

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: <u>0047886</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																											
Facility Name: <u>Parkway Manor</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/11</u> to <u>9/30/12</u> 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.																											
Address: <u>3116 Williamson County Parkway</u> <u>Marion</u> <u>62959</u>																													
Number City Zip Code																													
County: <u>Williamson</u>																													
Telephone Number: <u>(618) 993-8600</u> Fax # <u>(618) 993-5887</u>																													
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Tina Calhoun</u></td></tr><tr><td>(Title) <u>Director of Operations</u></td></tr><tr><td>(Signed) <u>See Preparation Report</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>McGladrey LLP</u></td></tr><tr><td><u>117 E. Main St., Suite 210</u></td></tr><tr><td>(Firm Name & Address) <u>P.O. Box 1070</u></td></tr><tr><td colspan="2" rowspan="4"></td><td><u>Galesburg, IL 61401</u></td></tr><tr><td>(Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</u></td></tr><tr><td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE</td></tr><tr><td colspan="2">ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</td></tr><tr><td colspan="2" rowspan="3"></td><td colspan="2">201 S. Grand Avenue East</td></tr><tr><td colspan="2">Springfield, IL 62763-0001</td></tr><tr><td colspan="2">Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Tina Calhoun</u>	(Title) <u>Director of Operations</u>	(Signed) <u>See Preparation Report</u>	Paid Preparer	(Date) _____	(Print Name and Title) <u>McGladrey LLP</u>	<u>117 E. Main St., Suite 210</u>	(Firm Name & Address) <u>P.O. Box 1070</u>			<u>Galesburg, IL 61401</u>	(Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</u>	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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		Springfield, IL 62763-0001																											
		Phone # (217) 782-1630																											
Date of Initial License for Current Owners: <u>03/01/06</u>																													
Type of Ownership:																													
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>501 (c) (3)</u></td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code <u>501 (c) (3)</u>	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust			☐ Other _____					
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	☐ Trust																												
	☐ Other _____																												
In the event there are further questions about this report, please contact:																													
Name: <u>Ron Wilson</u> Telephone Number: <u>(309) 343-1550</u>																													
Email Address: _____																													

Facility Name & ID Number Parkway Manor# 0047886 Report Period Beginning: 10/1/11 Ending: 9/30/12

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 bedsN/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>119</u>	Skilled (SNF)	<u>119</u>	<u>43,554</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>119</u>	TOTALS	<u>119</u>	<u>43,554</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>12,227</u>	<u>10,751</u>	<u>8,783</u>	<u>31,761</u>	8
9	SNF/PED					9
10	ICF		<u>0</u>			10
11	ICF/DD					11
12	SC		<u>0</u>			12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,227</u>	<u>10,751</u>	<u>8,783</u>	<u>31,761</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 72.92%

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?

YesG. 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 03/01/06

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

YES ☒Date 03/01/06NO ☐

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

YES ☒NO ☐If YES, enter number
of beds certified 119 and days of care provided 7,837Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 9/30/12Fiscal Year: 9/30/12

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

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	233,013	33,857	15,760	282,630		282,630	(37,609)	245,021			1
2	Food Purchase		306,590		306,590		306,590	(45,399)	261,191			2
3	Housekeeping	137,365	63,764		201,129		201,129	(25,141)	175,988			3
4	Laundry	82,963	31,130		114,093		114,093	(14,261)	99,832			4
5	Heat and Other Utilities			157,865	157,865		157,865	(18,904)	138,961			5
6	Maintenance	53,848	32,540	49,148	135,536		135,536	(16,943)	118,593			6
7	Other (specify):*											7
8	TOTAL General Services	507,189	467,881	222,773	1,197,843		1,197,843	(158,257)	1,039,586			8
	B. Health Care and Programs											
9	Medical Director			6,500	6,500		6,500		6,500			9
10	Nursing and Medical Records	2,460,351	591,864	1,298	3,053,513		3,053,513	(119,698)	2,933,815			10
10a	Therapy	1,023,689		4,340	1,028,029		1,028,029		1,028,029			10a
11	Activities	78,078	1,628		79,706		79,706	(19,927)	59,779			11
12	Social Services	34,933			34,933		34,933		34,933			12
13	CNA Training			900	900		900		900			13
14	Program Transportation			741	741	2,934	3,675		3,675			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,597,051	593,492	13,779	4,204,322	2,934	4,207,256	(139,625)	4,067,631			16
	C. General Administration											
17	Administrative	120,544			120,544		120,544		120,544			17
18	Directors Fees							3,567	3,567			18
19	Professional Services			341,595	341,595		341,595	899	342,494			19
20	Dues, Fees, Subscriptions & Promotions			117,337	117,337		117,337	(100,197)	17,140			20
21	Clerical & General Office Expenses	106,784	50,787	38,239	195,810		195,810	(654)	195,156			21
22	Employee Benefits & Payroll Taxes			683,812	683,812		683,812	(32,110)	651,702			22
23	Inservice Training & Education			9,115	9,115		9,115		9,115			23
24	Travel and Seminar			2,449	2,449		2,449		2,449			24
25	Other Admin. Staff Transportation			5,868	5,868	(2,934)	2,934	(203)	2,731			25
26	Insurance-Prop.Liab.Malpractice			60,556	60,556		60,556	40,692	101,248			26
27	Other (specify):* See Att Sch V	62,328		131,767	194,095		194,095	(194,095)				27
28	TOTAL General Administration	289,656	50,787	1,390,738	1,731,181	(2,934)	1,728,247	(282,101)	1,446,146			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,393,896	1,112,160	1,627,290	7,133,346		7,133,346	(579,983)	6,553,363			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			61,094	61,094		61,094	268,453	329,547			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							360,307	360,307			32
33	Real Estate Taxes			4,643	4,643		4,643	95,040	99,683			33
34	Rent-Facility & Grounds			846,480	846,480		846,480	(846,480)				34
35	Rent-Equipment & Vehicles			16,887	16,887		16,887		16,887			35
36	Other (specify):* See Att Sch IV							5,553	5,553			36
37	TOTAL Ownership			929,104	929,104		929,104	(117,127)	811,977			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			91,228	91,228		91,228		91,228			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			5,650	5,650		5,650		5,650			41
42	Provider Participation Fee			247,025	247,025		247,025		247,025			42
43	Other (specify):* Outpatient Care			1,925	1,925		1,925		1,925			43
44	TOTAL Special Cost Centers			345,828	345,828		345,828		345,828			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,393,896	1,112,160	2,902,222	8,408,278		8,408,278	(697,110)	7,711,168			45

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

		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	(2,220)	V-2		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		V-30		9
10	Interest and Other Investment Income	(17,222)	V-32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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		V-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	(129,737)	V-27		24
25	Fund Raising, Advertising and Promotional	(99,885)	V-20		25
	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 See Att Sch XI	(506,067)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (755,131)		\$	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	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)	48,063		34
35	Other- Attach Schedule See Att Sch III	9,958		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 58,021		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (697,110)		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	TOTAL (C): (sum of lines 38-46)			\$		47

Parkway Manor

ID#

0047886

Report Period Beginning:

10/1/11

Ending:

9/30/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				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	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Parkway Manor # 0047886 Report Period Beginning: 10/1/11 Ending: 9/30/12

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Facility Name & ID Number Parkway Manor # 0047886 Report Period Beginning: 10/1/11 Ending: 9/30/12 Summary B

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	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	48,063	0	0	0	0	0	0	0	0	0	48,063	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	0	48,063	0	0	0	0	0	0	0	0	0	48,063	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	0	48,063	0	0	0	0	0	0	0	0	0	48,063	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
None	N/A	Unlimited Development, Inc (UDI)		See Attached Schedule I		
		Community Living Options, Inc. (CLO)				
		See Attached Schedule I for specific homes & other CLO subsidiaries				

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Facility Rent	\$ 846,480	Marion Williamson County Parkway, LLC	N/A	\$ 894,543	\$ 48,063	1
2	V								2
3	V				See Att Schedule IV and Preparation Report				3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 846,480			\$ 894,543	\$ * 48,063	14

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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See Attached Schedule II & III								\$ 3,567	18-7	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	\$ 3,567		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 Parkway Manor # 0047886 Report Period Beginning: 10/1/11 Ending: 9/30/12

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 Unlimited Development, Inc.
Street Address 285 S Farnham
City / State / Zip Code Galesburg, IL 61401
Phone Number (309) 343-1550
Fax Number (309) 343-2857

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2		See Att Sch II & III							9,958	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					\$	\$		9,958	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	Cambridge Realty Capital LTD. Of Illinois						\$		\$			\$	1		
2			X	Facility purchase SNF portion	\$32,468.00	6/01/2012		7,801,200	7,782,394	7/1/2047	3.5500	377,529	2		
3													3		
4													4		
5													5		
	Working Capital														
6	Miscellaneous		X										6		
7	Less Interest Income		X									(17,222)	7		
8													8		
9	TOTAL Facility Related				\$32,468.00		\$	7,801,200	\$	7,782,394			\$	360,307	9
	B. Non-Facility Related*														
10	Cambridge Realty Capital LTD. Of Illinois												10		
11			X	Facility purchase ALC portion	\$4,427.00	6/01/2012		1,063,800	1,061,235	7/1/2047	3.5500	51,481	11		
12													12		
13													13		
14	TOTAL Non-Facility Related				\$4,427.00		\$	1,063,800	\$	1,061,235			\$	51,481	14
15	TOTALS (line 9+line14)						\$	8,865,000	\$	8,843,629			\$	411,788	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 42,146 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

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	92,132	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.)			\$	114,603	2
3. Under or (over) accrual (line 2 minus line 1).			\$	22,471	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	85,528	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.)			\$	4,644	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.			\$	112,643	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007 113,338 8	FOR BHF USE ONLY		
		2008 121,269 9	13	FROM R. E. TAX STATEMENT FOR 2011 \$	13
		2009 119,513 10	14	PLUS APPEAL COST FROM LINE 5 \$	14
		2010 120,165 11	15	LESS REFUND FROM LINE 6 \$	15
		2011 114,603 12	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
This facility was purchased from an unrelated for-profit entity during 2006. A tax exemption has not yet been obtained					
Amount accrued includes estimated taxes for 9 months based on fiscal year end. Estimate is based on prior year tax					
bill. Real estate taxes reported on Sch V line 33 have been reduced by an allocation of expenses relating to ALC service					
based on an estimated 12%. See Att Sch XI. Taxes paid are for the entire 2011 tax bill.					

- 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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Parkway Manor

COUNTY
Williamson

FACILITY IDPH LICENSE NUMBER
0047886

CONTACT PERSON REGARDING THIS REPORT
Ron Wilson

TELEPHONE
(309) 343-1550
FAX #:
(309) 343-2857

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 06-10-301-042	RE-SUB OF PARCELS E, G & J	\$ 113,799.96	\$ 100,143.96
2.	OF IL CENTRE SUB. B PT OF	\$	\$
3.	PARCEL E, THE WEST 3.93	\$	\$
4.	AC OF THE E 6.6	\$	\$
5.		\$	\$
6. 06-10-100-014	E 595' OF S 141' OF SW1/4 +	\$ 803.34	\$ 706.94
7.	W 173' OF S 141' C SE1/4	\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 114,603.30	\$ 100,850.90

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,356 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility - SNF	8.3 Acres	2006 - 2011	\$ 538,600	1
2	Facility - SNF	0.530 Acres	2012	26,721	2
3	TOTALS	#VALUE!		\$ 565,321	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	119		2006	1995	\$ 9,095,197	\$ 227,380	40	\$ 227,380	\$	\$ 1,496,918
5										
6										
7										
8										
	Improvement Type**									
9	Landscaping		2006		7,930	793	10	793		5,221
10	Water Heaters, Carpet, Blacktop, Bus. Office remodel, carpet, PT addition		2008		151,430	12,495	5-25 yrs	12,495		48,430
11	3 Shower Rooms - Marble Stalls/Tile work		2009		77,123	3,856	20	3,856		12,211
12	1/2" Water Meter 2-3" Water Meter		2009		4,373	438	10	438		1,313
13	Reroof		2009		130,134	13,013	10	13,013		38,979
14	Cabinets		2010		6,477	432	15	432		1,188
15	Water Heater		2010		4,268	427	10	427		1,103
16	Activity Room remodel-Carpet/Window coverings		2010		3,841	768	5	768		1,856
17	New Front Windows/Varnish		2010		17,873	1,191	15	1,191		2,978
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 9,498,646	\$ 260,793		\$ 260,793	\$	\$ 1,610,197	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$694,649	\$68,543	\$68,543		3-15 yrs	\$385,897	71
72	Current Year Purchases	2,817	211	211		7 yrs	211	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$697,466	\$68,754	\$68,754			\$386,108	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	Patient Care	2003 GMC G3500 Van	2006	\$29,848				4 yrs	\$29,848	76
77										77
78										78
79										79
80	TOTALS			\$29,848					\$29,848	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)	\$10,791,28181
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$329,54782
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$329,54783**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,026,15385

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	2006 Toyota Corolla - 2006	\$14,900	\$	\$14,900	86
87	Land ALC - 2006	56,400			87
88	Facility ALC - 2006	1,240,254	31,006	204,123	88
89					89
90					90
91	TOTALS	\$1,311,554	\$31,006	\$219,023	91

G. Construction-in-Progress

	Description	Cost	
92	Wing Addition	\$538,332	92
93			93
94			94
95		\$538,332	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: Marion Williamson County Parkway, LLC
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:				\$ See Attached			3
4	Additions				Schedule IV			4
5					Related Party			5
6					Lease			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
- N/A
9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms: N/A
- *

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: \$ 16,887
- Description: See Attached Schedule XIII
- (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.	/2013	\$ N/A
13.	/2014	\$ N/A
14.	/2015	\$ N/A

* 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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		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)	\$			

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

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

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

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

12345678										
	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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 42,401	\$ 416,505	1
2	Cash-Patient Deposits	3,587	3,587	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 130,024)	1,229,307	1,229,307	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	149,064	178,786	6
7	Other Prepaid Expenses	780	780	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Att Sch VII	6,933,603	6,978,703	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 8,358,742	\$ 8,807,668	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		621,721	13
14	Buildings, at Historical Cost		10,335,451	14
15	Leasehold Improvements, at Historical Cost	403,449	403,449	15
16	Equipment, at Historical Cost	331,547	742,214	16
17	Accumulated Depreciation (book methods)	(273,777)	(2,245,176)	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): See Att Sch VII	538,332	1,065,168	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 999,551	\$ 10,922,827	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,358,293	\$ 19,730,495	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 630,823	\$ 895,569	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,587	3,587	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	97,277	97,277	30
31	Accrued Taxes Payable (excluding real estate taxes)	72,406	72,406	31
32	Accrued Real Estate Taxes(Sch.IX-B)		85,528	32
33	Accrued Interest Payable	3,780	29,942	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Interdivision Payable		2,841,717	36
37	Current portion of long term payable		130,914	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 807,873	\$ 4,156,940	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,712,715	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Security Deposits	49,320	49,320	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 49,320	\$ 8,762,035	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 857,193	\$ 12,918,975	46
47	TOTAL EQUITY(page 18, line 24)	\$ 8,501,100	\$ 6,811,520	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,358,293	\$ 19,730,495	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,774,151	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,774,151	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	726,949	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)	\$ 726,949	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)	\$ 8,501,100	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Parkway Manor# 0047886Report Period Beginning: 10/1/11Ending: 9/30/12

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	\$ 8,913,549	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,913,549	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	182,838	6
7	Oxygen	6,232	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 189,070	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	5,731	12
13	Barber and Beauty Care	2,753	13
14	Non-Patient Meals	2,220	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	487	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 11,191	23
	D. Non-Operating Revenue		
24	Contributions	180	24
25	Interest and Other Investment Income***	17,222	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17,402	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund Income		28
28a	See Att Schdule X	4,015	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,015	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,135,227	30

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,197,843	31
32	Health Care	4,204,322	32
33	General Administration	1,731,181	33
	B. Capital Expense		
34	Ownership	929,104	34
	C. Ancillary Expense		
35	Special Cost Centers	98,803	35
36	Provider Participation Fee	247,025	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,408,278	40
41	Income before Income Taxes (line 30 minus line 40)**	726,949	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 726,949	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,167,305	44
45	Private Pay - Net Inpatient Revenue	1,690,330	45
46	Medicare - Net Inpatient Revenue	5,208,705	46
47	Other-(specify) <u>Assisted Living</u>	599,700	47
48	Other-(specify) <u>See Att Sch XII</u>	247,509	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,913,549	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	1,983	2,110	\$ 93,322	\$ 44.23	1
2	Assistant Director of Nursing	627	667	13,402	20.09	2
3	Registered Nurses	13,612	14,481	354,501	24.48	3
4	Licensed Practical Nurses	27,170	28,904	546,002	18.89	4
5	CNAs & Orderlies	107,818	114,670	1,266,285	11.04	5
6	CNA Trainees					6
7	Licensed Therapist	9,606	10,219	604,683	59.17	7
8	Rehab/Therapy Aides	16,661	17,724	419,006	23.64	8
9	Activity Director			0		9
10	Activity Assistants	7,747	8,241	78,078	9.47	10
11	Social Service Workers	2,848	3,030	34,933	11.53	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,793	24,248	233,013	9.61	15
16	Dishwashers					16
17	Maintenance Workers	4,053	4,311	53,848	12.49	17
18	Housekeepers	13,264	14,111	137,365	9.73	18
19	Laundry	9,132	9,715	82,963	8.54	19
20	Administrator	1,956	2,080	85,509	41.11	20
21	Assistant Administrator	1,855	1,974	35,035	17.75	21
22	Other Administrative	3,713	3,950	62,328	15.78	22
23	Office Manager					23
24	Clerical	8,598	9,146	106,784	11.68	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,894	2,015	30,218	15.00	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,633	2,801	28,852	10.30	31
32	Other Health Care(specify)	5,298	5,636	127,769	22.67	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	263,261	280,033	\$ 4,393,896 *	\$ 15.69	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	***	\$ 15,760	1-3	35
36	Medical Director	***	6,500	9-3	36
37	Medical Records Consultant	***	1,298	10-3	37
38	Nurse Consultant	***	0	10-3	38
39	Pharmacist Consultant	***	0	10-3	39
40	Physical Therapy Consultant	***	4,015	10a-3	40
41	Occupational Therapy Consultant	***	0	10a-3	41
42	Respiratory Therapy Consultant	***	0	10a-3	42
43	Speech Therapy Consultant	***	325	10a-3	43
44	Activity Consultant	***		11-3	44
45	Social Service Consultant	***		12-3	45
46	Other(specify)	***	0	10-3	46
47					47
48	*** Monthly Fee				48
49	TOTAL (lines 35 - 48)		\$ 27,898		49

C. CONTRACT NURSES

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

STATE OF ILLINOIS

Facility Name & ID Number

0047886

Report Period Beginning: 10/1/11

Page 21

Parkway Manor

Ending: 9/30/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Yolanda Fisher	Administrator	None	\$ 85,509
Tina Wright	Asst Admin	None	35,035
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 120,544

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
RFMS, Inc	Administrative Services	\$ 171,600
McGladrey LLP	Accounting Services	8,000
LTC Support Services, LLC	Support Services	154,200
Crain, Miller & Wernsman, LTD.	Legal Services	6,369
Sanders & Sanders	Collection Services	479
Polsinelli Shughart PC	Legal Services	865
Williamson Count Recorder	Legal Services	17
Singleton Law Firm, P.C.	Legal Services	65
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 341,595

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 174,740
Unemployment Compensation Insurance	36,010
FICA Taxes	329,144
Employee Health Insurance	86,666
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401 (k)	46,914
Other Employee Benefits	10,338
Less Allocation ALC - Att Sch XI	(32,110)
TOTAL (agree to Schedule V, line 22, col.8)	\$ 651,702

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	669
Health Care Worker Background Check (Indicate # of checks performed 115)	3,210
Patient Background Checks	565
Advertising - Promotion	99,885
Subscriptions	2,697
IHCA Dues	4,457
Other Licenses & Fees	769
Ind Costs-Att Sch III, ALC-Att Sch XI	(312)
Less: Public Relations Expense	()
Non-allowable advertising	(99,885)
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 17,140

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Staff use of personal vehicle on facility business and meals (under \$250 per travel voucher)	0
Seminar Expense	2,449
Less: non-allowable out-of-state travel	0
Indirect costs - See Att Sch III	0
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 2,449

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. See Page 21 section F

(3) Did the nursing home make political contributions or payments to a political action organization? Yes - IHCA dues 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? 7 yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 24,444 Line 10

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 247,025
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. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,220

(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? None
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
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? Yes
Firm Name: McGladrey LLP

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

(19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.