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: 0047886

Facility Name: Parkway Manor

Address: 3116 Williamson Cnty (Number) — Marion (City) — 62959 (Zip Code)

County: Williamson

Telephone Number: (618) 993-8600 **Fax #** (618) 993-5887

HFS ID Number:

Date of Initial License for Current Owners: 03/01/06

Type of Ownership:

X	VOLUNTARY,NON-PROFIT
X	Charitable Corp.
	Trust

IRS Exemption Code 501 (c) (3)

	PROPRIETARY
	Individual
	Partnership
	Corporation
	"Sub-S" Corp.
	Limited Liability Co.
	Trust
	Other

	GOVERNMENTAL
	State
	County
	Other

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/14 to 9/30/15 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)	Matt Hails
	(Title)	LTC CEO
Paid Preparer	(Signed)	See Preparation Report (Date)
	(Print Name and Title)	RSM US LLP 117 E. Main St., Suite 210
	(Firm Name & Address)	P.O. Box 1070 Galesburg, IL 61401
	(Telephone)	(309) 342-1175 Fax # (309) 342-7816

In the event there are further questions about this report, please contact:
Name: Ron Wilson Telephone Number: (309) 343-1550
Email Address:

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 Parkway Manor # 0047886 Report Period Beginning: 10/1/14 Ending: 9/30/15

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	131	Skilled (SNF)	131	47,815	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	131	TOTALS	131	47,815	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	8,121	12,650	17,249	38,020	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,121	12,650	17,249	38,020	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.51%

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 03/01/06

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/01/06 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 131 and days of care provided 13,576

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 9/30/15 Fiscal Year: 9/30/15

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

Facility Name & ID Number Parkway Manor # 0047886 Report Period Beginning: 10/1/14 Ending: 9/30/15

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	281,295	35,331	19,226	335,852		335,852	(44,290)	291,562			1
2	Food Purchase		418,051		418,051		418,051	(58,992)	359,059			2
3	Housekeeping	221,560	46,586		268,146		268,146	(30,801)	237,345			3
4	Laundry	57,009	24,856		81,865		81,865	(9,346)	72,519			4
5	Heat and Other Utilities			215,375	215,375		215,375	(23,082)	192,293			5
6	Maintenance	76,207	42,998	123,059	242,264		242,264	(27,827)	214,437			6
7	Other (specify):*											7
8	**TOTAL General Services**	636,071	567,822	357,660	1,561,553		1,561,553	(194,338)	1,367,215			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	3,238,865	927,737	8,783	4,175,385		4,175,385	(151,536)	4,023,849			10
10a	Therapy	1,406,994		58,868	1,465,862		1,465,862		1,465,862			10a
11	Activities	86,265	3,999		90,264		90,264	(22,566)	67,698			11
12	Social Services	58,489			58,489		58,489		58,489			12
13	CNA Training			900	900		900		900			13
14	Program Transportation			1,079	1,079	2,740	3,819		3,819			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,790,613	931,736	69,630	5,791,979	2,740	5,794,719	(174,102)	5,620,617			16
	C. General Administration											
17	Administrative	126,885			126,885		126,885		126,885			17
18	Directors Fees							3,220	3,220			18
19	Professional Services			372,793	372,793		372,793	4,219	377,012			19
20	Dues, Fees, Subscriptions & Promotions			183,442	183,442		183,442	(155,201)	28,241			20
21	Clerical & General Office Expenses	91,484	66,239	59,575	217,298		217,298	(1,890)	215,408			21
22	Employee Benefits & Payroll Taxes			848,039	848,039		848,039	(37,666)	810,373			22
23	Inservice Training & Education			12,791	12,791		12,791		12,791			23
24	Travel and Seminar			1,853	1,853		1,853		1,853			24
25	Other Admin. Staff Transportation			5,479	5,479	(2,740)	2,739	(414)	2,325			25
26	Insurance-Prop.Liab.Malpractice			75,426	75,426		75,426	43,629	119,055			26
27	Other (specify):* See Att Sch V	54,837		586,381	641,218		641,218	(641,218)				27
28	**TOTAL General Administration**	273,206	66,239	2,145,779	2,485,224	(2,740)	2,482,484	(785,321)	1,697,163			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,699,890	1,565,797	2,573,069	9,838,756		9,838,756	(1,153,761)	8,684,995			29

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			165,880	165,880		165,880	461,342	627,222			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							262,889	262,889			32
33	Real Estate Taxes							114,946	114,946			33
34	Rent-Facility & Grounds			697,356	697,356		697,356	(697,356)				34
35	Rent-Equipment & Vehicles			6,820	6,820		6,820		6,820			35
36	Other (specify):*											36
37	TOTAL Ownership			870,056	870,056		870,056	141,821	1,011,877			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			165,128	165,128		165,128		165,128			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			4,875	4,875		4,875		4,875			41
42	Provider Participation Fee			205,828	205,828		205,828		205,828			42
43	Other (specify):* Outpatient Care			10,637	10,637		10,637		10,637			43
44	TOTAL Special Cost Centers			386,468	386,468		386,468		386,468			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,699,890	1,565,797	3,829,593	11,095,280		11,095,280	(1,011,940)	10,083,340			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 Parkway Manor # 0047886 Report Period Beginning: 10/1/14 Ending: 9/30/15

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	(568)	V-2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		V-30		9
10	Interest and Other Investment Income	(2,694)	V-32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties		V-21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(585,721)	V-27		24
25	Fund Raising, Advertising and Promotional	(154,692)	V-20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Att Sch VI	(562,983)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,306,658)		$	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)	283,766		34
35	Other- Attach Schedule	10,952		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 294,718		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,011,940)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Parkway Manor

ID# 0047886

Report Period Beginning: 10/1/14

Ending: 9/30/15

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

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Parkway Manor # 0047886 Report Period Beginning: 10/1/14 Ending: 9/30/15

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

	Operating Expenses A. General Services	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)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Parkway Manor # 0047886 Report Period Beginning: 10/1/14 Ending: 9/30/15

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	283,766	0	0	0	0	0	0	0	0	0	283,766	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	283,766	0	0	0	0	0	0	0	0	0	283,766	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	283,766	0	0	0	0	0	0	0	0	0	283,766	45

Facility Name & ID Number Parkway Manor # 0047886 Report Period Beginning: 10/1/14 Ending: 9/30/15

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
None	N/A	Unlimited Development, Inc (UDI)		See Attached Schedule I		
		Community Living Options, Inc. (CLO)				
		See Attached Schedule I for specific homes & other CLO subsidiaries				

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Facility Rent	$ 697,356	Marion Williamson County Parkway, LLC	N/A	$ 981,122	$ 283,766	1
2	V								2
3	V				See Att Schedule IV and Preparation Report				3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 697,356			$ 981,122	$ * 283,766	14

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

Facility Name & ID Number Parkway Manor # 0047886 Report Period Beginning: 10/1/14 Ending: 9/30/15

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								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 Parkway Manor # 0047886 Report Period Beginning: 10/1/14 Ending: 9/30/15

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	See Attached Schedule II & III								$ 3,220	18-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 3,220		13

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

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

Facility Name & ID Number Parkway Manor # 0047886 Report Period Beginning: 10/1/14 Ending: 9/30/15

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2		See Att Sch II & III							10,952	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					$	$		$ 10,952	25

Facility Name & ID Number Parkway Manor # 0047886 Report Period Beginning: 10/1/14 Ending: 9/30/15

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	Cambridge Realty Capital						$	$			$	1
2	LTD. Of Illinois		X	Facility purchase	$32,468.00	6/1/12	7,801,200	7,424,160	7/1/2047	3.5500	265,583	2
3				SNF portion								3
4												4
5												5
	Working Capital											
6	Miscellaneous		X									6
7	Less Interest Income		X								(2,694)	7
8												8
9	TOTAL Facility Related				$32,468.00		$ 7,801,200	$ 7,424,160			$ 262,889	9
	B. Non-Facility Related*											
10	Cambridge Realty Capital											10
11	LTD. Of Illinois		X	Facility purchase	$4,427.00	6/1/12	1,063,800	1,012,386	7/1/2047	3.5500	36,216	11
12				ALC portion								12
13												13
14	TOTAL Non-Facility Related				$4,427.00		$ 1,063,800	$ 1,012,386			$ 36,216	14
15	TOTALS (line 9+line14)						$ 8,865,000	$ 8,436,546			$ 299,105	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 42,443 Line # 26

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

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

Facility Name & ID Number Parkway Manor # 0047886 Report Period Beginning: 10/1/14 Ending: 9/30/15

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Item		Amount	Line
1. Real Estate Tax accrual used on 2014 report.	$	93,493	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.)	$	127,916	2
3. Under or (over) accrual (line 2 minus line 1).	$	34,423	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	$	96,197	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.	$	130,620	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2010	120,165	8
2011	114,603	9
2012	121,074	10
2013	123,541	11
2014	127,916	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

This facility was purchased from an unrelated for-profit entity during 2006. A tax exemption has not yet been obtained
Amount accrued includes the taxes for 9 months based on fiscal year end. Estimate is based on prior year tax bill
Real estate taxes reported on Sch V line 33 have been reduced by an allocation of expenses relating to ALC
services based on as estimated 12%. See Att Sch VI. Taxes paid during year represents the entire 2014 bill

NOTES:

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

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Parkway Manor COUNTY Williamson

FACILITY IDPH LICENSE NUMBER 0047886

CONTACT PERSON REGARDING THIS REPORT

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

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

Enter the tax index number and real estate tax assessed for 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)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	06-10-301-042	RE-SUB OF PARCELS E, G & J	$ 126,797.34	$ 111,581.66
2.		OF IL CENTRE SUB. BE PT OF	$	$
3.		PARCEL E, THE WEST 3.93	$	$
4.		AC OF THE E 6.60	$	$
5.	06-10-100-014	E 595' OF S 141' OF SW1/4 +	$ 932.00	$ 820.16
6.		W 173' OF S 141' C SE1/4	$	$
7.	06-10-100-018	E 594.35' OF W 1346.1' OF N 30'	$ 186.86	$ 164.44
8.		OF S 171.44' OF SW 1/4 + N 30'	$	$
9.		OF S 171.44' OF W 175.59' OF	$	$
10.		SE 1/4	$	$
		TOTALS	$ 127,916.20	$ 112,566.26

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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 Parkway Manor # 0047886 Report Period Beginning: 10/1/14 Ending: 9/30/15

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Parkway Manor # 0047886 Report Period Beginning: 10/1/14 Ending: 9/30/15

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	119		2006	1995	$ 9,095,197	$ 227,380	40	$ 227,380	$	$ 2,179,058	4
5	12		2013	2013	4,062,647	101,566	40	101,566		186,204	5
6											6
7											7
8											8
	Improvement Type**										
9	Landscaping			2006	7,930	793	10	793		7,600	9
10	Water Heaters, Carpet, Blacktop, Bus. Office remodel, carpet, PT Additio			2008	151,430	5,625	5-25 yrs	5,625		73,315	10
11	Shower Rooms, Water Meter, ReRoof, Roof Repairs			2009	211,630	17,306	10-20 yrs	17,306		104,423	11
12	Cabinets, Water Heater, New Front Windows/Varnish			2010	28,618	2,050	10-15 yrs	2,050		11,419	12
13	Activity Room remodel-Carpet/Window coverings			2010	3,841	448	5	448		3,841	13
14	Water Heater			2013	3,910	390	10	390		977	14
15	Concrete sidewalk			2013	26,295	1,752	15	1,752		3,797	15
16	Workstation			2013	5,868	586	10	586		1,222	16
17	Land Improvements-Parkway Manor Addition (contracted total)			2013	854,000	56,933	15	56,933		104,377	17
18	Nurse Call System			2013	14,101	1,410	10	1,410		2,585	18
19	Bally Freezer			2014	19,993	1,999	10	1,999		2,999	19
20	Double Faced Sign With Message Board			2014	46,503	4,650	10	4,650		6,588	20
21	Condensing Unit in Walk In Freezer			2014	3,551	237	15	237		316	21
22	Remodel-3 Wings: Tile/Wallpaper/Paint/Fixtures/Furniture/Therapy Equ			2014	601,947	50,162	12	50,162		54,342	22
23	Landscaping			2014	18,412	1,841	10	1,841		2,455	23
24	Water Heater			2014	3,160	263	10	263		263	24
25	Remodel-Tile/Wallpaper/Paint/Fixtures/Furniture/Therapy equip			2015	371,408	15,475	12	15,475		15,475	25
26	Workstation-Counter/Cabinets/Chair			2015	3,588	249	12	249		249	26
27	Surge Protector			2015	28,523	158	15	158		158	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Parkway Manor # 0047886 Report Period Beginning: 10/1/14 Ending: 9/30/15

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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 15,562,552	$ 491,273		$ 491,273	$	$ 2,761,663	70

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

Facility Name & ID Number Parkway Manor # 0047886 Report Period Beginning: 10/1/14 Ending: 9/30/15

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	$ 1,249,976	$ 124,609	124,609	$ 0	3-15 yrs	$ 699,354	71
72	Current Year Purchases	5,357	845	845	0	5 yrs	845	72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	$ 1,255,333	$ 125,454	$ 125,454	$ 0		$ 700,199	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2014 Braun Entervan	2014	$ 41,984	$ 10,495	$ 10,495	$ 0	4 yrs	$ 14,868	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 41,984	$ 10,495	$ 10,495	$ 0		$ 14,868	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)	$ 17,425,190	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 627,222	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 627,222	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,476,730	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	2006 Toyota Corolla - 2006	$ 14,900	$	$ 14,900	86
87	Land ALC - 2006	56,400			87
88	Facility ALC - 2006	1,240,254	31,006	297,144	88
89	2003 GMC G3500 Van - 2006	29,848		29,848	89
90					90
91	TOTALS	$ 1,341,402	$ 31,006	$ 341,892	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 Parkway Manor # 0047886 Report Period Beginning: 10/1/14 Ending: 9/30/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Marion Williamson County Parkway, LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [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:				$ See Attached			3
4	Additions				Schedule IV			4
5					Related Party			5
6					Lease			6
7	TOTAL				$ **			7

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2016	$ N/A
13.	/2017	$ N/A
14.	/2018	$ N/A

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 [ ] NO Terms: N/A *

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 6,820 Description: See Attached Schedule XII
(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 Parkway Manor # 0047886 Report Period Beginning: 10/1/14 Ending: 9/30/15

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	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

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.

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

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

Facility Name & ID Number Parkway Manor # 0047886 Report Period Beginning: 10/1/14 Ending: 9/30/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9/30/15 (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	$	$ 47,040	1
2	Cash-Patient Deposits	4,663	4,663	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 438,000)	2,244,371	2,244,371	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	149,514	202,630	6
7	Other Prepaid Expenses	4,320	4,320	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Att Sch VII	7,556,508	7,587,684	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 9,959,376	$ 10,090,708	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		621,721	13
14	Buildings, at Historical Cost	18,412	15,270,510	14
15	Leasehold Improvements, at Historical Cost	1,532,296	1,532,296	15
16	Equipment, at Historical Cost	587,398	1,342,065	16
17	Accumulated Depreciation (book methods)	(595,220)	(3,818,622)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Att Sch VII		521,871	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,542,886	$ 15,469,841	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,502,262	$ 25,560,549	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 550,832	$ 551,732	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,663	4,663	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	143,052	143,052	30
31	Accrued Taxes Payable (excluding real estate taxes)	81,285	81,285	31
32	Accrued Real Estate Taxes(Sch.IX-B)		96,197	32
33	Accrued Interest Payable	3,780	28,738	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Interdivision Payable		7,897,364	36
37	See Att Sch VII		145,602	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 783,612	$ 8,948,633	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,290,944	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Securty Deposits	67,320	67,320	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 67,320	$ 8,358,264	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 850,932	$ 17,306,897	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 10,651,330	$ 8,253,652	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,502,262	$ 25,560,549	48

*(See instructions.)

Facility Name & ID Number Parkway Manor # 0047886 Report Period Beginning: 10/1/14 Ending: 9/30/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 10,429,114	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 10,429,114	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	222,216	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 222,216	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)**	$ 10,651,330	24 *

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

Facility Name & ID Number Parkway Manor # 0047886 Report Period Beginning: 10/1/14 Ending: 9/30/15

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	$ 11,047,391	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,047,391	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	247,331	6
7	Oxygen	6,299	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 253,630	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	831	12
13	Barber and Beauty Care	1,378	13
14	Non-Patient Meals	568	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	3,526	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22	19
20	Radiology and X-Ray	169	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 6,494	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,694	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,694	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Durable Medical Equipment	7,167	28
28a	Miscellaneous Income	120	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,287	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,317,496	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,561,553	31
32	Health Care	5,791,979	32
33	General Administration	2,485,224	33
	B. Capital Expense		
34	Ownership	870,056	34
	C. Ancillary Expense		
35	Special Cost Centers	180,640	35
36	Provider Participation Fee	205,828	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,095,280	40
41	**Income before Income Taxes (line 30 minus line 40)****	222,216	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 222,216	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,119,744	44
45	Private Pay - Net Inpatient Revenue	2,308,417	45
46	Medicare - Net Inpatient Revenue	5,718,918	46
47	Other-(specify) Assited Living	724,635	47
48	Other-(specify) See Att Schedule XI	1,175,677	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,047,391	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.

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,908	2,080	$ 99,030	$ 47.61	1
2	Assistant Director of Nursing	1,952	2,080	60,786	29.22	2
3	Registered Nurses	23,858	25,246	657,821	26.06	3
4	Licensed Practical Nurses	34,307	36,033	698,206	19.38	4
5	CNAs & Orderlies	127,458	133,163	1,474,818	11.08	5
6	CNA Trainees					6
7	Licensed Therapist	13,864	14,696	799,541	54.41	7
8	Rehab/Therapy Aides	24,041	25,546	607,453	23.78	8
9	Activity Director					9
10	Activity Assistants	8,448	9,017	86,265	9.57	10
11	Social Service Workers	4,490	4,714	58,489	12.41	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,418	28,725	281,295	9.79	15
16	Dishwashers					16
17	Maintenance Workers	7,645	8,105	76,207	9.40	17
18	Housekeepers	20,941	22,362	221,560	9.91	18
19	Laundry	5,869	6,517	57,009	8.75	19
20	Administrator	1,888	2,080	87,672	42.15	20
21	Assistant Administrator	1,904	2,080	39,213	18.85	21
22	Other Administrative	1,896	2,080	54,837	26.36	22
23	Office Manager					23
24	Clerical	6,950	7,389	91,484	12.38	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,864	1,880	36,083	19.19	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,555	2,680	29,932	11.17	31
32	Other Health Care(specify)	7,960	8,627	182,189	21.12	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	327,216	345,100	$ 5,699,890 *	$ 16.52	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	***	$ 19,226	1-3	35
36	Medical Director	***	0	9-3	36
37	Medical Records Consultant	***	1,737	10-3	37
38	Nurse Consultant	***	0	10-3	38
39	Pharmacist Consultant	***	7,046	10-3	39
40	Physical Therapy Consultant	***	0	10a-3	40
41	Occupational Therapy Consultant	***	0	10a-3	41
42	Respiratory Therapy Consultant	***	58,868	10a-3	42
43	Speech Therapy Consultant	***	0	10a-3	43
44	Activity Consultant	***		11-3	44
45	Social Service Consultant	***		12-3	45
46	Other(specify)	***		10-3	46
47	***Monthly Fee				47
48					48
49	TOTAL (lines 35 - 48)		$ 86,877		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Yolanda Fisher	Administrator	None	$ 87,672
Tina Wright	Asst Admin	None	39,213
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 126,885

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
RFMS, Inc	Administrative Services	$ 171,600
RSM US LLP	Accounting Services	22,431
LTC Support Services, LLC	Support Services	177,360
Davis & Campbell LLC	Legal Services	270
Sanders & Sanders	Legal Services	288
Duane Morris, LLP	Legal Services	599
Polsinelli Shughart PC	Legal Services	245
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 372,793

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 139,295
Unemployment Compensation Insurance	38,486
FICA Taxes	430,549
Employee Health Insurance	171,415
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401 (k)	55,507
Other Employee Benefits	12,787
Less Allocation ALC - Att Sch VI	(37,666)
TOTAL (agree to Schedule V, line 22, col.8)	$ 810,373

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	7,926
Health Care Worker Background Check (Indicate # of checks performed 107)	7,859
Patient Background Checks 506	840
Advertising - Promotion	154,692
Subscriptions	1,659
IHCA Dues	6,658
Other Licenses & Fees	3,808
Ind Costs-Att Sch III, ALC-Att Sch VI	(509)
Less: Public Relations Expense	( )
Non-allowable advertising	(154,692)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,241

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Staff use of personal vehicle on facility business and meals (under $250 per travel voucher)	0
Seminar Expense	1,853
Less: non-allowable out-of-state travel	0
Indirect costs - See Att Sch III	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,853

**See instructions.

Facility Name & ID Number Parkway Manor # 0047886 Report Period Beginning: 10/1/14 Ending: 9/30/15

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
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	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 **Parkway Manor** **# 0047886** **Report Period Beginning: 10/1/14 Ending: 9/30/15**

XX. GENERAL INFORMATION:

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

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

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes-IHCA dues** If YES, have these costs been properly adjusted out of the cost report? **Yes**

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **23,176** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **205,828**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **568**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **RSM US LLP**

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

(19) 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- See Att Sch XIII**
Attach invoices and a summary of services for all architect and appraisal fees.