FOR BHF USE

LL1

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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0051375

Facility Name: PARKSHORE ESTATES N & R

Address: 6125 SOUTH KENWOOD (Number) CHICAGO (City) 60637 (Zip Code)

County: COOK

Telephone Number: 709-449-1900 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: 4/1/11

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Alan Sorscher **Telephone Number:** 708-449-1900
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/13 to 12/31/13 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Alan Sorscher
(Title) CFO

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) 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

Facility Name & ID Number PARKSHORE ESTATES N & R # 0051375 Report Period Beginning: 1/1/13 Ending: 12/31/13

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	318	Skilled (SNF)	318	116,070	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	318	TOTALS	318	116,070	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	68,102	514	4,475	73,091	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	68,102	514	4,475	73,091	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.97%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

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

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

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

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 4/1/11

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 64 and days of care provided 4,424

Medicare Intermediary WISCONSIN PHYSICIAN SERVICES

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

Facility Name & ID Number PARKSHORE ESTATES N & R # 0051375 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	362,921	41,072	26,309	430,302		430,302	(10,178)	420,124			1
2	Food Purchase		370,606		370,606		370,606	162	370,768			2
3	Housekeeping	264,368	33,829		298,197		298,197		298,197			3
4	Laundry	110,459	23,754		134,213		134,213		134,213			4
5	Heat and Other Utilities			312,307	312,307		312,307	1,883	314,190			5
6	Maintenance	98,773	33,815	72,134	204,722		204,722	5,520	210,242			6
7	Other (specify):*											7
8	TOTAL General Services	836,521	503,076	410,750	1,750,347		1,750,347	(2,613)	1,747,734			8
	B. Health Care and Programs											
9	Medical Director			25,000	25,000		25,000		25,000			9
10	Nursing and Medical Records	3,334,206	282,526	41,604	3,658,336		3,658,336	(3,719)	3,654,617			10
10a	Therapy			557,885	557,885		557,885		557,885			10a
11	Activities	135,185	25,754		160,939		160,939		160,939			11
12	Social Services	190,798		9,087	199,885		199,885		199,885			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharmacy Consultant			21,609	21,609		21,609		21,609			15
16	TOTAL Health Care and Programs	3,660,189	308,280	655,185	4,623,654		4,623,654	(3,719)	4,619,935			16
	C. General Administration											
17	Administrative	108,405			108,405		108,405	(11,000)	97,405			17
18	Directors Fees											18
19	Professional Services			377,553	377,553		377,553	(252,176)	125,377			19
20	Dues, Fees, Subscriptions & Promotions			32,674	32,674		32,674		32,674			20
21	Clerical & General Office Expenses	210,682	30,989	83,815	325,486		325,486	70,520	396,006			21
22	Employee Benefits & Payroll Taxes			883,481	883,481		883,481	31,785	915,266			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,366	2,366		2,366	3,325	5,691			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			298,590	298,590		298,590	620	299,210			26
27	Other (specify):*											27
28	TOTAL General Administration	319,087	30,989	1,678,479	2,028,555		2,028,555	(156,926)	1,871,629			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,815,797	842,345	2,744,414	8,402,556		8,402,556	(163,258)	8,239,298			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number PARKSHORE ESTATES N & R #0051375 Report Period Beginning: 1/1/13 Ending: 12/31/13

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			135,680	135,680		135,680	(70,780)	64,900			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			467,531	467,531		467,531	240	467,771			32
33	Real Estate Taxes			360,000	360,000		360,000		360,000			33
34	Rent-Facility & Grounds			4,260,000	4,260,000		4,260,000	(2,809,330)	1,450,670			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			5,223,211	5,223,211		5,223,211	(2,879,870)	2,343,341			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		268,780		268,780		268,780		268,780			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			587,684	587,684		587,684		587,684			42
43	Other (specify):* Bad Debt			534,225	534,225		534,225	(534,225)				43
44	TOTAL Special Cost Centers		268,780	1,121,909	1,390,689		1,390,689	(534,225)	856,464			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,815,797	1,111,125	9,089,534	15,016,456		15,016,456	(3,577,353)	11,439,103			45

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

Facility Name & ID Number PARKSHORE ESTATES N & R # 0051375 Report Period Beginning: 1/1/13 Ending: 12/31/13

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(70,780)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(534,225)	43		24
25	Fund Raising, Advertising and Promotional	(27,112)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,843,687)	various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (3,475,804)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(101,549)	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (101,549)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (3,577,353)		37

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

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

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

PARKSHORE ESTATES N & R

ID# 0051375

Report Period Beginning: 1/1/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	misc income	$ (23,687)	21	1
2	rent	(2,820,000)	34	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(2,843,687)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PARKSHORE ESTATES N & R # 0051375 **Report Period Beginning:** 1/1/13 **Ending:** 12/31/13

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	(10,178)	0	0	0	0	0	0	0	0	0	(10,178)	1
2	Food Purchase	0	162	0	0	0	0	0	0	0	0	0	162	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	1,883	0	0	0	0	0	0	0	0	0	1,883	5
6	Maintenance	0	5,520	0	0	0	0	0	0	0	0	0	5,520	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	(2,613)	0	0	0	0	0	0	0	0	0	(2,613)	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	(3,719)	0	0	0	0	0	0	0	0	0	(3,719)	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	(3,719)	0	0	0	0	0	0	0	0	0	(3,719)	16
	C. General Administration													
17	Administrative	0	(11,000)	0	0	0	0	0	0	0	0	0	(11,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(252,176)	0	0	0	0	0	0	0	0	0	(252,176)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(50,799)	121,319	0	0	0	0	0	0	0	0	0	70,520	21
22	Employee Benefits & Payroll Taxes	0	31,785	0	0	0	0	0	0	0	0	0	31,785	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,325	0	0	0	0	0	0	0	0	0	3,325	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	620	0	0	0	0	0	0	0	0	0	620	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(50,799)	(106,127)	0	0	0	0	0	0	0	0	0	(156,926)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(50,799)	(112,459)	0	0	0	0	0	0	0	0	0	(163,258)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PARKSHORE ESTATES N & R # 0051375 **Report Period Beginning:** 1/1/13 **Ending:** 12/31/13

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(70,780)	0	0	0	0	0	0	0	0	0	0	(70,780)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	240	0	0	0	0	0	0	0	0	0	240	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(2,820,000)	10,670	0	0	0	0	0	0	0	0	0	(2,809,330)	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	(2,890,780)	10,910	0	0	0	0	0	0	0	0	0	(2,879,870)	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):*	(534,225)	0	0	0	0	0	0	0	0	0	0	(534,225)	43
44	TOTAL Special Cost Centers	(534,225)	0	0	0	0	0	0	0	0	0	0	(534,225)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(3,475,804)	(101,549)	0	0	0	0	0	0	0	0	0	(3,577,353)	45

Facility Name & ID Number PARKSHORE ESTATES N & R # 0051375 Report Period Beginning: 1/1/13 Ending: 12/31/13

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
MOISHE GUBIN	30%			INFINITY HEALTHC	HILLSIDE, IL	MANAGEMENT C
MICHAEL BLISKO	30%					
A & F REALTY	20%					
DAVID SCHECHTER	20%					

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	DIETARY	$ 22,351	INFINITY HEALTHCARE MANAGEMENT		$ 12,173	$ (10,178)	1
2	V	6	MAINTENANCE		INFINITY HEALTHCARE MANAGEMENT		5,520	5,520	2
3	V	10	NURSING	45,379	INFINITY HEALTHCARE MANAGEMENT		41,660	(3,719)	3
4	V	21	OFFICE EXPENSE	32,205	INFINITY HEALTHCARE MANAGEMENT		153,524	121,319	4
5	V	19	PROFESSIONAL SERVICES	253,510	INFINITY HEALTHCARE MANAGEMENT		1,334	(252,176)	5
6	V	22	EMPLOYEE BENEFITS	862	INFINITY HEALTHCARE MANAGEMENT		32,647	31,785	6
7	V	24	AUTO/TRAVEL EXPENSE	644	INFINITY HEALTHCARE MANAGEMENT		3,969	3,325	7
8	V	26	INSURANCE		INFINITY HEALTHCARE MANAGEMENT		620	620	8
9	V	34	FACILITY/GROUNDS		INFINITY HEALTHCARE MANAGEMENT		10,670	10,670	9
10	V	2	FOOD	(162)	INFINITY HEALTHCARE MANAGEMENT			162	10
11	V	17	Administrator	11,000	INFINITY HEALTHCARE MANAGEMENT			(11,000)	11
12	V	32	interest		INFINITY HEALTHCARE MANAGEMENT		240	240	12
13	V	5	UTILITIES		INFINITY HEALTHCARE MANAGEMENT		1,883	1,883	13
14	Total			$ 365,789			$ 264,240	$ * (101,549)	14

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

Facility Name & ID Number PARKSHORE ESTATES N & R # 0051375 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

Facility Name & ID Number PARKSHORE ESTATES N & R # 0051375 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number PARKSHORE ESTATES N & R # 0051375 Report Period Beginning: 1/1/13 Ending: 12/31/13

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 [x]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 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										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PARKSHORE ESTATES N & R # 0051375 Report Period Beginning: 1/1/13 Ending: 12/31/13

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	A & F Realty	x		Property	none	various	$ various	$ 2,700,000	various	various	$ 216,000	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Infinity Funding	x		working capital	none	various	various	3,024,386	various	various	208,110	6
7	Capital One		x	working capital	none	8/31/12	5,000,000	903,979	8/31/15	2.9590	43,421	7
8												8
9	TOTAL Facility Related						$ 5,000,000	$ 6,628,365			$ 467,531	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,000,000	$ 6,628,365			$ 467,531	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** n/a **Line #** n/a

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

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

Facility Name & ID Number PARKSHORE ESTATES N & R # 0051375 **Report Period Beginning:** 1/1/13 **Ending:** 12/31/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ (7,396)	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.)		$ 386,276	2
3. Under or (over) accrual (line 2 minus line 1).		$ 393,672	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ (33,672)	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 360,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008		8
	2009		9
	2010	331,059	10
	2011	306,337	11
	2012	386,276	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PARKSHORE ESTATES N & R COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0051375

CONTACT PERSON REGARDING THIS REPORT Alan Sorscher

TELEPHONE 708-449-1900 FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	20-14-408-015-0000	NURSING HOME	$ 3,025.82	$ 3,025.82
2.	20-14-408-016-0000	NURSING HOME	$ 2,954.57	$ 2,954.57
3.	20-14-408-017-0000	NURSING HOME	$ 1,463.92	$ 1,463.92
4.	20-14-409-004-0000	NURSING HOME	$ 94,678.84	$ 94,678.84
5.	20-14-409-005-0000	NURSING HOME	$ 284,152.85	$ 284,152.85
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 386,276.00	$ 386,276.00

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? _____ 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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.

Facility Name & ID Number PARKSHORE ESTATES N & R # 0051375 Report Period Beginning: 1/1/13 Ending: 12/31/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 83,520 B. General Construction Type: Exterior BRICK Frame CONCRETE Number of Stories 6

C. Does the Operating Entity? [ ] (a) Own the Facility [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).

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number PARKSHORE ESTATES N & R # 0051375 Report Period Beginning: 1/1/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	318				$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	DOOR SCREEN			8/9/2011	1,875	48	39	48		132	9
10	NEW LIGHT FIXTURES FOR FACILITY			4/28/2011	28,695	736	39	736		2,023	10
11	CEILING TILE			8/9/2011	1,361	35	39	35		96	11
12	FENCE			11/4/2011	2,971	76	39	76		209	12
13	CEMENT FOR HANDICAP RAMP			11/8/2011	8,000	205	39	205		564	13
14	COUNTERTOPS, CEILING TILE, CROWN MOLDING,										14
15	MINI BLINDS, LED STRIP LIGHT, W.A.C. LIGHTING, TILE										15
16	FLOORING, WOOD PANELING, HAND RAILS, WALL										16
17	COVERING, PARTITION, DOUBLE DOOR, VINYL BASE										17
18	VINYL FLOORING, VINYL WALL BASE, LAMINATE PANELS										18
19	FOR LOBBY, PHYSICAL THERAPY ROOM, AND ELEVATOR			12/23/2011	57,107	1,464	39	1,464		4,027	19
20											20
21	PLUMBING AND DRYWALL IN 6TH FLOOR DIALYSIS ROOM			11/23/2012	8,246	211	39	211		423	21
22	DOOR LOCK SYSTEM ON LOBBY DOOR			10/15/2012	2,851	73	39	73		146	22
23	FLOORING & WALLS ON 1ST FLOOR THERAPY ROOMS			11/1/2012	11,274	289	39	289		578	23
24	FLORING & WALLS IN MAIN LOBBY			12/14/2012	11,274	289	39	289		578	24
25	INSTALL SPRINKLER SYSTEM			7/18/2012	4,775	122	39	122		245	25
26											26
27	EIDCO CREDIT??			1/1/2012	(57,107)	(1,464)	39	(1,464)		(2,929)	27
28	REMOVE WALLPAPER, PRIME, PAINT ON 1ST FLOOR ADMIN OF			5/3/2012	4,500	115	39	115		231	28
29	ROOFING REPAIR			6/28/2012	1,200	31	39	31		62	29
30	REPAIR FOUNDATIONAL CRACKS			6/21/2012	2,600	67	39	67		133	30
31	INSTALLATION OF FIRE ALARM SYSTEM			8/6/2012	17,990	461	39	461		923	31
32	REMOVE CARPETING AND INSTALL NEW FLOOR ON 1ST FLOOR			7/5/2012	1,165	30	39	30		60	32
33	PLUMBING AND ROUGH IN FOR 10 DIALYSIS STATIONS										33
34	INCLUDING NEW DRAINS, BACK FLOW PREVENTOR, AND PIPING										34
35	FOR 6th FLOOR DIALYIS ROOMS			10/3/2012	12,000	308	39	308		615	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number PARKSHORE ESTATES N & R # 0051375 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	REPAIR BOILER	11/1/2012	$ 2,929	$ 75	39	$ 75	$	$ 150	37
38									38
39	INSTALL SIGN AND MOUNT ON WALL	10/22/2012	1,150	29	39	29		59	39
40									40
41	1ST FLOOR LOBBY/RECEPTION - NEW FLOORING, NEW								41
42	COUNTERS, LIGHTING, PAINT AND CROWN MOLDING,								42
43	WALLCOVERINGS & BLINDS								43
44	1ST FLOOR ELEVATOR LOBBY - LIGHTING, TILE								44
45	FLOORING, WALL BASE, RAILINGS, WALLCOVERINGS								45
46	1ST FLOOR NEW PT ROOM - FLOORING, LIGHTING								46
47	GLASS DOOR, VINYL BASE, PAINT	1/1/2012	117,214	3,006	39	3,005	(1)	6,012	47
48									48
49	Toshiba phone system	7/20/2012	21,732	279	39	557	278	279	49
50	3rd floor corridor / dining room	10/31/2013	116,909	1,499	39	500	(999)	1,499	50
51	Fire alarm	5/22/2013	2,721	35	39	41	6	35	51
52	Durolast roofing system	9/23/2013	68,800	882	39	588	(294)	882	52
53	Storage room & locks	8/8/2012	4,716	60	39	50	(10)	60	53
54	Sign / logo / Lettering	8/26/2013	1,150	15	39	10	(5)	15	54
55	Awning support posts	3/26/2013	5,100	65	39	87	22	65	55
56	Awning support posts	5/31/2013	1,000	13	39	15	2	13	56
57	Permits	7/15/2013	1,650	21	39	21	0	21	57
58	Building cooling tower	7/30/2013	2,275	29	39	24	(5)	29	58
59	Electrical Wiring -	7/26/2013	17,985	231	39	192	(39)	231	59
60	Electrical Wiring - 3rd floor	7/1/2013	4,610	59	39	59		59	60
61	Masonry on outide of building	6/30/2013	114,600	63,030	39	2,938	(60,092)	63,030	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 605,317	$ 72,424		$ 11,288	$ (61,136)	$ 80,555	70

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

Facility Name & ID Number PARKSHORE ESTATES N & R # 0051375 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	$ 142,771	$	$ 28,554	$ 28,554		$ 142,771	71
72	Current Year Purchases	115,227	63,256	25,058	(38,198)		63,255	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 257,998	$ 63,256	$ 53,612	$ (9,644)		$ 206,026	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 863,315	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 135,680	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 64,900	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (70,780)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 286,581	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number PARKSHORE ESTATES N & R # 0051375 Report Period Beginning: 1/1/13 Ending: 12/31/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Parkshore Estates Nursing Realty, 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. [X] 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:	1975	318	4/1/11	$ 1,440,000	10		3
4	Additions							4
5								5
6								6
7	TOTAL		318		$ 1,440,000 **			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 [X] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning 4/1/11
    Ending 3/21/21

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2014	$ ########
13.	12/31/2015	$ ########
14.	12/31/2016	$ ########

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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.

Facility Name & ID Number PARKSHORE ESTATES N & R # 0051375 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number PARKSHORE ESTATES N & R # 0051375 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A-3	hrs	$		$ 207,488	$		$ 207,488	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs			100,674			100,674	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs			249,723			249,723	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				249,528		249,528	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): RADIOLOGY/LABOF	39-2					19,252		19,252	13
14	TOTAL			$		$ 557,885	$ 268,780		$ 826,665	14

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

Facility Name & ID Number PARKSHORE ESTATES N & R # 0051375 Report Period Beginning: 1/1/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13 (last day of reporting year)

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	$ (122,629)	$ (118,351)	1
2	Cash-Patient Deposits	(14,823)	(14,823)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,706,362	3,706,362	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	156,222	156,222	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,725,132	$ 3,729,410	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	490,717	490,717	15
16	Equipment, at Historical Cost	372,598	372,598	16
17	Accumulated Depreciation (book methods)	(286,581)	(286,581)	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 (spe**deposits**	(397)	2,017,103	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 576,337	$ 2,593,837	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,301,469	$ 6,323,247	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 853,476	$ 853,476	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	690,733	690,733	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	working capital	903,979	903,979	36
37	working capital	3,024,386	3,024,386	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,472,574	$ 5,472,574	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		2,700,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,700,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,472,574	$ 8,172,574	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,171,105)	$ (1,849,327)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,301,469	$ 6,323,247	48

***(See instructions.)**

Facility Name & ID Number PARKSHORE ESTATES N & R **#** 0051375 **Report Period Beginning:** 1/1/13 **Ending:** 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (232,123)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (232,123)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(193,467)	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) **Related Party Property Co net income**	(745,515)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (938,982)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,171,105)	24 *

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

Facility Name & ID Number PARKSHORE ESTATES N & R # 0051375 Report Period Beginning: 1/1/13 Ending: 12/31/13

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,811,044	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,811,044	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	168,258	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 168,258	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		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)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Related Party Property Co income	2,820,000	28
28a	miscellaneous income	23,687	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,843,687	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,822,989	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,750,347	31
32	Health Care	4,623,654	32
33	General Administration	2,028,555	33
	B. Capital Expense		
34	Ownership	5,223,211	34
	C. Ancillary Expense		
35	Special Cost Centers	268,780	35
36	Provider Participation Fee	587,684	36
	D. Other Expenses (specify):		
37	bad debt	534,225	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,016,456	40
41	**Income before Income Taxes (line 30 minus line 40)****	(193,467)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (193,467)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 9,901,214	44
45	Private Pay - Net Inpatient Revenue	168,782	45
46	Medicare - Net Inpatient Revenue	1,728,474	46
47	Other-(specify) Commercial Net Inpatient Revenue	12,574	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,811,044	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.**

Facility Name & ID Number PARKSHORE ESTATES N & R # 0051375 Report Period Beginning: 1/1/13 Ending: 12/31/13

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,696	1,840	$ 82,087	$ 44.61	1
2	Assistant Director of Nursing	1,960	2,231	94,650	42.42	2
3	Registered Nurses	11,304	11,940	363,023	30.40	3
4	Licensed Practical Nurses	43,785	47,487	1,489,867	31.37	4
5	CNAs & Orderlies	111,624	122,643	1,304,579	10.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	10,967	12,007	135,185	11.26	9
10	Activity Assistants					10
11	Social Service Workers	9,646	10,504	190,798	18.16	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,166	32,204	362,921	11.27	15
16	Dishwashers					16
17	Maintenance Workers	5,601	6,077	98,773	16.25	17
18	Housekeepers	21,918	24,051	264,368	10.99	18
19	Laundry	10,522	11,678	110,459	9.46	19
20	Administrator	1,832	1,947	108,405	55.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,940	10,889	178,599	16.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,944	2,104	32,083	15.25	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	271,905	297,602	$ 4,815,797 *	$ 16.18	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	526	$ 26,309	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	832	41,604	10-3	38
39	Pharmacist Consultant	432	21,609	15-3	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	182	9,087	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,972	$ 98,609		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number PARKSHORE ESTATES N & R # 0051375 Report Period Beginning: 1/1/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JEFF INGRAFFIA	admin		$ 22,259
Thomeka Brown			86,146
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 108,405

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
infinity funding	legal	$ 6,491
infinity healthcare	consulting	253,510
bradley & associates	acctg	7,571
johnson goldberg	acctg	2,500
stirs	consulting	47,500
moshe calamaro	consulting	4,920
mts consulting	consulting	16,237
life safety	prof fees	743
various	legal	38,081
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 377,553

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 182,489
Unemployment Compensation Insurance	213,055
FICA Taxes	401,039
Employee Health Insurance	79,955
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
employee exp	17,881
uniform	20,847
TOTAL (agree to Schedule V, line 22, col.8)	$ 915,266

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
illinois council	29,772
city of chicago	912
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,674

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
mileage	1,446
auto allownace	3,325
Seminar Expense	
education	815
seminar	105
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,691

**See instructions.

Facility Name & ID Number PARKSHORE ESTATES N & R # 0051375 Report Period Beginning: 1/1/13 Ending: 12/31/13

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number PARKSHORE ESTATES N & R # 0051375 Report Period Beginning: 1/1/13 Ending: 12/31/13

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILLINOIS COUNCIL**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **44,288** Line **10-2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **587,683**
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. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

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

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

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

(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.