

		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.

I. IDPH License ID Number: <u>0047969</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Pekin Manor</u>		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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
Address: <u>1520 El Camino Drive</u> <u>Pekin</u> <u>61554</u>			
Number City Zip Code			
County: <u>Tazewell</u>			
Telephone Number: <u>(309) 353-1099</u> Fax # <u>(309) 353-1363</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>04/26/06</u>			
Type of Ownership:			
☒ VOLUNTARY,NON-PROFIT			
☒ Charitable Corp.			
☐ Trust			
IRS Exemption Code <u>501 (c) (3)</u>			
☐ PROPRIETARY			
☐ Individual			
☐ Partnership			
☐ Corporation			
☐ "Sub-S" Corp.			
☐ Limited Liability Co.			
☐ Trust			
☐ Other _____			
☐ GOVERNMENTAL			
☐ State			
☐ County			
☐ Other _____			
In the event there are further questions about this report, please contact:			
Name: <u>Ron Wilson</u>			
Telephone Number: <u>(309) 343-1550</u>			
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) <u>Ben Perkins</u>	
		(Title) <u>Director of Operations</u>	
		Paid Preparer	
		(Signed) <u>See Attached Independent Accountant's Report</u> (Date) _____	
		(Print Name and Title) <u>McGladrey & 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>	
		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	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pekin Manor

0047969 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>120</u>	Skilled (SNF)	<u>120</u>	<u>43,800</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>120</u>	TOTALS	<u>120</u>	<u>43,800</u>	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	<u>13,103</u>	<u>15,148</u>	<u>6,713</u>	<u>34,964</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>13,103</u>	<u>15,148</u>	<u>6,713</u>	<u>34,964</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.83%

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 04/26/06

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 04/01/06 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 120 and days of care provided 4,685

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number		Pekin Manor		STATE OF ILLINOIS		#	0047969	Report Period Beginning:		10/1/10	Ending:		Page 3	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			
	A. General Services													
1	Dietary	280,069	26,828	6,705	313,602		313,602		313,602				1	
2	Food Purchase		362,662		362,662		362,662	(55)	362,607				2	
3	Housekeeping	115,374	36,221		151,595		151,595		151,595				3	
4	Laundry	36,592	17,421		54,013		54,013		54,013				4	
5	Heat and Other Utilities			124,932	124,932		124,932	180	125,112				5	
6	Maintenance	83,558	35,347	58,537	177,442		177,442		177,442				6	
7	Other (specify):*												7	
8	TOTAL General Services	515,593	478,479	190,174	1,184,246		1,184,246	125	1,184,371				8	
	B. Health Care and Programs													
9	Medical Director			18,000	18,000		18,000		18,000				9	
10	Nursing and Medical Records	1,999,047	341,408	8,591	2,349,046		2,349,046		2,349,046				10	
10a	Therapy			382,645	382,645		382,645		382,645				10a	
11	Activities	75,376	6,794	59	82,229		82,229		82,229				11	
12	Social Services	35,682			35,682		35,682		35,682				12	
13	CNA Training												13	
14	Program Transportation			31	31	5,054	5,085		5,085				14	
15	Other (specify):*												15	
16	TOTAL Health Care and Programs	2,110,105	348,202	409,326	2,867,633	5,054	2,872,687		2,872,687				16	
	C. General Administration													
17	Administrative	86,286			86,286		86,286		86,286				17	
18	Directors Fees							3,381	3,381				18	
19	Professional Services			366,406	366,406		366,406	1,079	367,485				19	
20	Dues, Fees, Subscriptions & Promotions			55,877	55,877		55,877	(36,198)	19,679				20	
21	Clerical & General Office Expenses	71,371	48,573	44,232	164,176		164,176	9	164,185				21	
22	Employee Benefits & Payroll Taxes			596,827	596,827		596,827		596,827				22	
23	Inservice Training & Education			1,636	1,636		1,636		1,636				23	
24	Travel and Seminar			2,386	2,386		2,386		2,386				24	
25	Other Admin. Staff Transportation			10,108	10,108	(5,054)	5,054		5,054				25	
26	Insurance-Prop.Liab.Malpractice			76,026	76,026		76,026	36,922	112,948				26	
27	Other (specify):* See Att Sch V	28,496		(12,517)	15,979		15,979	(15,979)					27	
28	TOTAL General Administration	186,153	48,573	1,140,981	1,375,707	(5,054)	1,370,653	(10,786)	1,359,867				28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,811,851	875,254	1,740,481	5,427,586		5,427,586	(10,661)	5,416,925				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.

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			115,971	115,971		115,971	230,664	346,635			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							348,847	348,847			32
33	Real Estate Taxes							98,400	98,400			33
34	Rent-Facility & Grounds			667,904	667,904		667,904	(667,904)				34
35	Rent-Equipment & Vehicles			11,298	11,298		11,298		11,298			35
36	Other (specify):* See Att Sch IV							8,307	8,307			36
37	TOTAL Ownership			795,173	795,173		795,173	18,314	813,487			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			30,314	30,314		30,314		30,314			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			2,950	2,950		2,950		2,950			41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):* Outpatient Care			2,548	2,548		2,548		2,548			43
44	TOTAL Special Cost Centers			101,512	101,512		101,512		101,512			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,811,851	875,254	2,637,166	6,324,271		6,324,271	7,653	6,331,924			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

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	(55)	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	(2,570)	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	14,724	V-27		24
25	Fund Raising, Advertising and Promotional	(36,433)	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	(32,594)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (56,928)		\$	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)	57,806		34
35	Other- Attach Schedule See Att Sch III	6,775		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 64,581		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 7,653		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

Pekin Manor

ID# 0047969

Report Period Beginning: 10/1/10

Ending: 9/30/11

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

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

Summary A

9/30/11

[illegible]

Summary B

9/30/11

[illegible]

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	\$ 667,904	Pekin El Camino, LLC	N/A	\$ 725,710	\$ 57,806	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			\$ 667,904			\$ 725,710	\$ * 57,806	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

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See Attached Schedule II & III								\$ 3,381	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	\$ 3,381		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

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	\$38,590.99	04/01/06	6,480,000	5,955,652	8/1/2035	5.8500		351,417	2
3													3
4													4
5													5
	Working Capital												
6	Miscellaneous		X										6
7	Less Interest Income		X									(2,570)	7
8													8
9	TOTAL Facility Related				\$38,590.99		\$ 6,480,000	\$ 5,955,652			\$ 348,847	9	
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 6,480,000	\$ 5,955,652			\$ 348,847	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 30,032 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

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	71,400	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.)				\$	97,834	2
3. Under or (over) accrual (line 2 minus line 1).				\$	26,434	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	71,966	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.				\$	98,400	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2006	88,776	8	FOR BHF USE ONLY	
		2007	90,864	9		
		2008	92,828	10		
		2009	94,873	11		
		2010	97,834	12		
This facility was purchased from an unrelated for-profit entity during 2006. A tax exemption has not yet been obtained.				13	FROM R. E. TAX STATEMENT FOR 2010	13
Amount accrued includes the taxes for 9 months based on fiscal year end. Estimate is based on prior year tax bill.				14	PLUS APPEAL COST FROM LINE 5	14
Taxes paid during year represents the entire 2010 bill.				15	LESS REFUND FROM LINE 6	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Pekin Manor

COUNTY

Tazewell

FACILITY IDPH LICENSE NUMBER

0047969

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</u> <u>Applicable to</u> <u>Nursing Home</u>
1. <u>10-10-11-400-015</u>	<u>Sec 11 T24N R5W</u>	\$ <u>96,974.00</u>	\$ <u>96,974.00</u>
2. <u></u>	<u>PT OF E 1/2 SE 1/2</u>	\$ <u></u>	\$ <u></u>
3. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4. <u>10-10-14-205-010</u>	<u>SEC 14 T24N R5W</u>	\$ <u>860.00</u>	\$ <u>860.00</u>
5. <u></u>	<u>PT OF E 1/2 NE 1/4</u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u>97,834.00</u>	\$ <u>97,834.00</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? YES X NO

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

C. Tax Bills

Attach a copy of the original 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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

43,948

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

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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	6.24 Acres	2006	\$ 450,000	1
2					2
3	TOTALS	#VALUE!		\$ 450,000	3

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	120		2006	1988	\$ 7,174,313	\$ 179,353	40	\$ 179,353		\$ 986,468
5										
6										
7										
8										
	Improvement Type**									
9	Light Sign - Double Faced, Fire Alarm Panel			2006	43,700	4,368	10	4,368		24,447
10	Replace Defective Pipe for Dry System, Roof			2007	139,058	13,026	10-25 yrs	13,026		51,024
11	Water Heater			2007		330	10	330		
12	Roof Repair			2008	49,473	4,955	10	4,955		17,316
13	Furnace Duct Repair			2008	6,779	678	10	678		2,542
14	Sprinkler System			2008	123,396	4,936	25	4,936		14,808
15	A/C Unit			2009	5,890	1,178	5	1,178		3,043
16	Shower Room Repairs			2009	27,671	1,846	15	1,846		4,766
17	Installed Firewall (Sheet Rock)			2009	15,586	1,560	10	1,560		3,897
18	Wall/Ceiling Repairs & Paint			2009	11,772	1,178	10	1,178		2,943
19	Kitchen Wall & Floor Repairs			2009	17,948	1,196	15	1,196		3,191
20	Shower Room Tile			2009	2,587	129	20	129		323
21	Shower Room (Tile & Paint)			2009	11,694	779	15	779		1,884
22	Tile (Shower Room Walls)			2009	2,967	149	20	149		359
23	Air Conditioners			2009	2,680	536	5	536		1,206
24	Carpet - Main Entry Offices/Hall			2009	4,500	900	5	900		1,875
25	Sprinkler System			2009	7,197	288	25	288		648
26	Sidewalks - SW Corners/Exit/Courtyard			2009	18,410	1,228	15	1,228		2,455
27	Water Heater			2009	4,750	475	10	475		871
28	Landscaping/Lights in Center Courtyard			2009	7,280	728	10	728		1,335
29	Single Face Lighted Sign			2010	2,734	273	10	273		387
30	Physical Therapy Completion			2010	392,863	32,738	12	32,738		51,836
31	Water Heater			2010	3,039	304	10	304		304
32	Water Heater			2010	4,309	359	10	359		359
33	Apollo Tub Room - Sink/Mirror/Shower/Tile/Drywall/Drains/Faucets			2011	56,049	3,114	12	3,114		3,114
34	Water heater			2011	4,926	205	10	205		205
35	Condensor-5 ton			2011	2,500	42	15	42		42
36	Bathrm Remodel-sink/mirror/walls/tile/floor/curtains/drywall/plumbing			2011	39,773	829	12	829		829

*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

Facility Name & ID Number Pekin Manor

0047969

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 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	Physical Therapy Remodel - Contracted Total	2011	\$ 147,137	\$ 6,131	12	\$ 6,131	\$	\$ 6,131	37
38	Dining Room Addition (Contracted Total)	2011	183,361	7,640	12	7,640		7,640	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)		\$ 8,514,342	\$ 271,451		\$ 271,451	\$	\$ 1,196,248	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 670,462	\$ 74,774	\$ 74,774	\$	5-15 yrs	\$ 311,397	71
72	Current Year Purchases	8,201	410	410		5-10 yrs	410	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 678,663	\$ 75,184	\$ 75,184	\$		\$ 311,807	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	2004 Chevy G3500	2006	\$ 34,100	\$	\$	\$	4 yrs	\$ 34,100	76
77										77
78										78
79										79
80	TOTALS			\$ 34,100	\$	\$	\$		\$ 34,100	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,677,105	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 346,635	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 346,635	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)	\$ 1,542,155	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					87
88					88
89					89
90					90
91	TOTALS	\$ 14,900	\$	\$ 14,900	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: Pekin El Camino, 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:				\$ See Attached			3
4	Additions				Schedule IV			4
5					Related Party			5
6					Lease			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: \$ 11,298
- 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.	/2012	\$ N/A
13.	/2013	\$ N/A
14.	/2014	\$ N/A

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

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

- (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.

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	

- (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.)

		1	2	3	4	5	6	7	8	
	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 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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 178,996	\$ 248,186	1
2	Cash-Patient Deposits	9,949	9,949	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>115,264</u>)	788,059	788,059	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	108,199	132,797	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Att Sch VII</u>		75,048	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,085,203	\$ 1,254,039	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		450,000	13
14	Buildings, at Historical Cost		7,407,147	14
15	Leasehold Improvements, at Historical Cost	1,107,195	1,107,195	15
16	Equipment, at Historical Cost	340,463	727,663	16
17	Accumulated Depreciation (book methods)	(332,673)	(1,557,055)	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>	98,025	652,450	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,213,010	\$ 8,787,400	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,298,213	\$ 10,041,439	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 144,697	\$ 144,697	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,949	9,949	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	58,693	58,693	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,304	3,304	31
32	Accrued Real Estate Taxes(Sch.IX-B)		71,966	32
33	Accrued Interest Payable		29,034	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Interdivision Payable</u>	3,291,142	5,434,972	36
37	<u>Current portion of long term payable</u>		117,812	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,507,785	\$ 5,870,427	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,837,840	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	<u>Security Deposits</u>	72,500	72,500	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 72,500	\$ 5,910,340	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,580,285	\$ 11,780,767	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,282,072)	\$ (1,739,328)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,298,213	\$ 10,041,439	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,493,438)	1
2	Restatements (describe):		2
3	See Attached Schedule X	(11,755)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,505,193)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	223,121	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)	\$ 223,121	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,282,072)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,390,174	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,390,174	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	121,627	6
7	Oxygen	6,395	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 128,022	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	4,484	12
13	Barber and Beauty Care	5,600	13
14	Non-Patient Meals	55	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	5,059	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,007	19
20	Radiology and X-Ray	198	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 16,403	23
	D. Non-Operating Revenue		
24	Contributions	610	24
25	Interest and Other Investment Income***	2,570	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,180	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund Income		28
28a	See Att Schedule XI	9,613	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,613	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,547,392	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,184,246	31
32	Health Care	2,867,633	32
33	General Administration	1,375,707	33
	B. Capital Expense		
34	Ownership	795,173	34
	C. Ancillary Expense		
35	Special Cost Centers	35,812	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,324,271	40
41	Income before Income Taxes (line 30 minus line 40)**	223,121	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 223,121	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.

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	1,705	1,833	\$ 54,722	\$ 29.85	1
2	Assistant Director of Nursing	656	705	17,633	25.01	2
3	Registered Nurses	8,669	9,322	220,640	23.67	3
4	Licensed Practical Nurses	24,645	26,500	549,871	20.75	4
5	CNAs & Orderlies	89,702	96,454	1,068,711	11.08	5
6	CNA Trainees					6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides			0		8
9	Activity Director			0		9
10	Activity Assistants	5,970	6,420	75,376	11.74	10
11	Social Service Workers	1,972	2,120	35,682	16.83	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,145	27,038	280,069	10.36	15
16	Dishwashers					16
17	Maintenance Workers	5,831	6,270	83,558	13.33	17
18	Housekeepers	12,015	12,920	115,374	8.93	18
19	Laundry	3,912	4,206	36,592	8.70	19
20	Administrator	967	1,040	42,000	40.38	20
21	Assistant Administrator	1,956	2,080	44,286	21.29	21
22	Other Administrative	1,378	1,482	28,496	19.23	22
23	Office Manager					23
24	Clerical	4,967	5,341	71,371	13.36	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	217	217	1,847	8.51	31
32	Other Health Care(specify)	4,163	4,476	85,623	19.13	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	193,870	208,424	\$ 2,811,851 *	\$ 13.49	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 6,705	1-3	35
36	Medical Director		18,000	9-3	36
37	Medical Records Consultant		2,200	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		6,391	10-3	39
40	Physical Therapy Consultant		160,314	10a-3	40
41	Occupational Therapy Consultant		142,363	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		79,968	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)		\$ 415,941		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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		
Ben Perkins	Asst Admin	None	\$ 42,000	Workers' Compensation Insurance		\$ 145,486	IDPH License Fee		\$		
Nicole Friend	Asst Admin	None	44,286	Unemployment Compensation Insurance		131,617	Advertising: Employee Recruitment		7,806		
				FICA Taxes		206,014	Health Care Worker Background Check				
				Employee Health Insurance		104,433	(Indicate # of checks performed	124	3,484		
				Employee Meals			Patient Background Checks	183	1,837		
				Illinois Municipal Retirement Fund (IMRF)*			Advertising - Promotion		36,433		
				401 (k)		7,206	Subscriptions		1,450		
				Other Employee Benefits		2,071	IHCA Dues		4,168		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 86,286				Other Licenses & Fees		699		
B. Administrative - Other							Indirect Costs - See Att Sch III		235		
Description			Amount				Less: Public Relations Expense	(			
			\$				Non-allowable advertising		(36,433)		
							Yellow page advertising	(			
							TOTAL (agree to Sch. V, line 20, col. 8)				
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 596,827	\$ 19,679			
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description		Amount		
RFMS, Inc.	Administrative Services		\$ 171,600			\$	Out-of-State Travel		\$		
McGladrey & Pullen, LLP	Accounting Services		8,540								
LTC Support Services, LLC	Support Services		146,880								
American Healthcare Manag.	Healthcare Services		3,053				In-State Travel				
Davis & Campbell, LLC	Legal Services		9,290				Staff use of personal vehicle on facility				
Polsinelli Shughart PC	Legal Services		25,152				business and meals (under \$250 per				
Michael T. Mahoney, LTD.	Legal Services		1,216				travel voucher)		0		
Quinn Johnston	Collections Services		675				Seminar Expense		2,386		
							Less: non-allowable out-of-state travel		0		
							Indirect costs - See Att Sch III		0		
							Entertainment Expense	(			
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 366,406	TOTAL			\$	(agree to Sch. V, line 24, col. 8)			
								TOTAL	\$ 2,386		

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

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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? 8 yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 51,137 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. \$ 65,700
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. \$ 55

(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 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