



Facility Name & ID Number Parc At Joliet, Llc

# 0052571 Report Period Beginning: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>203</u>	Skilled (SNF)	<u>203</u>	<u>74,095</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>203</u>	TOTALS	<u>203</u>	<u>74,095</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>30,466</u>	<u>3,595</u>	<u>10,309</u>	<u>44,370</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>30,466</u>	<u>3,595</u>	<u>10,309</u>	<u>44,370</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.88%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 11/01/2013

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 11/01/2013 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 203 and days of care provided 9,274

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name &amp; ID Number

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# 0052571

Report Period Beginning:

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**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
	<b>A. General Services</b>										
1	Dietary	282,955	72,365	15,685	371,005		371,005	8,281	379,286		1
2	Food Purchase		315,128		315,128		315,128	136	315,264		2
3	Housekeeping	263,226	62,660		325,886		325,886	1,141	327,027		3
4	Laundry	54,395	18,110		72,505		72,505		72,505		4
5	Heat and Other Utilities			206,831	206,831		206,831	1,716	208,547		5
6	Maintenance	133,381	17,896	220,336	371,613		371,613	8,086	379,699		6
7	Other (specify):*							1,800	1,800		7
8	<b>TOTAL General Services</b>	733,957	486,159	442,852	1,662,968		1,662,968	21,160	1,684,128		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			36,000	36,000		36,000		36,000		9
10	Nursing and Medical Records	2,688,708	288,886	20,515	2,998,109		2,998,109	38,521	3,036,630		10
10a	Therapy	164,538			164,538		164,538		164,538		10a
11	Activities	139,619	18,115	2,315	160,049		160,049		160,049		11
12	Social Services	218,761	49	1,024	219,834		219,834	23,208	243,042		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							7,958	7,958		15
16	<b>TOTAL Health Care and Programs</b>	3,211,626	307,050	59,854	3,578,530		3,578,530	69,687	3,648,217		16
	<b>C. General Administration</b>										
17	Administrative	177,407			177,407		177,407	81,534	258,941		17
18	Directors Fees										18
19	Professional Services			460,384	460,384		460,384	(343,513)	116,871		19
20	Dues, Fees, Subscriptions & Promotions			81,749	81,749		81,749	(45,665)	36,084		20
21	Clerical & General Office Expenses	105,562	22,427	436,582	564,571		564,571	(245,113)	319,458		21
22	Employee Benefits & Payroll Taxes			927,358	927,358		927,358	(7,853)	919,505		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,508	2,508		2,508	1,355	3,863		24
25	Other Admin. Staff Transportation			733	733		733	1,260	1,993		25
26	Insurance-Prop.Liab.Malpractice			205,989	205,989		205,989	1,789	207,778		26
27	Other (specify):*							36,138	36,138		27
28	<b>TOTAL General Administration</b>	282,969	22,427	2,115,303	2,420,699		2,420,699	(520,068)	1,900,631		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,228,552	815,636	2,618,009	7,662,197		7,662,197	(429,222)	7,232,975		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

Parc At Joliet, Llc

#0052571

Report Period Beginning:

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## 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			19,273	19,273		19,273	328,506	347,779			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,856	27,856		27,856	298,752	326,608			32
33	Real Estate Taxes			172,286	172,286		172,286	4,533	176,819			33
34	Rent-Facility & Grounds			1,228,742	1,228,742		1,228,742	(1,227,198)	1,544			34
35	Rent-Equipment & Vehicles			22,637	22,637		22,637	752	23,389			35
36	Other (specify):*							46,322	46,322			36
37	<b>TOTAL Ownership</b>			1,470,794	1,470,794		1,470,794	(548,333)	922,461			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		581,262	1,227,716	1,808,978		1,808,978		1,808,978			39
40	Barber and Beauty Shops			21	21		21		21			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			328,048	328,048		328,048		328,048			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		581,262	1,555,785	2,137,047		2,137,047		2,137,047			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,228,552	1,396,898	5,644,588	11,270,038		11,270,038	(977,554)	10,292,484			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.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	79,354	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(255)	02		13
14	Non-Care Related Interest	(1,923)	32		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	(300)	21		18
19	Entertainment				19
20	Contributions	(7,350)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(362,830)	21		24
25	Fund Raising, Advertising and Promotional	(35,363)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(44,329)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (372,996)		\$	30

**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	2	
		Amount	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)	(604,558)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (604,558)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (977,554)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	52

Parc At Joliet, Llc

ID# 0052571

Report Period Beginning: 01/01/15

Ending: 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Patient Clothing	\$ (1,257)	10	1
2	Collection Expense	(4,560)	21	2
3	Theft Loss	(2,713)	21	3
4	Capitalized R&M	(5,494)	06	4
5	Building Company - Management Fee	(10,150)	17	5
6	Building Company - Accounting Fee	(1,500)	19	6
7	Building Company - State Replacement Tax	(178)	21	7
8	Building Company - Bank Charge	(202)	21	8
9	Building Company - Amortization Expense	(20,162)	36	9
10	Building Company - Filing Fee	(250)	21	10
11	Non-Allowable Rental Income	6,175	34	11
12	Non-Allowable Dues	(705)	20	12
13	PAC Dues	(3,333)	20	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	<b>Total</b>	(44,329)		49



## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Parc At Joliet, Llc# 0052571

Report Period Beginning:

01/01/15

Ending:

12/31/15

## 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			147		8,134							8,281	1
2	Food Purchase	(255)		391									136	2
3	Housekeeping			1,031		110							1,141	3
4	Laundry													4
5	Heat and Other Utilities			1,563		153							1,716	5
6	Maintenance	(5,494)		4,498	8,967	115							8,086	6
7	Other (specify):*				772	1,028							1,800	7
8	<b>TOTAL General Services</b>	<b>(5,749)</b>		<b>7,630</b>	<b>9,739</b>	<b>9,540</b>							<b>21,160</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(1,257)				39,778							38,521	10
10a	Therapy													10a
11	Activities													11
12	Social Services					23,208							23,208	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					7,958							7,958	15
16	<b>TOTAL Health Care and Programs</b>	<b>(1,257)</b>				<b>70,944</b>							<b>69,687</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(10,150)	10,150	2,810	15,726	62,998							81,534	17
18	Directors Fees													18
19	Professional Services	(1,500)	1,500	(251,161)		(92,352)							(343,513)	19
20	Fees, Subscriptions & Promotions	(46,751)		921		165							(45,665)	20
21	Clerical & General Office Expenses	(371,033)	630	11,505	94,185	19,600							(245,113)	21
22	Employee Benefits & Payroll Taxes					(7,853)							(7,853)	22
23	Inservice Training & Education													23
24	Travel and Seminar			316		1,039							1,355	24
25	Other Admin. Staff Transportation			1,260									1,260	25
26	Insurance-Prop.Liab.Malpractice			1,286		503							1,789	26
27	Other (specify):*				25,879	10,259							36,138	27
28	<b>TOTAL General Administration</b>	<b>(429,434)</b>	<b>12,280</b>	<b>(233,063)</b>	<b>127,937</b>	<b>2,212</b>							<b>(520,068)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(436,441)</b>	<b>12,280</b>	<b>(225,433)</b>	<b>137,676</b>	<b>82,696</b>							<b>(429,222)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Parc At Joliet, Llc

# 0052571

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	79,354	246,438	2,038		676							328,506	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,923)	292,285	8,197		193							298,752	32
33	Real Estate Taxes			4,108		425							4,533	33
34	Rent-Facility & Grounds	6,175	(1,233,373)										(1,227,198)	34
35	Rent-Equipment & Vehicles			752									752	35
36	Other (specify):*	(20,162)	66,484										46,322	36
37	<b>TOTAL Ownership</b>	<b>63,444</b>	<b>(628,166)</b>	<b>15,095</b>		<b>1,294</b>							<b>(548,333)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>													<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(372,996)</b>	<b>(615,886)</b>	<b>(210,338)</b>	<b>137,676</b>	<b>83,990</b>							<b>(977,554)</b>	<b>45</b>

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rental Income	\$ 1,233,373	Glenwood Real Estate	100.00%	\$	(1,233,373)	1
2	V	32 Interest	266	Glenwood Real Estate	100.00%	292,551	292,285	2
3	V	17 Management Fees		Glenwood Real Estate	100.00%	10,150	10,150	3
4	V	19 Accounting		Glenwood Real Estate	100.00%	1,500	1,500	4
5	V	21 State Replacement Tax		Glenwood Real Estate	100.00%	178	178	5
6	V	21 Bank Charge		Glenwood Real Estate	100.00%	202	202	6
7	V	36 Settlement		Glenwood Real Estate	100.00%	46,322	46,322	7
8	V	30 Depreciation		Glenwood Real Estate	100.00%	246,438	246,438	8
9	V	36 Amortization Expense		Glenwood Real Estate	100.00%	20,162	20,162	9
10	V	21 Filing Fee		Glenwood Real Estate	100.00%	250	250	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,233,639			\$ 617,753	\$ * (615,886)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	01 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 147	\$	147	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	391		391	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	1,031		1,031	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	1,563		1,563	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	4,498		4,498	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	2,810		2,810	20
21	V	19 Professional Fees	256,128	Extended Care Consulting, LLC	100.00%	4,967		(251,161)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	921		921	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	11,505		11,505	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	316		316	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,260		1,260	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	1,286		1,286	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	2,038		2,038	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	8,197		8,197	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	4,108		4,108	29
30	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	752		752	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		\$ 256,128			\$ 45,790	\$ *	(210,338)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	06 Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	8,967	\$	8,967	15
16	V	06 Maintenance (Direct)		Extended Care Consulting, LLC	100.00%				16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	772		772	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%				18
19	V								19
20	V								20
21	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	15,726		15,726	21
22	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	94,185		94,185	22
23	V	21 Office and Clerical (Direct)	26,175	Extended Care Consulting, LLC	100.00%	26,175			23
24	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	18,868		18,868	24
25	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	7,011		7,011	25
26	V	22 Employee Benefits	7,853	Extended Care Consulting, LLC	100.00%			(7,853)	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		\$ 34,028			\$ 171,704	\$ *	137,676	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	03 Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 110	\$	110	15
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	153		153	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	115		115	17
18	V	19 Professional Fees	92,921	Extended Care Clinical, LLC	100.00%	569		(92,352)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	165		165	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	1,408		1,408	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,039		1,039	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	503		503	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	676		676	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	193		193	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	425		425	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	8,134		8,134	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,028		1,028	27
28	V	10 Nursing Salary		Extended Care Clinical, LLC	100.00%	39,778		39,778	28
29	V	12 Social Service Salary		Extended Care Clinical, LLC	100.00%	23,208		23,208	29
30	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	7,958		7,958	30
31	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	62,998		62,998	31
32	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	18,192		18,192	32
33	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	10,259		10,259	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 92,921			\$ 176,911	\$ *	83,990	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 213,466	\$ 213,466	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	213,466	CCS Employee Benefits Group	100.00%		(213,466)	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 213,466			\$ 213,466	\$ *	39

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

**VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

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

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

**VII. RELATED PARTIES (continued)**

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  YES  NO

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

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

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

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

**VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

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

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





Facility Name & ID Number Parc At Joliet, Llc # 0052571 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Parc At Joliet, Llc

# 0052571

Report Period Beginning:

01/01/15

Ending: 12/31/15

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Parc At Joliet, Llc

# 0052571

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	31	\$ 4,390	\$	44,370	\$ 147	1
2	02	Food	Patient Days	31	11,689		44,370	391	2
3	03	Housekeeping	Patient Days	31	30,827		44,370	1,031	3
4	05	Utilities	Patient Days	31	46,718		44,370	1,563	4
5	06	Maintenance	Patient Days	31	134,435		44,370	4,498	5
6	17	Administrative	Patient Days	31	84,000		44,370	2,810	6
7	19	Professional Fees	Patient Days	31	148,456		44,370	4,967	7
8	20	Dues and Subscriptions	Patient Days	31	27,539		44,370	921	8
9	21	Office and Clerical	Patient Days	31	343,869		44,370	11,505	9
10	24	Seminar and Travel	Patient Days	31	9,455		44,370	316	10
11	25	Other Staff Admin. Trans.	Patient Days	31	37,668		44,370	1,260	11
12	26	Insurance	Patient Days	31	38,431		44,370	1,286	12
13	30	Depreciation	Patient Days	31	60,912		44,370	2,038	13
14	32	Interest	Patient Days	31	244,990		44,370	8,197	14
15	33	Real Estate Taxes	Patient Days	31	122,786		44,370	4,108	15
16	35	Rent - Equipment & Auto	Patient Days	31	22,475		44,370	752	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,368,640	\$		\$ 45,790	25

Facility Name & ID Number Parc At Joliet, Llc

# 0052571

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	06	Maintenance (Pooled)	Patient Days	1,326,152	31	268,019	268,019	44,370	8,967	1
2	06	Maintenance (Direct)	Direct		31	325,218	325,218			2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,326,152	31	23,065		44,370	772	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	38,919				4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,326,152	31	470,018	470,018	44,370	15,726	7
8	21	Office and Clerical (Pooled)	Patient Days	1,326,152	31	2,815,061	2,815,061	44,370	94,185	8
9	21	Office and Clerical (Direct)	Direct		31	402,441	402,441		26,175	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,326,152	31	563,937		44,370	18,868	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	58,253			7,011	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					\$ 4,964,932	\$ 4,280,758		\$ 171,704	25

Facility Name & ID Number Parc At Joliet, Llc

# 0052571

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Extended Care Clinical, LLC

Street Address

2201 Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

( 847) 905-3000

Fax Number

( 847) 905-3030

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	03	Housekeeping	Patient Days	794,254	19	\$ 1,974	\$ 44,370	\$ 110	1
2	05	Utilities	Patient Days	794,254	19	2,745	44,370	153	2
3	06	Maintenance	Patient Days	794,254	19	2,053	44,370	115	3
4	19	Professional Fees	Patient Days	794,254	19	10,180	44,370	569	4
5	20	Dues and Subscriptions	Patient Days	794,254	19	2,961	44,370	165	5
6	21	Office & Clerical	Patient Days	794,254	19	25,207	44,370	1,408	6
7	24	Travel and Seminar	Patient Days	794,254	19	18,605	44,370	1,039	7
8	26	Insurance	Patient Days	794,254	19	9,008	44,370	503	8
9	30	Depreciation	Patient Days	794,254	19	12,096	44,370	676	9
10	32	Interest	Patient Days	794,254	19	3,455	44,370	193	10
11	33	Real Estate Taxes	Patient Days	794,254	19	7,615	44,370	425	11
12	01	Dietary Salary	Patient Days	794,254	19	145,601	44,370	8,134	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	794,254	19	18,397	44,370	1,028	13
14	10	Nursing Salary	Patient Days	794,254	19	712,051	44,370	39,778	14
15	12	Social Service Salary	Patient Days	794,254	19	415,434	44,370	23,208	15
16	15	Emp. Ben. - Healthcare	Patient Days	794,254	19	142,463	44,370	7,958	16
17	17	Administration Salary	Patient Days	794,254	19	1,127,702	44,370	62,998	17
18	21	Office Salary	Patient Days	794,254	19	325,657	44,370	18,192	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	794,254	19	183,638	44,370	10,259	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,166,842	\$ 2,726,445	\$ 176,911	25

Facility Name & ID Number Parc At Joliet, Llc

# 0052571

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

CCS Employee Benefits Group, Inc.

Street Address

2201 Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

( 847)905-4000

Fax Number

( 847)905-4040

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.

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	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 213,466	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				\$	\$		\$ 213,466	25

Facility Name & ID Number Parc At Joliet, Llc

# 0052571 Report Period Beginning: 01/01/15 Ending: 12/31/15

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Parc At Joliet, Llc

# 0052571

Report Period Beginning:

01/01/15

Ending: 12/31/15

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Parc At Joliet, Llc

# 0052571

Report Period Beginning:

01/01/15

Ending: 12/31/15

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Parc At Joliet, Llc

# 0052571 Report Period Beginning: 01/01/15 Ending: 12/31/15

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Parc At Joliet, Llc

# 0052571 Report Period Beginning: 01/01/15 Ending: 12/31/15

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Parc At Joliet, Llc

# 0052571

Report Period Beginning:

01/01/15

Ending:

12/31/15

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	The Private Bank		X	Mortgage				\$	6,007,900			\$	292,551	1						
2														2						
3														3						
4														4						
5														5						
<b>Working Capital</b>																				
6	The Private Bank		X	Line of Credit					300,000				27,856	6						
7														7						
8														8						
9	<b>TOTAL Facility Related</b>							\$	6,307,900			\$	320,407	9						
<b>B. Non-Facility Related*</b>																				
10	Interest Income		X										(1,923)	10						
11	Alloc from Extended Care Consult		X										8,197	11						
12	Alloc from Extended Care Clinical		X										193	12						
13	See Supplemental Schedule												(266)	13						
14	<b>TOTAL Non-Facility Related</b>							\$				\$	6,201	14						
15	<b>TOTALS (line 9+line14)</b>							\$	6,307,900			\$	326,608	15						

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

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

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

Facility Name & ID Number

Parc At Joliet, Llc

# 0052571

Report Period Beginning:

01/01/15

Ending:

12/31/15

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE**

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	<b>TOTAL Long-Term</b>									7										
<b>Working Capital</b>																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	<b>TOTAL Working Capital</b>									14										
<b>B. Non-Facility Related*</b>																				
15	Interest Income - Bldg Co.		X							(266) 15										
16										16										
17										17										
18										18										
19										19										
20	<b>TOTAL Non-Facility Related</b>									(266) 20										

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

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* 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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2014 report.		\$	<b>159,338</b>	<b>1</b>	
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.)		\$	<b>166,301</b>	<b>2</b>	
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>6,963</b>	<b>3</b>	
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>169,856</b>	<b>4</b>	
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>	
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>176,819</b>	<b>7</b>	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	_____	<b>8</b>	<b>FOR BHF USE ONLY</b>	
	2011	_____	<b>9</b>	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2014 \$
	2012	_____	<b>10</b>	<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$
	2013	<b>151,750</b>	<b>11</b>	<b>15</b>	LESS REFUND FROM LINE 6 \$
	2014	<b>161,768</b>	<b>12</b>	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$
<b>2015 Accrual = \$161,768 x 1.05 = \$169,856</b>					
<b>Allocated from Extended Care Consulting, LLC = \$4,108</b>					
<b>Allocated from Extended Care Clinical LLC = \$425</b>					
<b>The beginning accrual reflects the ending 2014 accrual of the building company</b>					

**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 & ID Number Parc At Joliet, Llc

# 0052571

Report Period Beginning:

01/01/15

Ending:

12/31/15

**X. BUILDING AND GENERAL INFORMATION:**

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

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>75,625</u>		<u>\$ 747,850</u>	<u>1</u>
2	<u>Alloc from Care Centers Building</u>			<u>21,253</u>	<u>2</u>
3	<b>TOTALS</b>	<u>75,625</u>		<u>\$ 769,103</u>	<u>3</u>

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	203	2013	1970	\$ 6,657,211	\$ 246,438	35	\$ 190,206	\$ (56,232)	\$ 4,374,739	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Various		1993	27,837		20			27,837	9
10	Various		1994	4,980		20			4,980	10
11	Various		1995	20,929		20			20,929	11
12	Various		1996	21,845		20	1,092	1,092	21,845	12
13	Various		1997	15,491		20	775	775	14,716	13
14	Various		1998	28,751		20	1,438	1,438	25,876	14
15	Various		1999	17,798		20	890	890	15,128	15
16	Various		2000	67,420		20	3,371	3,371	53,936	16
17	Various		2001	37,385		20	1,869	1,869	28,039	17
18	Various		2002	81,564		20	4,078	4,078	57,095	18
19	Various		2003	22,069		20	1,103	1,103	14,498	19
20	Various		2005	43,812		20	2,191	2,191	24,097	20
21	Various		2006	7,414		20	371	371	3,707	21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68		89,511	1,206		1,206		65,071	68
69			19,272			(19,272)		69
70		\$ 7,144,017	\$ 266,916		\$ 208,589	\$ (58,327)	\$ 4,752,493	70

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 7,144,017	\$ 266,916		\$ 208,589	\$ (58,327)	\$ 4,752,493	1
2	Tile & Thinset For 1St Floor Bathrooms	2014	8,193		20	819	819	1,502	2
3	Signage	2014	6,550		20	437	437	728	3
4	Cut Open Concrete & Repipe Underground Sewer, Reconcete Flo	2014	43,136		20	4,314	4,314	5,033	4
5	Water Heater	2014	4,569		20	457	457	495	5
6	Plumbing	2015	4,660		20	388	388	388	6
7	80 Gallon Water Heater	2015	3,965		20	231	231	231	7
8	Resident Rm-Handrails,Bumper Guards,Lighting,Signs,Curtains	2015	23,515		20	11,161	11,161	11,161	8
9	Readjust Door Closer Panic Bar Outside Trim Lever	2015	2,564		20	128	128	128	9
10	Elevator Mechanical Door Restrictor	2015	2,930		20	146	146	146	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,244,100	\$ 266,916		\$ 226,671	\$ (40,245)	\$ 4,772,305	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 7,244,100	\$ 266,916		\$ 226,671	\$ (40,245)	\$ 4,772,305	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 7,244,100	\$ 266,916		\$ 226,671	\$ (40,245)	\$ 4,772,305	34

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

Facility Name & ID Number Parc At Joliet, Llc

# 0052571

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 7,244,100	\$ 266,916		\$ 226,671	\$ (40,245)	\$ 4,772,305	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 7,244,100	\$ 266,916		\$ 226,671	\$ (40,245)	\$ 4,772,305	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 7,244,100	\$ 266,916		\$ 226,671	\$ (40,245)	\$ 4,772,305	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 7,244,100	\$ 266,916		\$ 226,671	\$ (40,245)	\$ 4,772,305	34

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

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$	\$		\$	\$	\$	34

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

Facility Name &amp; ID Number Parc At Joliet, Llc

# 0052571

Report Period Beginning:

01/01/15

Ending:

12/31/15

## 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	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Extended Care Clinical LLC - BLDG	2002	2,829	73	39	73		964	3
4	Allocated from Extended Care Consulting LLC - BLDG	2002	26,458	678	39	678		9,017	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Clinical LLC - BLDG	2002	2,337		20			2,337	9
10	Allocated from Extended Care Clinical LLC - BLDG	2003	2,754		20			2,754	10
11	Allocated from Extended Care Clinical LLC - BLDG	2005	137	15	20	15		137	11
12	Allocated from Extended Care Clinical LLC - BLDG	2009	25	1	20	1		9	12
13	Allocated from Extended Care Clinical LLC - BLDG	2014	230	11	20	11		23	13
14	Allocated from Extended Care Clinical LLC - BLDG	2015	39	2	20	2		2	14
15									15
16	Allocated from Extended Care Consulting LLC - BLDG	2002	21,857		20			21,857	16
17	Allocated from Extended Care Consulting LLC - BLDG	2003	25,757		20			25,757	17
18	Allocated from Extended Care Consulting LLC - BLDG	2005	1,280	136	20	136		1,278	18
19	Allocated from Extended Care Consulting LLC - BLDG	2009	231	12	20	12		81	19
20	Allocated from Extended Care Consulting LLC - BLDG	2014	2,148	107	20	107		215	20
21	Allocated from Extended Care Consulting LLC - BLDG	2015	364	18	20	18		18	21
22									22
23	Allocated from Extended Care Consulting, LLC	2007	154	8	20	8		69	23
24	Allocated from Extended Care Consulting, LLC	2009	92	5	20	5		32	24
25	Allocated from Extended Care Consulting, LLC	2010	903	45	20	45		271	25
26	Allocated from Extended Care Consulting, LLC	2011	325	16	20	16		81	26
27	Allocated from Extended Care Consulting, LLC	2012	107	5	20	5		21	27
28	Allocated from Extended Care Consulting, LLC	2014	1,484	74	20	74		148	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 89,511	\$ 1,206		\$ 1,206	\$	\$ 65,071	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 89,511	\$ 1,206		\$ 1,206		\$ 65,071	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 89,511	\$ 1,206		\$ 1,206		\$ 65,071	34

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

Facility Name & ID Number Parc At Joliet, Llc

# 0052571

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	\$ 38,317	\$ 659	\$ 7,356	\$ 6,697	10	\$ 15,892	71
72	Current Year Purchases	1,141,913	103	113,005	112,902	10	113,005	72
73	Fully Depreciated Assets	395,417				10	395,417	73
74								74
75	TOTALS	\$ 1,575,647	\$ 762	\$ 120,361	\$ 119,599		\$ 524,315	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		Allocated from Extended Care Cl	2012	\$ 2,870	\$ 574	\$ 574		5	\$ 1,996	76
77		Allocated from Extended Care Cc	2015	6,038	171	171		5	5,526	77
78										78
79										79
80	TOTALS			\$ 8,908	\$ 745	\$ 745			\$ 7,522	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,597,758	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 268,423	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 347,777	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 79,354	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,304,142	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	New activity room / other	\$ 80,957	92
93			93
94			94
95		\$ 80,957	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: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  YES  NO

If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Storage Unit				1,544			5
6								6
7	TOTAL				\$ 1,544			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: \$ 23,389 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_  
Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>/2016</u>	\$ _____
13.	<u>/2017</u>	\$ _____
14.	<u>/2018</u>	\$ _____

\* 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.

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 447,029	\$		\$ 447,029	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			218,462			218,462	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			516,832			516,832	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				495,794		495,794	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>					45,393	85,468		130,861	13
14	TOTAL			\$		\$ 1,227,716	\$ 581,262		\$ 1,808,978	14

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

Facility Name & ID Number **Parc At Joliet, Llc**# **0052571**Report Period Beginning: **01/01/15**

Ending:

**12/31/15****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/15**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 5,275	\$ 203,788	1
2	Cash-Patient Deposits	43,970	43,970	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	855,914	855,914	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	329,497	329,497	6
7	Other Prepaid Expenses	9,515	9,515	7
8	Accounts Receivable (owners or related parties)	1,500	255,957	8
9	Other(specify):	250,951	250,951	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,496,622	\$ 1,949,592	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		747,850	13
14	Buildings, at Historical Cost		6,657,211	14
15	Leasehold Improvements, at Historical Cost	182,683	302,605	15
16	Equipment, at Historical Cost	15,968	1,040,985	16
17	Accumulated Depreciation (book methods)	(21,822)	(3,106,717)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	80,957	112,765	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 257,786	\$ 5,754,699	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,754,408	\$ 7,704,291	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,733,225	\$ 1,733,225	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	42,239	42,239	28
29	Short-Term Notes Payable	300,000	300,000	29
30	Accrued Salaries Payable	244,043	244,043	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,300	11,300	31
32	Accrued Real Estate Taxes(Sch.IX-B)	195,148	169,856	32
33	Accrued Interest Payable		24,529	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See Attached Schedule	1,000,000	1,351,755	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 3,525,955	\$ 3,876,947	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,007,900	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43			500,000	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 6,507,900	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,525,955	\$ 10,384,847	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,771,547)	\$ (2,680,556)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,754,408	\$ 7,704,291	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(753,498)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Consulting Fees</b>	<b>(1,000,000)</b>	<b>3</b>
<b>4</b>	<b>Rounding Adjustment</b>	<b>8</b>	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(1,753,490)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(18,057)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(18,057)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(1,771,547)</b>	<b>24</b> *

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

Facility Name &amp; ID Number Parc At Joliet, Llc

# 0052571

Report Period Beginning: 01/01/15

Ending:

12/31/15

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 11,288,795	1
2	Discounts and Allowances for all Levels	(5,283,181)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,005,614	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,767,821	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 4,767,821	8
<b>C. Other Operating Revenue</b>			
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	463,097	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	13,526	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 476,623	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,923	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,923	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 11,251,981	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,662,968	31
32	Health Care	3,578,530	32
33	General Administration	2,420,699	33
<b>B. Capital Expense</b>			
34	Ownership	1,470,794	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,808,999	35
36	Provider Participation Fee	328,048	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 11,270,038	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(18,057)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (18,057)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,371,069	44
45	Private Pay - Net Inpatient Revenue	750,509	45
46	Medicare - Net Inpatient Revenue	584,240	46
47	Other-(specify) <u>Hospice</u>	174,358	47
48	Other-(specify) <u>Insurance</u>	125,438	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 6,005,614	49

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

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

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

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

Facility Name & ID Number Parc At Joliet, Llc

# 0052571

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	2,078	2,188	\$ 114,768	\$ 52.45	1
2	Assistant Director of Nursing	2,086	2,167	90,634	41.82	2
3	Registered Nurses	19,355	21,254	681,672	32.07	3
4	Licensed Practical Nurses	32,921	35,271	939,570	26.64	4
5	CNAs & Orderlies	74,160	79,106	860,793	10.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,388	10,714	164,538	15.36	8
9	Activity Director	2,058	2,185	34,098	15.61	9
10	Activity Assistants	9,671	10,281	105,521	10.26	10
11	Social Service Workers	7,594	8,082	218,761	27.07	11
12	Dietician					12
13	Food Service Supervisor	3,572	3,953	72,924	18.45	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,120	20,614	210,031	10.19	15
16	Dishwashers					16
17	Maintenance Workers	6,110	6,652	133,381	20.05	17
18	Housekeepers	22,441	25,240	263,226	10.43	18
19	Laundry	3,905	4,225	54,395	12.88	19
20	Administrator	2,017	2,126	89,591	42.14	20
21	Assistant Administrator	3,258	3,654	87,816	24.04	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,403	8,035	105,562	13.14	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	63	63	1,271	20.17	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	227,198	245,808	\$ 4,228,552 *	\$ 17.20	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	334	\$ 15,685	01-03	35
36	Medical Director	Monthly	36,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	14,515	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	37	2,315	11-03	44
45	Social Service Consultant	16	1,024	12-03	45
46	Other(specify)				46
47	Psychiatrist	Monthly	6,000	10-03	47
48					48
49	TOTAL (lines 35 - 48)	387	\$ 75,539		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

**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	
Phillip Baratta	Administrator	0	\$ 89,591	Workers' Compensation Insurance	\$ 194,717	IDPH License Fee	\$	
Yosef Meyers	Asst Administrator	0	52,690	Unemployment Compensation Insurance	138,549	Advertising: Employee Recruitment	14,013	
Dawn Torres	Asst Administrator	0	35,126	FICA Taxes	313,950	Health Care Worker Background Check	5,472	
				Employee Health Insurance	235,039	(Indicate # of checks performed <u>395</u> )		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	8,259	
				Pension Expense	31,390	Licenses and Fees	7,254	
				Other Employee Welfare	3,740	Alloc from Extended Care Consult	921	
				Holiday Expense	2,120	Alloc. from Extended Care Clinical	165	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 177,407					
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				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
William Everett Group	Management & IT Consult.		\$ 160			\$	Out-of-State Travel	\$
Legat Architects Inc	Architectural Services		5,400					
Prospect Resources	Natural Gas Procurement		2,500					
Matrixcare	Data Processing		41,134				In-State Travel	
Personal Planners Inc	Unemployment Consulting		2,383					
See Attached	Legal Fees		4,731					
FR&R/Marcum LLP	Accounting Fees		12,000					
ECC Consulting	Bookkeeping Expense		256,128				Seminar Expense	2,508
ECC Clinical	Bookkeeping Expense		92,921				Alloc. from Extended Care Consult	316
Paycor Payroll Services	Payroll Services		24,090				Alloc. from Extended Care Clinical	1,039
Ehealth Data Solutions	MDS Software		11,368					
See Supplemental Schedule			7,569				Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V,	
(For legal fee disclosure, see page 39 of instructions)			\$ 460,384				line 24, col. 8)	\$ 3,863

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number Parc At Joliet, Llc

# 0052571

Report Period Beginning:

01/01/15

Ending:

12/31/15

**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. ICLTC \$10,000
- (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? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 190 Line 10-02
- (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. \$ 328,048  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A 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? 100% ln 14
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
- 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.