

		FOR BHF USE					

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

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

I. IDPH License ID Number: <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>10/1/15</u> to <u>9/30/16</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 Pkwy</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>Matt Hails</u></td></tr><tr><td>(Title) <u>LTC CEO</u></td></tr><tr><td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Larry Templin Partner</u></td></tr><tr><td>(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 9, Dunlap, IL 61525</u></td></tr><tr><td>(Telephone) <u>(630) 361-2868</u> Fax # ()</td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Matt Hails</u>	(Title) <u>LTC CEO</u>	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	Paid Preparer	(Print Name and Title) <u>Larry Templin Partner</u>	(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 9, Dunlap, IL 61525</u>	(Telephone) <u>(630) 361-2868</u> Fax # ()	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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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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	☐ "Sub-S" Corp.																								
	☐ Limited Liability Co.																								
	☐ 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: _____																									

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Parkway Manor

0047886 Report Period Beginning: 10/1/15 Ending: 9/30/16

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
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	131	Skilled (SNF)	131	47,946	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	131	TOTALS	131	47,946	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	10,191	11,916	17,019	39,126	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,191	11,916	17,019	39,126	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.60%

SEE ACCOUNTANTS' PREPARATION REPORT

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 X Non-allowable costs have been eliminated in Schedule V, Column 7

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

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 X Date 03/01/06 NO

K. Was the facility certified for Medicare during the reporting year? YES X NO If YES, enter number of beds certified 131 and days of care provided 14,347

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS
ACCRUAL X MODIFIED CASH* CASH*
Is your fiscal year identical to your tax year? YES X NO

Tax Year: 9/30/2016 Fiscal Year: 9/30/2016
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Parkway Manor # 0047886 Report Period Beginning: 10/1/15 Ending: 9/30/16

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	305,091	27,002	20,244	352,337		352,337	(40,342)	311,995			1
2	Food Purchase		356,652		356,652		356,652	(45,039)	311,613			2
3	Housekeeping	212,014	60,517		272,531		272,531	(31,733)	240,798			3
4	Laundry	50,596	16,938		67,534		67,534	(7,864)	59,670			4
5	Heat and Other Utilities			202,534	202,534		202,534	(23,583)	178,951			5
6	Maintenance	80,001	28,066	76,269	184,336		184,336	(21,463)	162,873			6
7	Other (specify):*											7
8	TOTAL General Services	647,702	489,175	299,047	1,435,924		1,435,924	(170,024)	1,265,900			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	3,161,540	244,916	34,608	3,441,064		3,441,064	(144,428)	3,296,636			10
10a	Therapy	1,454,074		50,055	1,504,129		1,504,129		1,504,129			10a
11	Activities	86,799	2,818		89,617		89,617	(22,407)	67,210			11
12	Social Services	49,023			49,023		49,023		49,023			12
13	CNA Training											13
14	Program Transportation			2,387	2,387		2,387		2,387			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,751,436	247,734	87,050	5,086,220		5,086,220	(166,835)	4,919,385			16
	C. General Administration											
17	Administrative	34,040			34,040		34,040		34,040			17
18	Directors Fees							4,356	4,356			18
19	Professional Services			397,920	397,920		397,920	4,782	402,702			19
20	Dues, Fees, Subscriptions & Promotions			23,485	23,485		23,485	(2,637)	20,848			20
21	Clerical & General Office Expenses	142,547	36,358	62,527	241,432		241,432	(1,922)	239,510			21
22	Employee Benefits & Payroll Taxes			862,470	862,470		862,470	(37,222)	825,248			22
23	Inservice Training & Education			9,931	9,931		9,931		9,931			23
24	Travel and Seminar			2,964	2,964		2,964		2,964			24
25	Other Admin. Staff Transportation			2,386	2,386		2,386		2,386			25
26	Insurance-Prop.Liab.Malpractice			75,260	75,260		75,260	4,208	79,468			26
27	Other (specify):*											27
28	TOTAL General Administration	176,587	36,358	1,436,943	1,649,888		1,649,888	(28,435)	1,621,453			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,575,725	773,267	1,823,040	8,172,032		8,172,032	(365,294)	7,806,738			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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			188,817	188,817		188,817	435,410	624,227			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4	4		4	260,586	260,590			32
33	Real Estate Taxes							224,400	224,400			33
34	Rent-Facility & Grounds			720,987	720,987		720,987	(720,987)				34
35	Rent-Equipment & Vehicles			12,136	12,136		12,136		12,136			35
36	Other (specify):* Mort Ins							41,731	41,731			36
37	TOTAL Ownership			921,944	921,944		921,944	241,140	1,163,084			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			27,831	27,831		27,831		27,831			38
39	Ancillary Service Centers		698,140		698,140		698,140		698,140			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			5,370	5,370		5,370	(826)	4,544			41
42	Provider Participation Fee			208,954	208,954		208,954		208,954			42
43	Other (specify):* See Att Sch 4A	56,724		977,142	1,033,866		1,033,866	(926,242)	107,624			43
44	TOTAL Special Cost Centers	56,724	698,140	1,219,297	1,974,161		1,974,161	(927,068)	1,047,093			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,632,449	1,471,407	3,964,281	11,068,137		11,068,137	(1,051,222)	10,016,915			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Parkway Manor

Period Beginning 10/1/15
Period End 9/30/16

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
		1	2	3	4	5	6	7	8	9	10	
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory/Expenses			70,321	70,321		70,321		70,321			
	Radiology Expenses			37,303	37,303		37,303		37,303			
	Non-Allowable Expenses	56,724		891,279	948,003		948,003	(948,003)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special C	56,724	0	998,903	1,055,627	0	1,055,627	(948,003)	107,624			

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,830)	2		4
5	Telephone, TV & Radio in Resident Rooms	(15,025)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2	30		9
10	Interest and Other Investment Income	(84)	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	(2,307)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(724,949)	43		24
25	Fund Raising, Advertising and Promotional	(129,544)	43		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 See Page 5A	(554,872)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,428,609)		\$	30

BHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	377,387		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 377,387		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,051,222)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES			Sch. V Line
	Amount	Reference	
1	Offset Vending Expenses Against Income	\$ (826)	41
2	Disallow Marketing Wages	(56,724)	43
3	Disallow R/E Entity HUD Audit	(13,390)	19
4	Disallow AL Expenses-Dietary	(40,342)	1
5	Disallow AL Expenses-Food	(43,209)	2
6	Disallow AL Expenses-Housekeeping	(31,733)	3
7	Disallow AL Expenses-Laundry	(7,864)	4
8	Disallow AL Expenses-Utilities	(23,583)	5
9	Disallow AL Expenses-Maintenance	(21,463)	6
10	Disallow AL Expenses-Nursing	(144,428)	10
11	Disallow AL Expenses-Activities	(22,407)	11
12	Disallow AL Expenses-Licenses & Fees	(582)	20
13	Disallow AL Expenses-Telephone	(1,928)	21
14	Disallow AL Expenses-Employee Benefits	(37,222)	22
15	Disallow AL Expenses-Insurance	(9,979)	26
16	Disallow AL Expenses-Depreciation Expense	(32,986)	30
17	Disallow AL Expenses-Interest Expense	(35,606)	32
18	Disallow AL Expenses-Real Estate Tax Expense	(30,600)	33
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	(554,872)	49

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 Page 6 Supplemental		
		Community Living Options, Inc. (CLO)				
		See Page 6 Supplemental for specific homes				

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	18	Director Fees	\$	Unlimited Development, Inc.	100.00%	\$ 4,356	\$ 4,356	1
2	V	19	Professional Fees		Unlimited Development, Inc.	100.00%	4,782	4,782	2
3	V	20	Dues, Licenses and Subs		Unlimited Development, Inc.	100.00%	2	2	3
4	V	21	General Admin Expense		Unlimited Development, Inc.	100.00%	6	6	4
5	V	26	Property/ Liability Insurance		Unlimited Development, Inc.	100.00%	1,000	1,000	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			\$			\$ 10,146	\$ * 10,146	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	19	Professional Fees	\$	Marion Williamson County Parkway, LLC	N/A	\$ 13,390	\$ 13,390	15
16	V	20	Dues, Fees, Subs & Prom		Marion Williamson County Parkway, LLC	N/A	250	250	16
17	V	26	Property Insurance		Marion Williamson County Parkway, LLC	N/A	13,187	13,187	17
18	V	30	Depreciation		Marion Williamson County Parkway, LLC	N/A	468,394	468,394	18
19	V	32	Interest Expense	437	Marion Williamson County Parkway, LLC	N/A	296,713	296,276	19
20	V	33	Property Taxes		Marion Williamson County Parkway, LLC	N/A	255,000	255,000	20
21	V	34	Facility Rent	720,987	Marion Williamson County Parkway, LLC	N/A		(720,987)	21
22	V	36	Mortgage Insurance		Marion Williamson County Parkway, LLC	N/A	41,731	41,731	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			\$ 721,424			\$ 1,088,665	\$ * 367,241	39

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Parkway Manor

0047886

Report Period Beginning:

10/1/15

Ending:

9/30/16

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	Community Living Options, Inc.	100%			Allen Court	Clinton	CILA	1
2	Community Living Options, Inc.	100%	Beardstown Terrace	Beardstown				2
3	Community Living Options, Inc.	100%	Bellefontaine Place	Waterloo				3
4	Community Living Options, Inc.	100%	Braun's Terrace	Greenville				4
5	Community Living Options, Inc.	100%	Carthage Terrace	Carthage				5
6	Community Living Options, Inc.	100%	Curtiss Court	Springfield				6
7	Community Living Options, Inc.	100%	Davies Square	Pekin				7
8	Community Living Options, Inc.	100%	Douglas Terrace	Jacksonville				8
9	Community Living Options, Inc.	100%	Edwardsville Terrace	Edwardsville				9
10	Community Living Options, Inc.	100%	Effingham Terrace	Effingham				10
11	Community Living Options, Inc.	100%			Eisenhower Terrace	Jacksonville	CILA	11
12	Community Living Options, Inc.	100%	Freeburg Terrace	Freeburg				12
13	Community Living Options, Inc.	100%	Froehlich House	Galesburg				13
14	Community Living Options, Inc.	100%	Gaines Mill Place	Springfield				14
15	Community Living Options, Inc.	100%	Glenwood Terrace	Springfield				15
16	Community Living Options, Inc.	100%			Hawthorne Terrace	Galesburg	CILA	16
17	Community Living Options, Inc.	100%	Highview Terrace	Paris				17
18	Community Living Options, Inc.	100%	Jacksonville Group Homes:					18
19	Community Living Options, Inc.	100%	Anna Terrace	Jacksonville				19
20	Community Living Options, Inc.	100%	Campbell Court	Jacksonville				20
21	Community Living Options, Inc.	100%	LaFayette Terrace	Jacksonville				21
22	Community Living Options, Inc.	100%	Kepley House	Pittsfield				22
23	Community Living Options, Inc.	100%	Lawrence Place	Lincoln				23
24	Community Living Options, Inc.	100%	Lincoln Terrace	Lincoln				24
25	Community Living Options, Inc.	100%	Maple Terrace	Quincy				25
26	Community Living Options, Inc.	100%	Plonka Terrace	Galesburg				26
27	Community Living Options, Inc.	100%	Quincy Terrace	Quincy				27
28	Community Living Options, Inc.	100%	Schultz House	Danville				28
29	Community Living Options, Inc.	100%	Stevens House	Galesburg				29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Parkway Manor

0047886

Report Period Beginning:

10/1/15

Ending:

9/30/16

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	Community Living Options, Inc.	100%	Tanner Place	Paris				1
2	Community Living Options, Inc.	100%	Taylor House	Springfield				2
3	Community Living Options, Inc.	100%	Thelma Terrace	Wood River				3
4	Community Living Options, Inc.	100%	Trulson House	Galesburg				4
5	Community Living Options, Inc.	100%	Vahle Terrace	Jerseyville				5
6	Community Living Options, Inc.	100%	Walsh Terrace	Galesburg				6
7	Community Living Options, Inc.	100%	Wetherell Place	Effingham				7
8	Community Living Options, Inc.	100%	Woodriver Group Homes:					8
9	Community Living Options, Inc.	100%	Aberdeen Terrace	Alton				9
10	Community Living Options, Inc.	100%	Linton Terrace	Wood River				10
11	Community Living Options, Inc.	100%	Madison Terrace	Wood River				11
12	Community Living Options, Inc.	100%	Pershing Terrace	Wood River				12
13	Community Living Options, Inc.	100%			Audrey Court-CILA	Clinton	CILA	13
14	Unlimited Development, Inc. (UDI)	100%	Parkway Manor	Marion				14
15	Unlimited Development, Inc. (UDI)	100%			Parkway Estates	Marion	Retirement living ce	15
16	Unlimited Development, Inc. (UDI)	100%	Maryville Manor	Maryville				16
17	Unlimited Development, Inc. (UDI)	100%	Shelbyville Manor	Shelbyville				17
18	Unlimited Development, Inc. (UDI)	100%	Leroy Manor	Leroy				18
19	Unlimited Development, Inc. (UDI)	100%			Liberty Estates of Carl	Carbondale	Retirement living ce	19
20	Unlimited Development, Inc. (UDI)	100%	Care Center of Abingdon	Abingdon				20
21	Unlimited Development, Inc. (UDI)	100%	Seminary Manor	Galesburg				21
22	Unlimited Development, Inc. (UDI)	100%			Seminary Estates	Galesburg	Retirement living ce	22
23	Unlimited Development, Inc. (UDI)	100%			Hawthorne Inn of Gale	Galesburg	Assisted Living Faci	23
24	Unlimited Development, Inc. (UDI)	100%	Centralia Manor	Centralia				24
25	Unlimited Development, Inc. (UDI)	100%			Centralia Estates	Centralia Estates	Retirement living ce	25
26	Unlimited Development, Inc. (UDI)	100%	Pittsfield Manor	Pittsfield				26
27	Unlimited Development, Inc. (UDI)	100%	Pekin Manor	Pekin				27
28	Unlimited Development, Inc. (UDI)	100%			Pekin Estates	Pekin	Retirement living ce	28
29	Unlimited Development, Inc. (UDI)	100%	Jerseyville Manor	Jerseyville				29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

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	Unlimited Development, Inc. (UDI)	100%	River Hills Manor	Keokuk, IA				1
2	Unlimited Development, Inc. (UDI)	100%			River Hills Estates	Keokuk, IA	Retirement living ce	2
3	Unlimited Development, Inc. (UDI)	100%			River Hills Inn	Keokuk, IA	Assisted living facili	3
4	Unlimited Development, Inc. (UDI)	100%			Centralia East McCorn	Galesburg	Lessor	4
5	Unlimited Development, Inc. (UDI)	100%			Galesburg North Semi	Galesburg	Lessor	5
6	Unlimited Development, Inc. (UDI)	100%			Jerseyville North State	Galesburg	Lessor	6
7	Unlimited Development, Inc. (UDI)	100%			Shelbyville Route 128,	Galesburg	Lessor	7
8	Unlimited Development, Inc. (UDI)	100%			Marion Willimason Co	Galesburg	Lessor	8
9	Unlimited Development, Inc. (UDI)	100%			Leroy South Buck, LL	Galesburg	Lessor	9
10	Unlimited Development, Inc. (UDI)	100%			2245 Seminary Street,	Galesburg	Lessor	10
11	Unlimited Development, Inc. (UDI)	100%			Pittsfield Lowry, LLC	Galesburg	Lessor	11
12	Unlimited Development, Inc. (UDI)	100%			Pekin El Camino, LLC	Galesburg	Lessor	12
13	Unlimited Development, Inc. (UDI)	100%			Abingdon West Marti	Galesburg	Lessor	13
14	Unlimited Development, Inc. (UDI)	100%			Keokuk Village Circle,	Galesburg	Lessor	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

SEE ACCOUNTANTS' PREPARATION REPORT

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 7A								\$ 4,356	L18, C7	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	\$ 4,356		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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Parkway Manor # 0047886 Report Period Beginning: 10/1/15 Ending: 9/30/16

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	18	Director Fees	Weighted Avail Bed Days	543,144	20	\$ 49,346	\$	47,946	\$ 4,356	1
2	19	Professional Fees	Weighted Avail Bed Days	543,144	20	54,173	\$	47,946	4,782	2
3	20	Dues, Licenses and Subs	Weighted Avail Bed Days	543,144	20	25		47,946	2	3
4	21	General Admin Expense	Weighted Avail Bed Days	543,144	20	70		47,946	6	4
5	26	Property/ Liability Insurance	Weighted Avail Bed Days	543,144	20	11,324		47,946	1,000	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					\$ 114,938	\$		\$ 10,146	25

SEE ACCOUNTANTS' PREPARATION REPORT

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						\$		\$			\$	1		
2	LTD. of Illinois		X	Facility purchase	\$32,468.00	6/1/12		7,801,200	7,296,031	7/1/2047	3.5500	261,107	2		
3				SNF portion									3		
4													4		
5													5		
	Working Capital														
6													6		
7													7		
8													8		
9	TOTAL Facility Related				\$32,468.00		\$	7,801,200	\$	7,296,031			\$	261,107	9
	B. Non-Facility Related*														
10	Cambridge Realty Capital			Facility purchase -AL Portion	\$4,427.00	6/1/12		1,063,800	994,913	7/1/2047	3.5500	35,606	10		
11	LTD. of Illinois									Misc Interest Exp		4	11		
12										Disallow AL Int Exp		(35,606)	12		
13										Int Income Offset		(521)	13		
14	TOTAL Non-Facility Related				\$4,427.00		\$	1,063,800	\$	994,913			\$	(517)	14
15	TOTALS (line 9+line14)						\$	8,865,000	\$	8,290,944			\$	260,590	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 41,731 Line # 36

* 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' PREPARATION REPORT

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

B. Real Estate Taxes

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

HFS 3745 (N-4-99)

2015 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 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 06-10-301-042	RE-SUB OF PARCELS E, G & J	\$ 133,651.46	\$ 117,613.28
2.	OF IL CENTRE SUB. BE PT OF	\$	\$
3.	PARCEL E, THE WEST 3.93	\$	\$
4.	AC OF THE E 6.60	\$	\$
5. 06-10-100-014	E 595' OF S 141' OF SW1/4 +	\$ 66,697.98	\$ 58,694.22
6.	W 173' OF S 141' C SE1/4	\$	\$
7. 06-10-100-018	E 594.35' OF W 1346.1' OF N 30'	\$ 191.08	\$ 168.15
8.	OF S 171.44' OF SW 1/4 + N 30'	\$	\$
9.	OF S 171.44' OF W 175.59' OF	\$	\$
10.	SE 1/4	\$	\$
TOTALS		\$ 200,540.52	\$ 176,475.65

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to providecopies 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).

Assisted Living-17 Units

- 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: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility-SNF	8.3 Acres	2006-2011	\$ 538,600	1
2	Facility-SNF	.53 Acres	2012	26,721	2
3	TOTALS	#VALUE!		\$ 565,321	3

SEE ACCOUNTANTS' PREPARATION REPORT

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	\$	40	\$ 227,380	\$ 227,380	\$ 2,406,438
5	12		2013	2013	4,062,647		40	101,566	101,566	287,770
6										
7										
8										
	Improvement Type**									
9	Landscaping		2006		7,930	330	10	330		7,930
10	Water Heaters, Carpet, Blacktop, Bus. Office remodel, carpet, PT Addition		2008		151,430	5,625	5-25 yrs	5,625		78,940
11	Shower Rooms, Water Meter, ReRoof, Roof Repairs		2009		211,630	17,307	10-20 yrs	17,307		121,730
12	Cabinets, Water Heater, New Front Windows/Varnish		2010		28,618	2,050	10-15 yrs	2,050		13,469
13	Activity Room remodel-Carpet/Window coverings		2010		3,841		5			3,841
14	Water Heater		2013		3,910	391	10	391		1,368
15	Concrete sidewalk		2013		26,295	1,753	15	1,753		5,550
16	Workstation		2013		5,868	587	10	587		1,809
17	Land Improvements-Parkway Manor Addition (contracted total)		2013		854,000		15	56,933	56,933	161,310
18	Nurse Call System		2013		14,101	1,410	10	1,410		3,995
19	Bally Freezer		2014		19,993	1,999	10	1,999		4,998
20	Double Faced Sign With Message Board		2014		46,503	4,650	10	4,650		11,238
21	Condensing Unit in Walk In Freezer		2014		3,551	237	15	237		553
22	Remodel-3 Wings: Tile/Wallpaper/Paint/Fixtures/Furniture/Therapy Equip		2014		601,947	50,162	12	50,162		104,504
23	Landscaping		2014		18,412	1,841	10	1,841		4,296
24	Water Heater		2014		3,160	316	10	316		579
25	Remodel-Tile/Wallpaper/Paint/Fixtures/Furniture/Therapy equip		2015		371,408	30,951	12	30,951		46,426
26	Workstation-Counter/Cabinets/Chair		2015		3,588	299	12	299		548
27	Surge Protector		2015		28,523	1,902	15	1,902		2,060
28	Paint Activity Room		2016		3,875	581	5	581		581
29	Automatic Doors		2016		14,298	596	10	596		596
30	PTAC Units		2016		2,540	169	5	169		169
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
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Parkway Manor

0047886

Report Period Beginning:

10/1/15

Ending:

9/30/16

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37							\$	\$	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)		\$ 15,583,265	\$ 123,156		\$ 509,035	\$ 385,879	\$ 3,270,698	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,255,333	\$ 48,677	\$ 100,188	\$ 51,511	3-15 yrs	\$ 800,387	71
72	Current Year Purchases	71,475	9,756	9,756		5-10 Yrs	9,756	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,326,808	\$ 58,433	\$ 109,944	\$ 51,511		\$ 810,143	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	2014 Braun Entervan	2014	\$	\$ 5,248	\$ 5,248	\$	4	\$	76
77	Disposed in 2015									77
78										78
79										79
80	TOTALS			\$	\$ 5,248	\$ 5,248	\$		\$	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)	\$ 17,475,394	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 186,837	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 624,227	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 437,390	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,080,841	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	2006 Toyota Corolla - 2006	\$ 14,900	\$	\$ 14,900	86
87	2003 GMC G3500 Van - 2006	29,848		29,848	87
88					88
89	Leasehold Imp-AL-2015	10,801	1,980	1,980	89
90					90
91	TOTALS	\$ 55,549	\$ 1,980	\$ 46,728	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
9. Option to Buy:
- ☐ YES☐ NO
- Terms: N/A
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$12,136
- Description: See Attached Schedule 14A
- (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	N/A				18
19					19
20					20
21	TOTAL		\$	\$	21

* 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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

It is the policy of this facility to only hire certified nurses aides.
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A(1)	16,504	hrs	\$ 489,994		\$	\$	16,504	\$ 489,994	1
2	Licensed Speech and Language Development Therapist	10A(1)	4,989	hrs	261,348				4,989	261,348	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A(1)	18,764	hrs	578,547				18,764	578,547	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39(2)		# of prescrpts				698,140		698,140	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							
10				hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	10A(3)				1,282	50,055		1,282	50,055	12
13	Other (specify): <u>Therapy Coordinator</u>	10A(1)	2,080		124,185				2,080	124,185	13
14	TOTAL				\$ 1,454,074	1,282	\$ 50,055	\$ 698,140	43,619	\$ 2,202,269	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 110,017	\$ 137,986	1
2	Cash-Patient Deposits	4,250	4,250	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 808,000)	2,576,162	2,588,809	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	172,903	212,095	6
7	Other Prepaid Expenses	2,603	2,603	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interdivision Receivable	7,339,129	7,339,129	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 10,205,064	\$ 10,284,872	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		565,321	13
14	Buildings, at Historical Cost	1,561,271	15,583,265	14
15	Leasehold Improvements, at Historical Cost	18,412		15
16	Equipment, at Historical Cost	619,435	1,326,808	16
17	Accumulated Depreciation (book methods)	(763,920)	(4,080,841)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe See Att Sch 17A		977,325	22
23	Other(specify): See Att Sch 17A		595,401	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,435,198	\$ 14,967,279	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,640,262	\$ 25,252,151	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 133,010	\$ 146,340	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,250	4,250	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	126,148	126,148	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	76,420	76,420	31
32	Accrued Real Estate Taxes(Sch.IX-B)		150,657	32
33	Accrued Interest Payable	3,780	28,307	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Interdivision Payable		7,897,364	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 343,608	\$ 8,429,486	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,290,944	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Security Deposits	54,288	54,288	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 54,288	\$ 8,345,232	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 397,896	\$ 16,774,718	46
47	TOTAL EQUITY(page 18, line 24)	\$ 11,242,366	\$ 8,477,433	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,640,262	\$ 25,252,151	48

Parkway Manor

Period 10/1/15

Period 9/30/16

Schedule 17A

XV. Balance Sheet
Line 22 Other Long Term Assets

	After Operating Consolidation
Land-Assisted Living	56,400
Building-Assisted Living	1,240,254
Reserve for Depr-Building-Assisted Living	(328,150)
Physical Therapy Addition-Assisted Living	
Reserve for Depr-Physical Therapy Addition-Assisted Living	
Leasehold Improvements-Assisted Living	10,801
Reserve for Depr-Leasehold Improvements-Assisted Living	(1,980)
2006 Toyota Corolla - 2006	14,900
Reserve for Depr-2006 Toyota Corolla - 2006	(14,900)
2003 GMC G3500 Van - 2006	29,848
Reserve for Depr-2003 GMC G3500 Van - 2006	(29,848)
TOTAL	977,325

XV. Balance Sheet
Line 23 Other

	After Operating Consolidation
Replacement Reserve	567,308
Loan Fees, Net	
Real Estate Tax Escrow	17,500
Insurance Escrow	3,000
MIP Escrow	7,593
TOTAL	595,401

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 10,651,330	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 10,651,330	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	591,036	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)	\$ 591,036	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)	\$ 11,242,366	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Parkway Manor

0047886

Report Period Beginning: 10/1/15

Ending:

9/30/16

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 11,516,952	1
2	Discounts and Allowances for all Levels	(122,216)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,394,736	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	218,882	6
7	Oxygen	3,508	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 222,390	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	2,690	12
13	Barber and Beauty Care	2,134	13
14	Non-Patient Meals	1,830	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,572	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	21,153	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 29,379	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	84	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 84	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Late Fees/Processing Fees/Fitness Center	12,481	28
28a	Gain on Disposal	103	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,584	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,659,173	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,435,924	31
32	Health Care	5,086,220	32
33	General Administration	1,649,888	33
	B. Capital Expense		
34	Ownership	921,944	34
	C. Ancillary Expense		
35	Special Cost Centers	1,765,207	35
36	Provider Participation Fee	208,954	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,068,137	40
41	Income before Income Taxes (line 30 minus line 40)**	591,036	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 591,036	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,457,546	44
45	Private Pay - Net Inpatient Revenue	2,663,176	45
46	Medicare - Net Inpatient Revenue	6,116,067	46
47	Other-(specify) Medicare Replacement/Managed Care	1,067,641	47
48	Other-(specify) Hospice	90,306	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,394,736	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	1,892	2,080	\$ 101,925	\$ 49.00	1
2	Assistant Director of Nursing	1,860	2,022	62,638	30.98	2
3	Registered Nurses	30,674	33,243	791,420	23.81	3
4	Licensed Practical Nurses	35,564	37,315	745,052	19.97	4
5	CNAs & Orderlies	118,495	124,352	1,395,156	11.22	5
6	CNA Trainees					6
7	Licensed Therapist	39,700	42,337	1,454,074	34.35	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,190	8,843	86,799	9.82	10
11	Social Service Workers	3,354	3,716	49,023	13.19	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	28,547	29,997	305,091	10.17	15
16	Dishwashers					16
17	Maintenance Workers	7,769	8,282	80,001	9.66	17
18	Housekeepers	19,964	21,608	212,014	9.81	18
19	Laundry	5,035	5,287	50,596	9.57	19
20	Administrator	1,240	1,416	34,040	24.04	20
21	Assistant Administrator					21
22	Other Administrative	1,824	2,080	56,724	27.27	22
23	Office Manager					23
24	Clerical	10,694	11,191	142,547	12.74	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,912	2,080	39,459	18.97	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,074	2,198	25,890	11.78	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	318,788	338,046	\$ 5,632,449 *	\$ 16.66	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 20,244	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant	Monthly	1,323	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,175	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 29,742		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

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	
Tina Wright	Administrator	None	\$ 34,040	Workers' Compensation Insurance	\$	139,665	IDPH License Fee	\$ 2,000	
				Unemployment Compensation Insurance		35,392	Advertising: Employee Recruitment	887	
				FICA Taxes		422,758	Health Care Worker Background Check		
				Employee Health Insurance		209,677	(Indicate # of checks performed 94)	2,340	
				Employee Meals			Patient Background Checks 228	5,712	
				Illinois Municipal Retirement Fund (IMRF)*			Subscriptions	1,524	
				401k		39,714	IHCA Dues	8,027	
				Other Employee Benefits		15,264	Other Licenses & Fees	2,995	
							Allocation from Home Office	2	
TOTAL (agree to Schedule V, line 17, col. 1)							Disallow AL Allocated Costs	(2,639)	
(List each licensed administrator separately.)			\$ 34,040				Less: Public Relations Expense	()	
B. Administrative - Other							Non-allowable advertising	()	
Description			Amount				Yellow page advertising	()	
N/A			\$				TOTAL (agree to Sch. V, line 20, col. 8)		
							\$ 20,848		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 825,248		
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount	
Vendor/Payee	Type		Amount				Out-of-State Travel	\$	
RFMS, Inc	Administrative Services	\$	171,600	N/A					
LTC Support Services, LLC	Support Services		177,360						
RSM US LLP	Accounting Services		24,683				In-State Travel	2,964	
Polsinelli Shughart PC	Legal Services		24,227						
Sanders & Sanders	Legal Services		50						
							Seminar Expense		
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)		
(For legal fee disclosure, see page 39 of instructions)			\$ 397,920				TOTAL 2,964		

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT**

****See instructions.**

Facility Name & ID Number Parkway Manor		STATE OF ILLINOIS	# 0047886	Report Period Beginning: 10/1/15	Ending: 9/30/16	Page 22
XX. GENERAL INFORMATION:						
(1)	Are nursing employees (RN,LPN,NA) represented by a union?		<u>No</u>			
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.		<u>Yes</u> <u>8,027 IHCA</u>			
(3)	Did the nursing home make political contributions or payments to a political action organization? If YES, have these costs been properly adjusted out of the cost report?		<u>No</u> <u>N/A</u>			
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?		<u>No</u> <u>N/A</u>			
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?		<u>Yes</u> <u>7.5 Yrs</u>			
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.		\$ <u>25,002</u> Line <u>10</u>			
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.		<u>Yes</u>			
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.		<u>No</u> <u>N/A</u>			
(9)	Are you presently operating under a sublease agreement?		YES <u>X</u> NO			
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>NO</u> <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.		<u>X</u>			
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. This amount is to be recorded on line 42 of Schedule V.		\$ <u>208,954</u>			
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.		<u>No</u>			
(13)	Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?		<u>Yes</u>			
(14)	Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? (For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.		<u>No</u>			
(15)	Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. Has any meal income been offset against related costs?		\$ <u>0</u> <u>Yes</u> Indicate the amount. \$ <u>1,830</u>			
(16)	Travel and Transportation					
	a. Are there costs included for out-of-state travel? If YES, attach a complete explanation.		<u>No</u>			
	b. Do you have a separate contract with the Department to provide medical transportation for residents? If YES, please indicate the amount of income earned from such a program during this reporting period.		<u>No</u> \$ <u>N/A</u>			
	c. What percent of all travel expense relates to transportation of nurses and patients?		<u>100% line 14</u>			
	d. Have vehicle usage logs been maintained?		<u>Yes</u>			
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?		<u>Yes</u>			
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?		<u>N/A</u>			
	g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.		<u>No</u> \$ <u>N/A</u>			
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name:		<u>Yes</u> <u>RSM US LLP</u>			
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?		<u>Yes</u>			
(19)	Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Attach invoices and a summary of services for all architect and appraisal fees		<u>Yes</u>			

SEE ACCOUNTANTS' PREPARATION REPORT

Parkway Manor houses both the skilled nursing facility and the assisted living facility in the same bldg and reported as a single division of Unlimited Development, Inc. Therefore, the divisional income statement and balance sheet report both operations. The AL related costs have been adjusted out of this cost report

Attached Schedule 22A

SUMMARY SCHEDULE						
Sch. V of Allocation of Assisted Living Facility Costs						
Line #		Basis of Allocation	Salaries	Supplies	Other	Total
1	Dietary	Census	37,061	3,281		40,342
2	Food Purchase	Census		43,209		43,209
3	Housekeeping	Rooms	24,687	7,046		31,733
4	Laundry	Rooms	5,891	1,973		7,864
5	Heat and Other Utilities				23,583	23,583
6	Maintenance	Rooms	9,315	3,267	8,881	21,463
7	Other (specify):*					-
9	Medical Director					-
10	Nursing and Medical Records	100% of RSD/Personal Care	144,428			144,428
10a	Therapy					-
11	Activities	25%	21,700	707		22,407
12	Social Services					-
13	CNA Training					-
14	Program Transportation	Rooms				-
15	Other (specify):*					-
17	Administrative					-
18	Directors Fees					-
19	Professional Services					-
20	Dues, Fees, Subscriptions & Promotions	Rooms			582	582
21	Clerical & General Office Expenses	Rooms			1,928	1,928
22	Employee Benefits & Payroll Taxes	% of AL Wages			37,222	37,222
23	Inservice Training & Education					-
24	Travel and Seminar					-
25	Other Admin. Staff Transportation					-
26	Insurance-Prop.Liab.Malpractice	Rooms			9,979	9,979
27	Other (specify):*					-
30	Depreciation	Direct			32,986	32,986
31	Amortization of Pre-Op. & Org.					-
32	Interest	12%			35,606	35,606
33	Real Estate Taxes	12%			30,600	30,600
34	Rent-Facility & Grounds					-
35	Rent-Equipment & Vehicles					-
36	Other (specify):*					-
38	Medically Necessary Transportation					-
39	Ancillary Service Centers					-
40	Barber and Beauty Shops					-
41	Coffee and Gift Shops					-
42	Provider Participation Fee					-
43	Other (specify):*					-
TOTALS			243,082	59,483	181,367	483,932
Net adjustment required						483,932