildings, at Historical Cost		19,884,200	14
15	Leasehold Improvements, at Historical Cost	814,629	814,629	15
16	Equipment, at Historical Cost	548,920	2,806,720	16
17	Accumulated Depreciation (book methods)	(583,218)	(2,205,528)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	44,498	519,057	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(4,758)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	93,812	555,213	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 918,641	\$ 22,869,533	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,566,128	\$ 29,352,600	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,415,433	\$ 1,868,785	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,270	23,270	28
29	Short-Term Notes Payable		455,854	29
30	Accrued Salaries Payable	252,971	252,971	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,812	20,812	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		60,452	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Working Capital</u>	3,967,462	3,967,462	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,679,948	\$ 6,649,606	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		20,411,378	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 20,411,378	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,679,948	\$ 27,060,984	46
47	TOTAL EQUITY(page 18, line 24)	\$ (113,820)	\$ 2,291,616	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,566,128	\$ 29,352,600	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (635,815)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (635,815)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	521,995	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)	\$ 521,995	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)	\$ (113,820)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Parkshore Estates Nrsg & Reh

0051375

Report Period Beginning: 1/1/16

Ending: 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	\$ 13,412,527	1
2	Discounts and Allowances for all Levels	234,156	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,646,683	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	368,404	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 368,404	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	69,411	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	199	19
20	Radiology and X-Ray	144	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 69,754	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	59,064	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 59,064	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Misc. Income	1,610	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,610	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,145,515	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,961,290	31
32	Health Care	5,122,990	32
33	General Administration	2,350,424	33
	B. Capital Expense		
34	Ownership	2,777,426	34
	C. Ancillary Expense		
35	Special Cost Centers	143,879	35
36	Provider Participation Fee	598,668	36
	D. Other Expenses (specify):		
37	<u>Bad Debt</u>	668,843	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,623,520	40
41	Income before Income Taxes (line 30 minus line 40)**	521,995	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 521,995	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 11,283,384	44
45	Private Pay - Net Inpatient Revenue	138,670	45
46	Medicare - Net Inpatient Revenue	1,035,743	46
47	Other-(specify)	1,188,886	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 13,646,683	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	2,024	2,859	\$ 145,105	\$ 50.75	1
2	Assistant Director of Nursing	7,847	8,760	267,600	30.55	2
3	Registered Nurses	12,500	13,143	413,725	31.48	3
4	Licensed Practical Nurses	37,339	40,316	1,085,375	26.92	4
5	CNAs & Orderlies	108,578	117,875	1,324,260	11.23	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	14,164	16,605	207,378	12.49	9
10	Activity Assistants					10
11	Social Service Workers	9,914	10,836	197,464	18.22	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,714	29,447	369,110	12.53	15
16	Dishwashers					16
17	Maintenance Workers	8,924	9,361	123,698	13.21	17
18	Housekeepers	20,585	22,085	255,532	11.57	18
19	Laundry	9,305	10,466	110,789	10.59	19
20	Administrator	1,891	2,093	110,062	52.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,924	19,485	362,691	18.61	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	1,494	1,676	24,301	14.50	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	278,203	305,007	\$ 4,997,090 *	\$ 16.38	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	420	\$ 14,710	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	1,400	48,989	10-3	38
39	Pharmacist Consultant	445	22,239	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2,700	135,000	10a-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	264	9,224	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	5,229	\$ 230,162		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

Parkshore Estates Nrsg & Reh

STATE OF ILLINOIS

0051375

Report Period Beginning:

1/1/16

Page 21

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount	
Thomeka Brown		Administrator		\$ 110,062	Workers' Compensation Insurance		\$ 103,012	IDPH License Fee		\$	
					Unemployment Compensation Insurance		155,190	Advertising: Employee Recruitment			
					FICA Taxes		383,938	Health Care Worker Background Check			
					Employee Health Insurance		133,442	(Indicate # of checks performed)			
					Employee Meals			Patient Background Checks			
					Illinois Municipal Retirement Fund (IMRF)*			IHCA		10,759	
					Uniform Expense		11,069	City of Chicago		915	
					Pension Expense		1,944	IDPH		3,980	
					Employee Expense		41,592	Various		1,355	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 110,062							
B. Administrative - Other								Less: Public Relations Expense		()	
Description			Amount					Non-allowable advertising		()	
			\$					Yellow page advertising		()	
					TOTAL (agree to Schedule V, line 22, col.8)		\$ 830,187	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 17,009	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**		
C. Professional Services					Description		Line #	Amount	Description		Amount
Vendor/Payee	Type		Amount					\$	Out-of-State Travel		\$
Bradley Associates	Accounting		\$ 8,760								
Johnson, Goldburg, & Brown	Accounting		2,900								
Capital One Audit Fees	Accounting		8,343								
Wilson, Esler,Moskowitz, Edelman	Legal		10,125						In-State Travel		
US Legal Support	Legal		6,795						Mileage		2,163
Leahy, Eisenberg, & Frankael	Legal		55,520								
Segal, McCambridge, Singer	Legal		6,390								
Various Legal	Legal		8,078						Seminar Expense		
MTS Consulting	Professional		25,169						Seminars		2,393
Pinnacle Quality Insight	Professional		900								
Empire Risk Management	Professional/Mgmt		6,000								
Infinity	Professional/Mgmt		367,666						Entertainment Expense		()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$ 506,646	TOTAL			\$	(agree to Sch. V, line 24, col. 8)		\$ 4,556

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number Parkshore Estates Nrsg & Reh	STATE OF ILLINOIS # 0051375	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? Yes

(2) Are there any dues to nursing home associations included on the cost report? Yes
 If YES, give association name and amount. Illinois Healthcare Association \$10,759

(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. \$ 598,668
 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