FOR BHF USE

LL1

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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

I. IDPH License ID Number: 0051375

Facility Name: PARKSHORE ESTATES NRSG & REH

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

County: COOK

Telephone Number: 708 449-1900 **Fax #** 708 449-1500

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	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: Daniel S. Gaafar **Telephone Number:** 317 237-5500
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/15 to 12/31/15 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) Flora Reznik
(Title) CFO

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Daniel S. Gaafar, Partner
(Firm Name & Address) Bradley Associates, 201 S. Capitol Ave, Suite 700, Indianapolis, IN 46225
(Telephone) 317 237-5500 Fax # 317 235-5503

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number PARKSHORE ESTATES NRSG & REH # 0051375 Report Period Beginning: 1/1/15 Ending: 12/31/15

III. STATISTICAL DATA

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

	1 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	128	Skilled (SNF)	128	46,720	1
2		Skilled Pediatric (SNF/PED)			2
3	190	Intermediate (ICF)	190	69,350	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	29,326	46	5,358	34,730	8
9	SNF/PED					9
10	ICF	43,534	68	73	43,675	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	72,860	114	5,431	78,405	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.55%

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 5,309

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: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number PARKSHORE ESTATES NRSG & REH # 0051375 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	402,490		73,267	475,757		475,757	(17,282)	458,475			1
2	Food Purchase		405,866		405,866		405,866		405,866			2
3	Housekeeping	232,596	40,114		272,710		272,710		272,710			3
4	Laundry	118,334	36,010		154,344		154,344		154,344			4
5	Heat and Other Utilities			386,932	386,932		386,932	2,465	389,397			5
6	Maintenance	104,401	51,853	109,852	266,106		266,106	1,696	267,802			6
7	Other (specify):*											7
8	TOTAL General Services	857,821	533,843	570,051	1,961,715		1,961,715	(13,121)	1,948,594			8
	B. Health Care and Programs											
9	Medical Director			34,300	34,300		34,300		34,300			9
10	Nursing and Medical Records	3,552,972	339,231	46,242	3,938,445		3,938,445	(35,734)	3,902,711			10
10a	Therapy			745,820	745,820		745,820		745,820			10a
11	Activities	177,419	34,033		211,452		211,452		211,452			11
12	Social Services	216,186		3,464	219,650		219,650		219,650			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharmacy Consult			23,247	23,247		23,247	(23,247)				15
16	TOTAL Health Care and Programs	3,946,577	373,264	853,073	5,172,914		5,172,914	(58,981)	5,113,933			16
	C. General Administration											
17	Administrative	124,137			124,137		124,137		124,137			17
18	Directors Fees											18
19	Professional Services			489,023	489,023		489,023	(149,568)	339,455			19
20	Dues, Fees, Subscriptions & Promotions			3,280	3,280		3,280		3,280			20
21	Clerical & General Office Expenses	143,909	49,394	314,735	508,038		508,038	251,883	759,921			21
22	Employee Benefits & Payroll Taxes			845,227	845,227		845,227	33,687	878,914			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,364	2,364		2,364	2,037	4,401			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			405,791	405,791		405,791	2,907	408,698			26
27	Other (specify):*											27
28	TOTAL General Administration	268,046	49,394	2,060,420	2,377,860		2,377,860	140,946	2,518,806			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,072,444	956,501	3,483,544	9,512,489		9,512,489	68,844	9,581,333			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 NRSG & REH #0051375 Report Period Beginning: 1/1/15 Ending: 12/31/15

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			135,286	135,286		135,286	926,566	1,061,852			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			129,461	129,461		129,461	752,937	882,398			32
33	Real Estate Taxes			428,895	428,895		428,895	64,275	493,170			33
34	Rent-Facility & Grounds			2,151,504	2,151,504		2,151,504	(1,929,576)	221,928			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			2,845,146	2,845,146		2,845,146	(185,798)	2,659,348			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			7,786	7,786		7,786		7,786			38
39	Ancillary Service Centers		193,840		193,840		193,840		193,840			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			619,480	619,480		619,480		619,480			42
43	Other (specify):*			370,000	370,000		370,000	(370,000)				43
44	TOTAL Special Cost Centers		193,840	997,266	1,191,106		1,191,106	(370,000)	821,106			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,072,444	1,150,341	7,325,956	13,548,741		13,548,741	(486,954)	13,061,787			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 NRSG & REH # 0051375 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	136,655	30		9
10	Interest and Other Investment Income	(60,662)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,194)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(370,000)	43		24
25	Fund Raising, Advertising and Promotional	(13,357)	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	(27,979)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (337,540)		$	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)	(149,414)	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (149,414)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (486,954)		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 NRSG & REH

ID# 0051375

Report Period Beginning: 1/1/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (27,979)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(27,979)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PARKSHORE ESTATES NRSG & REH # 0051375 **Report Period Beginning:** 1/1/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	(3)	(17,279)	0	0	0	0	0	0	0	0	0	(17,282)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	2,465	0	0	0	0	0	0	0	0	0	2,465	5
6	Maintenance	0	1,696	0	0	0	0	0	0	0	0	0	1,696	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3)	(13,118)	0	0	0	0	0	0	0	0	0	(13,121)	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	(35,734)	0	0	0	0	0	0	0	0	0	(35,734)	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	(23,247)	0	0	0	0	0	0	0	0	0	(23,247)	15
16	**TOTAL Health Care and Programs**	0	(58,981)	0	0	0	0	0	0	0	0	0	(58,981)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(352,931)	203,363	0	0	0	0	0	0	0	0	(149,568)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(43,530)	191,222	104,191	0	0	0	0	0	0	0	0	251,883	21
22	Employee Benefits & Payroll Taxes	0	33,687	0	0	0	0	0	0	0	0	0	33,687	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,037	0	0	0	0	0	0	0	0	0	2,037	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	2,907	0	0	0	0	0	0	0	0	0	2,907	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(43,530)	(123,078)	307,554	0	0	0	0	0	0	0	0	140,946	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(43,533)	(195,177)	307,554	0	0	0	0	0	0	0	0	68,844	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PARKSHORE ESTATES NRSG & REH **#** 0051375 **Report Period Beginning:** 1/1/15 **Ending:** 12/31/15

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	136,655	0	789,911	0	0	0	0	0	0	0	0	926,566	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(60,662)	0	813,599	0	0	0	0	0	0	0	0	752,937	32
33	Real Estate Taxes	0	4,275	60,000	0	0	0	0	0	0	0	0	64,275	33
34	Rent-Facility & Grounds	0	6,178	(1,935,754)	0	0	0	0	0	0	0	0	(1,929,576)	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	75,993	10,453	(272,244)	0	0	0	0	0	0	0	0	(185,798)	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):*	(370,000)	0	0	0	0	0	0	0	0	0	0	(370,000)	43
44	TOTAL Special Cost Centers	(370,000)	0	0	0	0	0	0	0	0	0	0	(370,000)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(337,540)	(184,724)	35,310	0	0	0	0	0	0	0	0	(486,954)	45

Facility Name & ID Number PARKSHORE ESTATES NRSG & REH # 0051375 Report Period Beginning: 1/1/15 Ending: 12/31/15

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Michael Blisko	40%	Ambassador Nursing & Rehab Center	Chicago	Infinity Healthcare	Hillside	Management Co.
Moishe Gubin	40%	Belhaven Nursing & Rehab Center	Chicago			
A & F Realty	20%	City View Multicare Center	Cicero			
		Continental Nursing & Rehab Center	Chicago			
		Forest View Rehab & Nursing Center	Itasca			
		Lakeview Nursing & Rehab Center	Chicago			
		Midway Neurological & Rehab Center	Bridgeview			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	$ 27,602	Infinity Healthcare Management		$ 10,323	$ (17,279)	1
2	V	10	Nursing Wages	84,578	Infinity Healthcare Management		48,844	(35,734)	2
3	V	21	Office Wages		Infinity Healthcare Management		201,463	201,463	3
4	V	5	Utilities		Infinity Healthcare Management		2,465	2,465	4
5	V	6	Maintenance		Infinity Healthcare Management		1,696	1,696	5
6	V	19	Professional Services	353,992	Infinity Healthcare Management		1,061	(352,931)	6
7	V	21	Office Expense	27,681	Infinity Healthcare Management		17,440	(10,241)	7
8	V	22	Employee Benefit	3,470	Infinity Healthcare Management		37,157	33,687	8
9	V	24	Auto/Travel Expense	678	Infinity Healthcare Management		2,715	2,037	9
10	V	26	Insurance		Infinity Healthcare Management		2,907	2,907	10
11	V	33	Property Tax		Infinity Healthcare Management		4,275	4,275	11
12	V	34	Rent		Infinity Healthcare Management		6,178	6,178	12
13	V	15	Pharmacy Consultant	23,247	Infinity Healthcare Management			(23,247)	13
14	Total			$ 521,248			$ 336,524	$ * (184,724)	14

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

Facility Name & ID Number PARKSHORE ESTATES NRSG & REH # 0051375 Report Period Beginning: 1/1/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 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)	
15	V	33	Property Tax	$	Parkshore Estates Nursing Realty		$ 60,000	$ 60,000	15
16	V	34	Rent	2,151,504	Parkshore Estates Nursing Realty		215,750	(1,935,754)	16
17	V	19	Professional Fees		Parkshore Estates Nursing Realty		203,363	203,363	17
18	V	21	Office Expense		Parkshore Estates Nursing Realty		104,191	104,191	18
19	V	30	Depreciation		Parkshore Estates Nursing Realty		789,911	789,911	19
20	V	32	Interest		Parkshore Estates Nursing Realty		813,599	813,599	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,151,504			$ 2,186,814	$ * 35,310	39

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

Facility Name & ID Number PARKSHORE ESTATES NRSG & REH # 0051375 Report Period Beginning: 1/1/15 Ending: 12/31/15

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Momence Meadows Nursing & Rehab Ctr	Momence				1
2			Niles Nursing & Rehab Center	Niles				2
3			Oak Lawn Respiratory & Rehab Center	Oak Lawn				3
4			Parker Nursing & Rehab Center	Streator				4
5			Southpoint Nursing & Rehab Center	Chicago				5
6			West Suburban Nursing & Rehab Center	Bloomingdale				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 NRSG & REH # 0051375 Report Period Beginning: 1/1/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

	1	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 NRSG & REH # 0051375 Report Period Beginning: 1/1/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [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 NRSG & REH # 0051375 Report Period Beginning: 1/1/15 Ending: 12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	SPA		x	property	various	1/28/15	$ 4,892,000	$ 4,601,829	1/28/25	7.0000	$ 185,122	1
2	Midwest Bank		x	property	various	2/5/15	16,000,000	15,622,900	2/1/18	7.3500	628,477	2
3												3
4												4
5												5
	Working Capital											
6	Capital One		x	working capital	none	8/31/14	15,000,000	1,736,510	8/31/18	2.9500	63,329	6
7	Infinity Funding	x		working capital	none	various	various	1,813,347	none	various	66,132	7
8												8
9	TOTAL Facility Related						$ 35,892,000	$ 23,774,586			$ 943,060	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 35,892,000	$ 23,774,586			$ 943,060	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 NRSG & REH # 0051375 Report Period Beginning: 1/1/15 Ending: 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ (91,501)	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.)		$ 379,646	2
3. Under or (over) accrual (line 2 minus line 1).		$ 471,147	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 22,023	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.		$ 493,170	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	331,059	8
	2011	306,337	9
	2012	386,276	10
	2013	366,930	11
	2014	379,646	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PARKSHORE ESTATES NRSG & REH COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0051375

CONTACT PERSON REGARDING THIS REPORT Daniel S. Gaafar

TELEPHONE 317 237-5500 FAX #: 317 235-5503

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	20-14-408-015-0000	NURSING HOME	$ 3,112.41	$ 3,112.41
2.	20-14-408-016-0000	NURSING HOME	$ 3,043.79	$ 3,043.79
3.	20-14-408-017-0000	NURSING HOME	$ 1,506.41	$ 1,506.41
4.	20-14-409-004-0000	NURSING HOME	$ 91,638.54	$ 91,638.54
5.	20-14-409-005-0000	NURSING HOME	$ 275,020.67	$ 275,020.67
6.	20-14-409-006-0000	NURSING HOME	$ 5,324.60	$ 5,324.60
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 379,646.42	$ 379,646.42

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 X _____ 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

Facility Name & ID Number PARKSHORE ESTATES NRSG & REH # 0051375 Report Period Beginning: 1/1/15 Ending: 12/31/15

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).

None

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

1. Total Amount Incurred: 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			2015	$ 500,000	1
2					2
3	TOTALS			$ 500,000	3

Facility Name & ID Number PARKSHORE ESTATES NRSG & REH # 0051375 Report Period Beginning: 1/1/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 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		2015		$ 19,884,200	$ 467,368	39	$ 509,851	$ 42,483	$ 467,368	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	DOOR SCREEN			2011	1,875	48	39	48		228	9
10	NEW LIGHT FIXTURES FOR FACILITY			2011	28,695	736	39	736		3,495	10
11	CEILING TILE			2011	1,361	35	39	35		166	11
12	FENCE			2011	2,971	76	39	76		361	12
13	CEMENT FOR HANDICAP RAMP			2011	8,000	205	39	205		974	13
14	COUNTERTOPS, CEILING TILE, CROWN MOLDING,										14
15	MINI BLINDS, LED STRIP LIGHT, W.A.C. LIGHTING, TILE										15
16	FLOORING, WOOD PANELING, HAND RAILS, WALL										16
17	COVERING, PARTITION, DOUBLE DOOR, VINYL BASE										17
18	VINYL FLOORING, VINYL WALL BASE, LAMINATE PANELS										18
19	FOR LOBBY, PHYSICAL THERAPY ROOM, AND ELEVATOR			2011	57,107	1,464	39	1,464		6,955	19
20											20
21	PLUMBING AND DRYWALL IN 6TH FLOOR DIALYSIS ROOM			2012	8,246	211	39	211		845	21
22	DOOR LOCK SYSTEM ON LOBBY DOOR			2012	2,851	73	39	73		292	22
23	FLOORING & WALLS ON 1ST FLOOR THERAPY ROOMS			2012	11,274	289	39	289		1,156	23
24	FLORING & WALLS IN MAIN LOBBY			2012	11,274	289	39	289		1,156	24
25	INSTALL SPRINKLER SYSTEM			2012	4,775	122	39	122		489	25
26											26
27	EIDCO CREDIT??			2012	(57,107)	(1,464)	39	(1,464)		(5,857)	27
28	REMOVE WALLPAPER, PRIME, PAINT ON 1ST FLOOR ADMIN OF			2012	4,500	115	39	115		461	28
29	ROOFING REPAIR			2012	1,200	31	39	31		124	29
30	REPAIR FOUNDATIONAL CRACKS			2012	2,600	67	39	67		267	30
31	INSTALLATION OF FIRE ALARM SYSTEM			2012	17,990	461	39	461		1,845	31
32	REMOVE CARPETING AND INSTALL NEW FLOOR ON 1ST FLOOR			2012	1,165	30	39	30		120	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			2012	12,000	308	39	308		1,231	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number PARKSHORE ESTATES NRSG & REH # 0051375 Report Period Beginning: 1/1/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 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	2012	$ 2,929	$ 75	39	$ 75	$	$ 300	37
38									38
39	INSTALL SIGN AND MOUNT ON WALL	2012	1,150	29	39	29		117	39
40									40
41	1ST FLOOR LOBBY/RECEPTION - NEW FLOORING, NEW								41
42	COUNTERS, LIGHTING, PAINT AND CROWN MOLDING,								42
43	WALLCOVERINGS & BLINDS								43
44	1ST FLOOR ELEVATOR LOBBY - LIGHTING, TILE								44
45	FLOORING, WALL BASE, RAILINGS, WALLCOVERINGS								45
46	1ST FLOOR NEW PT ROOM - FLOORING, LIGHTING								46
47	GLASS DOOR, VINYL BASE, PAINT	2012	117,214	3,005	39	3,005		12,023	47
48	Toshiba phone system	2012	21,732	557	39	557		1,393	48
49	3rd floor corridor floor & cove base, wall coverings, nurses	2013	116,909	2,998	39	2,998		7,495	49
50	station counter top & lighting, dining room floor & cove base,								50
51	lighting, common area and resident room signage								51
52	Fire alarm	2013	2,721	70	39	70		175	52
53	Durolast roofing system	2013	68,800	1,764	39	1,764		4,410	53
54	Storage room & locks	2013	4,716	121	39	121		302	54
55	Sign / logo / Lettering	2013	1,150	29	39	29		73	55
56	Awning support posts	2013	5,100	131	39	131		327	56
57	Awning support posts	2013	1,000	26	39	26		65	57
58	Permits	2013	1,650	42	39	42		105	58
59	Building cooling tower	2013	2,275	58	39	58		145	59
60	Electrical Wiring on 6th floor for WAP at nurses station and kiosk	2013	17,985	461	39	461		1,153	60
61	Electrical Wiring & lighting - 3rd floor dialysis & nurses station	2013	4,610	118	39	118		295	61
62	Masonry on outide of building	2013	114,600	2,938	39	2,938		77,428	62
63	Water Heaters	2014	23,900	613	39	613		1,226	63
64	Doors	2014	5,939	152	39	152		304	64
65	Paint every hallway and the dining room on 3rd floor	2014	18,825	483	39	483		966	65
66	Fire Doors in laundry & therapy	2014	4,459	114	39	114		228	66
67	Elevator mainenance	2014	2,575	66	39	66		132	67
68	Remover Adv Medical from 2013	2014	(2,275)	(58)	39	(58)		(116)	68
69	Flat Scan & monitor module	2014	4,047	104	39	104		208	69
70	TOTAL (lines 4 thru 69)		$ 20,546,987	$ 484,360		$ 526,843	$ 42,483	$ 590,430	70

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

Facility Name & ID Number PARKSHORE ESTATES NRSG & REH # 0051375 Report Period Beginning: 1/1/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 20,546,987	$ 484,360		$ 526,843	$ 42,483	$ 590,430	1
2	New Passage Lever Door Locks	2015	8,316		39	213	213		2
3	Replaced A/C Cooling Tower	2015	18,460		39	473	473		3
4	Add Scale Remover to Cooling Tower	2015	4,190		39	107	107		4
5	New walls, tile, and flooring in Shower Room	2015	7,342	188	39	188		188	5
6	New walls, tile, & flooring 2nd & 4th Floor Shower Room	2015	6,253	160	39	160		160	6
7	Replaced Exhaust Fan Motors	2015	5,006	128	39	128		128	7
8	Replaced Exhaust Fan	2015	8,737	224	39	224		224	8
9	Replaced A/C Control Unit	2015	7,210	185	39	185		185	9
10	Remodeled 5th Floor Shower Room	2015	6,814	175	39	175		175	10
11	Plumberex Sink Covers	2015	5,151	132	39	132		132	11
12	New Passage Lever Door Locks	2015	2,626	67	39	67		67	12
13	New Passage Lever Door Locks	2015	5,711	146	39	146		146	13
14	Tuck Pointing and Spalled Brick Repairs to the Building	2015	8,000	226	39	205	(21)	226	14
15	Clean, Sealcoat, Repave, and Restripe Parking Lot	2015	36,815	944	39	944		944	15
16	Installation of New Flooring and Door Thresholds	2015	11,298	290	39	290		290	16
17	Install Door Restrictors for Elevators	2015	5,500	225	39	141	(84)	141	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 20,694,415	$ 487,450		$ 530,621	$ 43,171	$ 593,436	34

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

Facility Name & ID Number PARKSHORE ESTATES NRSG & REH # 0051375 Report Period Beginning: 1/1/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 302,955	$ 19,807	$ 60,591	$ 40,784	5	$ 282,065	71
72	Current Year Purchases	2,353,199	417,941	470,640	52,699	5	417,941	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,656,154	$ 437,748	$ 531,231	$ 93,483		$ 700,006	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)	$ 23,850,569	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 925,198	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 1,061,852	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 136,654	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,293,442	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 NRSG & REH # 0051375 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	$ 215,750	10		3
4	Additions							4
5								5
6								6
7	TOTAL		318		$ 215,750 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
   This amount was calculated by dividing the total amount to be amortized N/A
   by the length of the lease N/A .

9. Option to Buy: [ ] YES [X] NO Terms: _____ *

10. Effective dates of current rental agreement:
    Beginning 4/1/11
    Ending 3/31/21

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

	Fiscal Year Ending	Annual Rent
12.		$
13.		$
14.		$

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 NRSG & REH # 0051375 Report Period Beginning: 1/1/15 Ending: 12/31/15

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 NRSG & REH # 0051375 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	$	5,806	$ 319,447	$	5,806	$ 319,447	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		1,915	134,359		1,915	134,359	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		4,507	276,015		4,507	276,015	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				173,505		173,505	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): radiology	39-2					9,103		9,103	12
13	Other (specify): laboratory	39-2					11,232		11,232	13
14	TOTAL			$	12,228	$ 729,821	$ 193,840	12,228	$ 923,661	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.

STATE OF ILLINOIS

Facility Name & ID Number PARKSHORE ESTATES NRSG & REH # 0051375 Report Period Beginning: 1/1/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (234,037)	$ 104,268	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,695,077	3,695,077	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	305,137	305,137	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		200,300	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,766,177	$ 4,304,782	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		500,000	13
14	Buildings, at Historical Cost		19,884,200	14
15	Leasehold Improvements, at Historical Cost	699,716	699,716	15
16	Equipment, at Historical Cost	512,953	2,770,753	16
17	Accumulated Depreciation (book methods)	(503,622)	(1,293,532)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		98,140	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 709,047	$ 22,659,277	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,475,224	$ 26,964,059	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,250,577	$ 1,721,605	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	29,141	29,141	28
29	Short-Term Notes Payable		823,756	29
30	Accrued Salaries Payable	254,370	254,370	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,094	27,094	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		57,299	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	working capital	1,736,510	1,736,510	36
37	working capital	1,813,347	1,813,347	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,111,039	$ 6,463,122	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		19,400,973	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)**	$	$ 19,400,973	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,111,039	$ 25,864,095	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (635,815)	$ 1,099,964	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,475,224	$ 26,964,059	48

***(See instructions.)**

Facility Name & ID Number PARKSHORE ESTATES NRSG & REH # 0051375 Report Period Beginning: 1/1/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,435,579)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,435,579)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	929,765	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	(130,001)	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)**	$ 799,764	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)**	$ (635,815)	24	*

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

Facility Name & ID Number PARKSHORE ESTATES NRSG & REH # 0051375 Report Period Beginning: 1/1/15 Ending: 12/31/15

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,438,909	1
2	Discounts and Allowances for all Levels	10,883	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,449,792	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	846,253	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 846,253	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	92,994	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	260	19
20	Radiology and X-Ray	574	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 93,828	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	60,654	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 60,654	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Miscellaneous Income	27,979	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 27,979	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,478,506	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,961,715	31
32	Health Care	5,172,914	32
33	General Administration	2,377,860	33
	B. Capital Expense		
34	Ownership	2,845,146	34
	C. Ancillary Expense		
35	Special Cost Centers	201,626	35
36	Provider Participation Fee	619,480	36
	D. Other Expenses (specify):		
37	Bad Debt	370,000	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,548,741	40
41	**Income before Income Taxes (line 30 minus line 40)****	929,765	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 929,765	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 10,452,597	44
45	Private Pay - Net Inpatient Revenue	13,262	45
46	Medicare - Net Inpatient Revenue	1,493,013	46
47	Other-(specify)	1,490,920	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 13,449,792	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 NRSG & REH # 0051375 Report Period Beginning: 1/1/15 Ending: 12/31/15

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,274	1,753	$ 87,984	$ 50.19	1
2	Assistant Director of Nursing	8,066	9,647	340,368	35.28	2
3	Registered Nurses	12,300	13,910	431,634	31.03	3
4	Licensed Practical Nurses	36,899	43,435	1,154,383	26.58	4
5	CNAs & Orderlies	114,922	128,185	1,416,787	11.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	12,221	14,540	177,419	12.20	9
10	Activity Assistants					10
11	Social Service Workers	11,338	12,387	216,186	17.45	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,877	33,167	402,490	12.14	15
16	Dishwashers					16
17	Maintenance Workers	6,249	6,671	104,401	15.65	17
18	Housekeepers	18,551	20,305	232,596	11.46	18
19	Laundry	10,180	11,427	118,334	10.36	19
20	Administrator	2,672	2,907	124,137	42.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,977	14,719	229,735	15.61	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,012	2,368	35,990	15.20	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	279,538	315,421	$ 5,072,444 *	$ 16.08	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	789	$ 27,602	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	1,321	46,242	10-3	38
39	Pharmacist Consultant	465	23,247	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	320	16,000	10A-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	99	3,464	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,994	$ 116,555		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 NRSG & REH # 0051375 Report Period Beginning: 1/1/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Thomeka Brown	Administrator		$ 124,137
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 124,137

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
Bradley Associates	Accounting	$ 8,245
Johnson, Goldburg & Brown	Accounting	2,500
Lewis Brisbois Bisgarard & Smith	Legal	5,383
Polsinelli PC	Legal	4,704
Leahy Eisenberg & Fraenkel	Legal	29,249
Global Recovery Services	Legal	50,000
Meyer Magence	Legal	1,072
Infinity	Mgmt/Professional	384,120
Various	Professional	3,750
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 489,023

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 179,565
Unemployment Compensation Insurance	147,018
FICA Taxes	359,438
Employee Health Insurance	161,075
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniform Expense	10,962
Employee Expense	20,856
TOTAL (agree to Schedule V, line 22, col.8)	$ 878,914

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	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
City of Chicago	1,310
IHCA	1,076
various	894
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,280

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
mileage	4,276
Seminar Expense	
education	125
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,401

**See instructions.

Facility Name & ID Number PARKSHORE ESTATES NRSG & REH # 0051375 Report Period Beginning: 1/1/15 Ending: 12/31/15

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 NRSG & REH # 0051375 Report Period Beginning: 1/1/15 Ending: 12/31/15

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council $1,076**

(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. $ **34,022** 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. $ **619,480**
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 of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.