

		FOR BHF USE					

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**2011  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
FINANCIAL AND STATISTICAL REPORT (COST REPORT)  
FOR LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2011)**

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.

<p><b>I. IDPH License ID Number:</b> <u>0047886</u></p> <p><b>Facility Name:</b> <u>Parkway Manor</u></p> <p><b>Address:</b> <u>3116 Williamson County Parkway</u> <u>Marion</u> <u>62959</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Williamson</u></p> <p><b>Telephone Number:</b> <u>(618) 993-8600</u> <b>Fax #</b> <u>(618) 993-5887</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>03/01/06</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT  <input checked="" type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust  <b>IRS Exemption Code</b> <u>501 (c) (3)</u> </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Ron Wilson</u> <b>Telephone Number:</b> <u>(309) 343-1550</u>  <b>Email Address:</b> _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> <u>501 (c) (3)</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/10</u> to <u>9/30/11</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Tina Calhoun</u> (Title) <u>Director of Operations</u></td> </tr> <tr> <td style="width:20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) <u>See Attached Independent Accountant's Report</u> (Print Name and Title) <u>McGladrey &amp; Pullen, LLP</u> <u>117 E. Main St., Suite 210</u> (Firm Name &amp; Address) <u>P.O. Box 1070</u> <u>Galesburg, IL 61401</u> (Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</u></td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Tina Calhoun</u> (Title) <u>Director of Operations</u>	Paid Preparer	(Signed) <u>See Attached Independent Accountant's Report</u> (Print Name and Title) <u>McGladrey &amp; Pullen, LLP</u> <u>117 E. Main St., Suite 210</u> (Firm Name & Address) <u>P.O. Box 1070</u> <u>Galesburg, IL 61401</u> (Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</u>
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Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Tina Calhoun</u> (Title) <u>Director of Operations</u>							
Paid Preparer	(Signed) <u>See Attached Independent Accountant's Report</u> (Print Name and Title) <u>McGladrey &amp; Pullen, LLP</u> <u>117 E. Main St., Suite 210</u> (Firm Name & Address) <u>P.O. Box 1070</u> <u>Galesburg, IL 61401</u> (Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</u>							

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parkway Manor

# 0047886 Report Period Beginning: 10/1/10 Ending: 9/30/11

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	<u>119</u>	Skilled (SNF)	<u>119</u>	<u>43,435</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>119</u>	TOTALS	<u>119</u>	<u>43,435</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	<u>8,096</u>	<u>12,765</u>	<u>13,424</u>	<u>34,285</u>	8
9	SNF/PED					9
10	ICF		<u>0</u>			10
11	ICF/DD					11
12	SC		<u>0</u>			12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,096</u>	<u>12,765</u>	<u>13,424</u>	<u>34,285</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.93%

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

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

I. On what date did you start providing long term care at this location?  
Date started 03/01/06

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

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 119 and days of care provided 12,846

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 9/30/11 Fiscal Year: 9/30/11

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	245,491	34,227	16,910	296,628		296,628	(47,748)	248,880		1
2	Food Purchase		351,030		351,030		351,030	(60,543)	290,487		2
3	Housekeeping	134,185	47,886		182,071		182,071	(22,759)	159,312		3
4	Laundry	78,365	29,613		107,978		107,978	(13,498)	94,480		4
5	Heat and Other Utilities			183,067	183,067		183,067	(21,892)	161,175		5
6	Maintenance	52,589	33,326	60,976	146,891		146,891	(18,362)	128,529		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	510,630	496,082	260,953	1,267,665		1,267,665	(184,802)	1,082,863		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,000	7,000		7,000		7,000		9
10	Nursing and Medical Records	2,239,750	569,558	1,228	2,810,536		2,810,536	(142,204)	2,668,332		10
10a	Therapy	880,604		81	880,685		880,685		880,685		10a
11	Activities	74,809	2,646		77,455		77,455	(19,363)	58,092		11
12	Social Services	24,750			24,750		24,750		24,750		12
13	CNA Training			900	900		900		900		13
14	Program Transportation			329	329	2,914	3,243		3,243		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	3,219,913	572,204	9,538	3,801,655	2,914	3,804,569	(161,567)	3,643,002		16
	<b>C. General Administration</b>										
17	Administrative	111,374			111,374		111,374		111,374		17
18	Directors Fees							3,353	3,353		18
19	Professional Services			359,755	359,755		359,755	(2,792)	356,963		19
20	Dues, Fees, Subscriptions & Promotions			87,366	87,366		87,366	(58,148)	29,218		20
21	Clerical & General Office Expenses	90,696	45,229	52,767	188,692		188,692	(1,512)	187,180		21
22	Employee Benefits & Payroll Taxes			639,199	639,199		639,199	(37,669)	601,530		22
23	Inservice Training & Education			7,999	7,999		7,999		7,999		23
24	Travel and Seminar			3,305	3,305		3,305		3,305		24
25	Other Admin. Staff Transportation			5,828	5,828	(2,914)	2,914	(162)	2,752		25
26	Insurance-Prop.Liab.Malpractice			49,091	49,091		49,091	38,764	87,855		26
27	Other (specify):* <u>See Att Sch V</u>	71,275		50,676	121,951		121,951	(121,951)			27
28	<b>TOTAL General Administration</b>	273,345	45,229	1,255,986	1,574,560	(2,914)	1,571,646	(180,117)	1,391,529		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,003,888	1,113,515	1,526,477	6,643,880		6,643,880	(526,486)	6,117,394		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

Parkway Manor

#0047886

Report Period Beginning:

10/1/10

Ending:

9/30/11

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			62,459	62,459		62,459	268,442	330,901			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							404,938	404,938			32
33	Real Estate Taxes			610	610		610	107,800	108,410			33
34	Rent-Facility & Grounds			846,480	846,480		846,480	(846,480)				34
35	Rent-Equipment & Vehicles			1,221	1,221		1,221		1,221			35
36	Other (specify):* See Att Sch IV							7,503	7,503			36
37	<b>TOTAL Ownership</b>			910,770	910,770		910,770	(57,797)	852,973			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			72,541	72,541		72,541		72,541			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			4,791	4,791		4,791		4,791			41
42	Provider Participation Fee			65,153	65,153		65,153		65,153			42
43	Other (specify):* Outpatient Care			650	650		650		650			43
44	<b>TOTAL Special Cost Centers</b>			143,135	143,135		143,135		143,135			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,003,888	1,113,515	2,580,382	7,697,785		7,697,785	(584,283)	7,113,502			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parkway Manor

# 0047886

Report Period Beginning:

10/1/10

Ending:

9/30/11

**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.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(762)	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	(8,933)	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	(48,487)	V-27		24
25	Fund Raising, Advertising and Promotional	(57,255)	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 XV	(580,653)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (696,090)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	105,087		34
35	Other- Attach Schedule See Att Sch III	6,720		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 111,807		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (584,283)		37

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

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

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

BHF USE ONLY							
48		49		50		51	
							52

SEE ACCOUNTANTS' COMPILATION REPORT

Parkway Manor

ID# 0047886

Report Period Beginning: 10/1/10

Ending: 9/30/11

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
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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	<b>Total</b>	0	49



## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Parkway Manor# 0047886

Report Period Beginning:

10/1/10

Ending:

9/30/11

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

	Capital Expense	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)	
	<b>D. Ownership</b>													
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	105,087	0	0	0	0	0	0	0	0	0	105,087	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	<b>TOTAL Ownership</b>	<b>0</b>	<b>105,087</b>	<b>0</b>	<b>105,087</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>0</b>	<b>105,087</b>	<b>0</b>	<b>105,087</b>	<b>45</b>								

Facility Name & ID Number

Parkway Manor

# 0047886

Report Period Beginning:

10/1/10

Ending:

9/30/11

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Facility Rent	\$ 846,480	Marion Williamson County Parkway, LLC	N/A	\$ 951,567	\$ 105,087	1
2	V							2
3	V			See Att Schedule IV and Independent Accountant's Report				3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 846,480			\$ 951,567	\$ * 105,087	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								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 &amp; ID Number

Parkway Manor

# 0047886

Report Period Beginning:

10/1/10

Ending:

9/30/11

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See Attached Schedule II & III								\$ 3,353	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	\$ 3,353		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parkway Manor

# 0047886

Report Period Beginning:

10/1/10

Ending: 9/30/11

VIII. ALLOCATION OF INDIRECT COSTS

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

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	See Att Sch II & III							6,720	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				\$	\$		\$	6,720

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Parkway Manor

# 0047886

Report Period Beginning:

10/1/10

Ending:

9/30/11

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										
										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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Cambridge Realty Capital					\$		\$		1									
2	LTD. Of Illinois		X	Facility purchase	\$42,406.00	3/1/06	7,801,200	7,346,772	4/1/2041	5.6000	413,871	2							
3				SNF portion								3							
4												4							
5												5							
<b>Working Capital</b>																			
6	Miscellaneous		X									6							
7	Less Interest Income		X								(8,933)	7							
8												8							
9	TOTAL Facility Related				\$42,406.00		\$ 7,801,200	\$ 7,346,772			\$ 404,938	9							
<b>B. Non-Facility Related*</b>																			
10	Cambridge Realty Capital											10							
11	LTD. Of Illinois		X	facility purchase	\$5,783.00	3/1/06	1,063,800	1,001,833	4/1/2041	5.6000	56,437	11							
12				ALC portion								12							
13												13							
14	TOTAL Non-Facility Related				\$5,783.00		\$ 1,063,800	\$ 1,001,833			\$ 56,437	14							
15	TOTALS (line 9+line14)						\$ 8,865,000	\$ 8,348,605			\$ 461,375	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 41,988 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2010 report.		\$	<b>92,295</b>	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.)		\$	<b>120,773</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>28,478</b>	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>92,132</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>2,500</b>	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>123,110</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2006	<b>83,805</b>	8
	2007	<b>113,338</b>	9
	2008	<b>121,269</b>	10
	2009	<b>119,513</b>	11
	2010	<b>120,165</b>	12

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2010	\$	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 estimated taxes for 9 months based on fiscal year end. Estimate is based on prior year tax bill. Real estate taxes reported on Sch V line 33 have been reduced by an allocation of expenses relating to ALC services based on an estimated 12%. See Att Sch XV. Taxes paid are for the entire 2010 tax bill.**

**NOTES:**

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

**SEE ACCOUNTANTS' COMPILATION REPORT**

# 2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Parkway Manor COUNTY Williamson

FACILITY IDPH LICENSE NUMBER 0047886

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

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

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>06-10-301-042</u>	<u>RE-SUB OF PARCELS E, G &amp; J</u>	\$ <u>120,165.00</u>	\$ <u>105,745.00</u>
2.	<u></u>	<u>OF IL CENTRE SUB. B PT OF</u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u>PARCEL E, THE WEST 3.93</u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u>AC OF THE E 6.6</u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u>06-10-301-026</u>	<u>RE-SUB OF PARCELS E,G &amp; J OF</u>	\$ <u>610.00</u>	\$ <u>537.00</u>
8.	<u></u>	<u>IL CENTRE SUB. PT OF PARCELS</u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u>E W 20' OF S 338.36'</u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
<b>TOTALS</b>			\$ <u><u>120,775.00</u></u>	\$ <u><u>106,282.00</u></u>

**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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

**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:

10/1/10

Ending:

9/30/11

**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  (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?  (a) Own the Equipment  (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

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility - SNF</u>	<u>5.8 Acres</u>	<u>2006</u>	<u>\$ 413,600</u>	<u>1</u>
2	<u>Facility - SNF</u>	<u>2.5 Acres</u>	<u>2011</u>	<u>125,000</u>	<u>2</u>
3	<b>TOTALS</b>	<b>#VALUE!</b>		<b>\$ 538,600</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	119	2006	1995	\$ 9,095,197	\$ 227,380	40	\$ 227,380	\$	\$ 1,269,538
5									
6									
7									
8									
	Improvement Type**								
9	Landscaping	2006		7,930	793	10	793		4,428
10	Water Heater	2008		3,400	340	10	340		1,247
11	Water Heater	2008		3,677	368	10	368		1,195
12	Carpet	2008		25,023	5,005	5	5,005		14,180
13	Blacktop	2008		4,671	584	8	584		1,703
14	Business Office Remodel	2008		4,510	301	15	301		902
15	Carpet	2008		9,318	1,863	5	1,863		5,280
16	Marion PT Addition	2008		100,831	4,034	25	4,034		11,428
17	3 Shower Rooms - Marble Stalls/Tile Work	2009		77,123	3,856	20	3,856		8,355
18	1/2" Water Meter 2-3" Water Meter	2009		4,373	438	10	438		875
19	Reroof	2009		130,134	13,013	10	13,013		25,966
20	Cabinets	2010		6,477	432	15	432		756
21	Water Heater	2010		4,268	427	10	427		676
22	Activity Room Remodel Carpet/Window Coverings	2010		3,841	768	5	768		1,088
23	New Front Windows/Varnish	2010		17,873	1,191	15	1,191		1,787
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parkway Manor

# 0047886

Report Period Beginning:

10/1/10

Ending:

9/30/11

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 9,498,646	\$ 260,793		\$ 260,793	\$	\$ 1,349,404	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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:

10/1/10

Ending:

9/30/11

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	\$ 687,925	\$ 69,023	\$ 69,023	\$	5-15 yrs	\$ 316,269	71
72	Current Year Purchases	6,724	1,085	1,085		3-5 yrs	1,085	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 694,649	\$ 70,108	\$ 70,108	\$		\$ 317,354	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2003 GMC G3500 Van	2006	\$ 29,848	\$	\$	\$	4 yrs	\$ 29,848	76
77										77
78										78
79										79
80	TOTALS			\$ 29,848	\$	\$	\$		\$ 29,848	80

E. Summary of Care-Related Assets

		1 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)	\$ 10,761,743	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 330,901	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 330,901	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,696,606	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	173,117	88
89					89
90					90
91	TOTALS	\$ 1,311,554	\$ 31,006	\$ 188,017	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.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

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

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>See Attached</u>			3
4	Additions				<u>Schedule IV</u>			4
5					<u>Related Party</u>			5
6					<u>Lease</u>			6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A 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: \$ 1,221 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

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.	<u>/2012</u>	\$ <u>N/A</u>
13.	<u>/2013</u>	\$ <u>N/A</u>
14.	<u>/2014</u>	\$ <u>N/A</u>

\* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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	<b>TOTAL</b>			\$		\$	\$		\$	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Parkway Manor

# 0047886

Report Period Beginning: 10/1/10

Ending: 9/30/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/11 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 79,555	\$ 165,499	1
2	Cash-Patient Deposits	2,691	2,691	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>128,740</u> )	1,233,471	1,233,471	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	139,566	169,751	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Att Sch VII</u>	6,047,695	6,257,084	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 7,502,978	\$ 7,828,496	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		595,000	13
14	Buildings, at Historical Cost		10,335,451	14
15	Leasehold Improvements, at Historical Cost	403,449	403,449	15
16	Equipment, at Historical Cost	328,730	739,397	16
17	Accumulated Depreciation (book methods)	(212,683)	(1,884,623)	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): <u>See Att Sch VII</u>		550,161	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 519,496	\$ 10,738,835	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 8,022,474	\$ 18,567,331	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 72,133	\$ 73,483	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,691	2,691	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	95,533	95,533	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,358	5,358	31
32	Accrued Real Estate Taxes(Sch.IX-B)		92,132	32
33	Accrued Interest Payable	3,780	42,740	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Interdivision Payable</u>		2,841,717	36
37	<u>Current portion mortgage payable</u>		113,631	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 179,495	\$ 3,267,285	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,234,974	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44	<u>Security Deposits</u>	68,828	68,828	44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 68,828	\$ 8,303,802	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 248,323	\$ 11,571,087	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 7,774,151	\$ 6,996,244	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 8,022,474	\$ 18,567,331	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 5,664,617	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	See Attached Schedule X	(11,755)	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 5,652,862	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	2,121,289	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 2,121,289	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 7,774,151	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Parkway Manor

# 0047886

Report Period Beginning: 10/1/10

Ending:

9/30/11

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,671,658	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 9,671,658	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	114,889	6
7	Oxygen	6,514	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 121,403	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	8,342	12
13	Barber and Beauty Care	2,388	13
14	Non-Patient Meals	762	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 11,492	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	100	24
25	Interest and Other Investment Income***	8,933	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 9,033	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Activity Fund Income</b>		28
28a	<b>See Att Schedule XI</b>	5,488	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 5,488	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,819,074	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,267,665	31
32	Health Care	3,801,655	32
33	General Administration	1,574,560	33
<b>B. Capital Expense</b>			
34	Ownership	910,770	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	77,982	35
36	Provider Participation Fee	65,153	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,697,785	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	2,121,289	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 2,121,289	43

\* 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. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Parkway Manor

# 0047886

Report Period Beginning:

10/1/10

Ending:

9/30/11

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	2,069	2,224	\$ 89,818	\$ 40.39	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	9,578	10,299	253,551	24.62	3
4	Licensed Practical Nurses	23,399	25,160	478,299	19.01	4
5	CNAs & Orderlies	105,624	113,575	1,247,049	10.98	5
6	CNA Trainees					6
7	Licensed Therapist	7,631	8,205	493,686	60.17	7
8	Rehab/Therapy Aides	14,217	15,287	386,918	25.31	8
9	Activity Director		0			9
10	Activity Assistants	7,416	7,974	74,809	9.38	10
11	Social Service Workers	1,996	2,147	24,750	11.53	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,672	26,529	245,491	9.25	15
16	Dishwashers					16
17	Maintenance Workers	3,621	3,893	52,589	13.51	17
18	Housekeepers	12,980	13,957	134,185	9.61	18
19	Laundry	8,574	9,219	78,365	8.50	19
20	Administrator	1,956	2,080	77,867	37.44	20
21	Assistant Administrator	1,861	2,002	33,507	16.74	21
22	Other Administrative	4,241	4,560	71,275	15.63	22
23	Office Manager					23
24	Clerical	7,324	7,876	90,696	11.52	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,841	1,979	29,251	14.78	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,806	1,942	19,338	9.96	31
32	Other Health Care(specify)	5,560	5,979	122,444	20.48	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	246,366	264,887	\$ 4,003,888 *	\$ 15.12	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	\$ 16,910	1-3	35
36	Medical Director	7,000	9-3	36
37	Medical Records Consultant	1,228	10-3	37
38	Nurse Consultant	0	10-3	38
39	Pharmacist Consultant	0	10-3	39
40	Physical Therapy Consultant	81	10a-3	40
41	Occupational Therapy Consultant	0	10a-3	41
42	Respiratory Therapy Consultant	0	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)	0	10-3	46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 25,219		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

SEE ACCOUNTANTS' COMPILATION REPORT



**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	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Parkway Manor

# 0047886

Report Period Beginning: 10/1/10

Ending: 9/30/11

**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? 4 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 19,505 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. \$ 65,153  
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. \$ 762
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: McGladrey & Pullen, LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' COMPILATION REPORT**