

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 0047878 Facility Name: Shelbyville Manor Address: 1111 W. North 12th Street Shelbyville 62565 County: Shelby Telephone Number: (217) 774-2111 Fax #: (217) 774-2209 HFS ID Number: Date of Initial License for Current Owners: 02/02/2006 Type of Ownership: ☒ VOLUNTARY,NON-PROFIT ☒ Charitable Corp. ☐ Trust IRS Exemption Code 501 (c) (3) ☐ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☐ Limited Liability Co. ☐ Trust ☐ Other ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other

In the event there are further questions about this report, please contact:

Name: Ron Wilson Telephone Number: (309) 343-1550

Email Address:

Facility Name & ID Number Shelbyville Manor# 0047878 Report Period Beginning: 10/1/11 Ending: 9/30/12

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 bedsN/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>115</u>	Skilled (SNF)	<u>115</u>	<u>42,090</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>115</u>	TOTALS	<u>115</u>	<u>42,090</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>15,006</u>	<u>5,872</u>	<u>6,257</u>	<u>27,135</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>15,006</u>	<u>5,872</u>	<u>6,257</u>	<u>27,135</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 64.47%

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?

YesG. 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 02/02/06

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 02/01/06NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number
of beds certified 115 and days of care provided 6,253Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 9/30/12Fiscal Year: 9/30/12

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

	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	228,552	25,007	4,027	257,586		257,586	(50,499)	207,087			1
2	Food Purchase		297,241		297,241		297,241	(59,115)	238,126			2
3	Housekeeping	126,365	43,175	340	169,880		169,880	(25,117)	144,763			3
4	Laundry	55,952	18,575		74,527		74,527	(11,041)	63,486			4
5	Heat and Other Utilities			152,413	152,413		152,413	(21,296)	131,117			5
6	Maintenance	39,322	30,365	51,861	121,548		121,548	(18,008)	103,540			6
7	Other (specify):*											7
8	TOTAL General Services	450,191	414,363	208,641	1,073,195		1,073,195	(185,076)	888,119			8
	B. Health Care and Programs											
9	Medical Director			16,800	16,800		16,800		16,800			9
10	Nursing and Medical Records	1,604,096	295,913	7,103	1,907,112		1,907,112	(180,644)	1,726,468			10
10a	Therapy			536,976	536,976		536,976		536,976			10a
11	Activities	71,933	1,564		73,497		73,497	(391)	73,106			11
12	Social Services	13,893			13,893		13,893		13,893			12
13	CNA Training											13
14	Program Transportation			1,025	1,025	7,389	8,414		8,414			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,689,922	297,477	561,904	2,549,303	7,389	2,556,692	(181,035)	2,375,657			16
	C. General Administration											
17	Administrative	137,604			137,604		137,604		137,604			17
18	Directors Fees							3,447	3,447			18
19	Professional Services			350,481	350,481		350,481	1,883	352,364			19
20	Dues, Fees, Subscriptions & Promotions			85,731	85,731		85,731	(71,857)	13,874			20
21	Clerical & General Office Expenses	64,883	32,426	37,927	135,236		135,236	(1,795)	133,441			21
22	Employee Benefits & Payroll Taxes			407,216	407,216		407,216	(44,444)	362,772			22
23	Inservice Training & Education			8,140	8,140		8,140		8,140			23
24	Travel and Seminar			477	477		477		477			24
25	Other Admin. Staff Transportation			14,778	14,778	(7,389)	7,389	(319)	7,070			25
26	Insurance-Prop.Liab.Malpractice			42,146	42,146		42,146	22,778	64,924			26
27	Other (specify):* See Att Sch V	44,348		72,184	116,532		116,532	(116,532)				27
28	TOTAL General Administration	246,835	32,426	1,019,080	1,298,341	(7,389)	1,290,952	(206,839)	1,084,113			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,386,948	744,266	1,789,625	4,920,839		4,920,839	(572,950)	4,347,889			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			68,759	68,759		68,759	215,972	284,731			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							198,117	198,117			32
33	Real Estate Taxes			1,400	1,400		1,400	77,902	79,302			33
34	Rent-Facility & Grounds			565,200	565,200		565,200	(565,200)				34
35	Rent-Equipment & Vehicles			10,547	10,547		10,547		10,547			35
36	Other (specify):* See Att Sch IV							7,359	7,359			36
37	TOTAL Ownership			645,906	645,906		645,906	(65,850)	580,056			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			48,066	48,066		48,066		48,066			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			248,884	248,884		248,884		248,884			42
43	Other (specify):* Outpatient Care			669	669		669		669			43
44	TOTAL Special Cost Centers			297,619	297,619		297,619		297,619			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,386,948	744,266	2,733,150	5,864,364		5,864,364	(638,800)	5,225,564			45

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

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	(180)	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	(7,921)	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	(70,223)	V-27		24
25	Fund Raising, Advertising and Promotional	(71,418)	V-20		25
	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 XI	(556,778)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (706,520)		\$	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	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)	58,096		34
35	Other- Attach Schedule See Att Sch III	9,624		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 67,720		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (638,800)		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	TOTAL (C): (sum of lines 38-46)			\$		47

Shelbyville Manor

Report Period Beginning:

ID#0047878

Ending:

10/1/11

9/30/12

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

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Shelbyville Manor # 0047878 Report Period Beginning: 10/1/11 Ending: 9/30/12

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

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

STATE OF ILLINOIS

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	58,096	0	0	0	0	0	0	0	0	0	58,096	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	58,096	0	0	0	0	0	0	0	0	0	58,096	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	0	58,096	0	0	0	0	0	0	0	0	0	58,096	45

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	\$ 565,200	Shelbyville Route 128, LLC	N/A	\$ 623,296	\$ 58,096	1
2	V								2
3	V				See Att Schedule IV and Preparation Report				3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 565,200			\$ 623,296	\$ * 58,096	14

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

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								\$ 3,447	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	\$ 3,447		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 LTD. Of Illinois						\$		\$			\$	1		
2			X	Facility purchase	\$20,381.00	6/1/2012		4,313,155	4,297,890	4/1/2040	3.5500	206,038	2		
3				SNF portion									3		
4													4		
5													5		
	Working Capital														
6	Miscellaneous		X										6		
7	Less Interest Income		X									(7,921)	7		
8													8		
9	TOTAL Facility Related				\$20,381.00		\$	4,313,155	\$	4,297,890			\$	198,117	9
	B. Non-Facility Related*														
10	Cambridge Realty Capital LTD. Of Illinois												10		
11			X	Facility purchase	\$3,597.00	6/1/2012		761,145	758,451	4/1/2040	3.5500	36,360	11		
12				ALC portion									12		
13													13		
14	TOTAL Non-Facility Related				\$3,597.00		\$	761,145	\$	758,451			\$	36,360	14
15	TOTALS (line 9+line14)						\$	5,074,300	\$	5,056,341			\$	234,477	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 23,818 Line # 26

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

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

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 2011 report.			\$	77,899	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.)			\$	95,914	2
3. Under or (over) accrual (line 2 minus line 1).			\$	18,015	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	75,035	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.			\$	93,050	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2007	92,404	8		
	2008	97,129	9		
	2009	97,779	10		
	2010	99,341	11		
	2011	95,914	12		
<u>This facility was purchased from an unrelated for-profit entity during 2006. A tax exemption has not yet been obtained</u>					
<u>Amount accrued includes estimated taxes for 9 months based on fiscal year end. Estimate based on prior year tax bill. Real estate taxes reported on Sch V 33 have been reduced by an allocation of expenses relating to ALC services based on an</u>					
<u>estimated 15%. See Att Sch XI. Real estate taxes paid are for the entire 2011 tax bill.</u>					
		FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2011	\$			13
14	PLUS APPEAL COST FROM LINE 5	\$			14
15	LESS REFUND FROM LINE 6	\$			15
16	AMOUNT TO USE FOR RATE CALCULATION	\$			16

NOTES:

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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Shelbyville Manor

COUNTY

Shelby

FACILITY IDPH LICENSE NUMBER

0047878

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 2011 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 2011.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 2013-06-17-305-001	W N 12TH	\$ 95,913.68	\$ 81,526.62
2.	SW COR SW SW 550' X 520' & 30'	\$	\$
3.	VAC STREET LESS .11 AC TO	\$	\$
4.	ST HWY 6.76 AC	\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 95,913.68	\$ 81,526.62

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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: 39,041 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	<u>Facility - SNF</u>	<u>5.84 Acres</u>	<u>2006</u>	<u>\$ 195,500</u>	1
2					2
3	TOTALS	#VALUE!		\$ 195,500	3

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	115		2006	1991	\$ 5,078,282	\$ 126,955	40	\$ 126,955		\$ 846,376
5										
6										
7										
8										
	Improvement Type**									
9	Dry Pipe Valve and Water Softner			2006	11,205	939	10-20 yrs	939		5,650
10	Ceramic Tile Repair, Carpet, Ceramic Tile			2007	11,750	779	5-20 yrs	779		5,252
11	Roof Repair			2008	84,157	8,416	10	8,416		39,274
12	Air Handler w/ Heat Strap and Condensor			2009	2,762	276	10	276		1,035
13	Water Heater			2009	9,323	932	10	932		3,340
14	Fire Protection System			2009	9,365	936	10	936		2,965
15	Water Heater			2010	10,671	1,067	10	1,067		2,401
16	Fire Sprinkler			2011	119,000	4,760	25	4,760		7,140
17	Physical Therapy Addition (Contracted Total)			2011	762,407	63,534	12	63,534		63,534
18	Oil/Chip Parking Lot			2011	4,200	525	8	525		525
19	Hallway Rmdl-Vinyl tile/Base/Drywall/Handrails/Wall & Crnr Grds/AC			2011	56,356	4,696	12	4,696		4,696
20	Shower Rmdl-Exhaust fan/Fire access dr/Flr-tile/wiring/fxts/drains			2012	130,718	8,170	12	8,170		8,170
21	Laundry/Hallway Rmdl-Handrails/Guardrails/Vinyl Tile/Drywall/Paint			2012	138,186	5,758	12	5,758		5,758
22	Faux Wood Blinds - 14			2012	5,256	438	5	438		438
23										
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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
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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)		\$ 6,433,638	\$ 228,181		\$ 228,181	\$	\$ 996,554	70

**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	\$489,248	\$48,576	\$48,576	\$	5-15 yrs	\$265,919	71
72	Current Year Purchases	93,982	7,974	7,974		3-12 yrs	7,974	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$583,230	\$56,550	\$56,550	\$		\$273,893	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	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)	\$7,242,21681
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$284,73182
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$284,73183**
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)	\$1,300,29585

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	34,500			87
88	Facility ALC - 2006	896,167	22,404	149,361	88
89	Physical Therapy Add. ALC-2011	134,542	11,212	11,212	89
90					90
91	TOTALS	\$1,080,109	\$33,616	\$175,473	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:Shelbyville Route 128, LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

X

YESNO

		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 leaseN/A.

N/A
9. Option to Buy:

YESNO

Terms: N/A*

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

15. Is Movable equipment rental included in building rental?

YESNO
16. Rental Amount for movable equipment: \$10,547Description: See Attached Schedule XIII
- (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 EndingAnnual Rent

12. /2013\$ N/A
13. /2014\$ N/A
14. /2015\$ 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.

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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

COMPLETED

1. From this facility

2. From other facilities (f)

DROP-OUTS

1. From this facility

2. From other facilities (f)

TOTAL TRAINED

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		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.

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	\$ 44,996	\$ 401,947	1
2	Cash-Patient Deposits	10,091	10,091	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 51,250)	1,180,407	1,180,407	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	84,331	100,566	6
7	Other Prepaid Expenses	4,449	4,449	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Att Sch VII	1,382,091	1,417,801	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,706,365	\$ 3,115,261	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		230,000	13
14	Buildings, at Historical Cost		6,871,398	14
15	Leasehold Improvements, at Historical Cost	592,949	592,949	15
16	Equipment, at Historical Cost	373,145	627,978	16
17	Accumulated Depreciation (book methods)	(235,392)	(1,475,768)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Att Sch VII		523,084	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 730,702	\$ 7,369,641	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,437,067	\$ 10,484,902	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 96,650	\$ 159,521	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,091	10,091	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	63,012	63,012	30
31	Accrued Taxes Payable (excluding real estate taxes)	64,580	64,580	31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,400	75,035	32
33	Accrued Interest Payable	13,605	28,563	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Interdivision Payable		2,300,436	36
37	Current portion of long term payable		110,009	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 249,338	\$ 2,811,247	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,946,332	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Security Deposits	51,000	51,000	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 51,000	\$ 4,997,332	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 300,338	\$ 7,808,579	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,136,729	\$ 2,676,323	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,437,067	\$ 10,484,902	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,593,730	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,593,730	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	542,999	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)	\$ 542,999	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)	\$ 3,136,729	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Shelbyville Manor# 0047878Report Period Beginning: 10/1/11Ending: 9/30/12

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		2
I. Revenue	Amount		
A. Inpatient Care			
1 Gross Revenue -- All Levels of Care	\$ 6,207,590	1	
2 Discounts and Allowances for all Levels	()	2	
3 SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,207,590	3	
B. Ancillary Revenue			
4 Day Care	7,740	4	
5 Other Care for Outpatients		5	
6 Therapy	169,722	6	
7 Oxygen	10,201	7	
8 SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 187,663	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	686	12	
13 Barber and Beauty Care	1,150	13	
14 Non-Patient Meals	180	14	
15 Telephone, Television and Radio		15	
16 Rental of Facility Space		16	
17 Sale of Drugs	502	17	
18 Sale of Supplies to Non-Patients		18	
19 Laboratory		19	
20 Radiology and X-Ray		20	
21 Other Medical Services		21	
22 Laundry		22	
23 SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,518	23	
D. Non-Operating Revenue			
24 Contributions	460	24	
25 Interest and Other Investment Income***	7,921	25	
26 SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,381	26	
E. Other Revenue (specify):****			
27 Settlement Income (Insurance, Legal, Etc.)		27	
28 Activity Fund Income		28	
28a See Att Schdule X	1,211	28a	
29 SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,211	29	
30 TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,407,363	30	

	1		2
II. Expenses	Amount		
A. Operating Expenses			
31 General Services	1,073,195	31	
32 Health Care	2,549,303	32	
33 General Administration	1,298,341	33	
B. Capital Expense			
34 Ownership	645,906	34	
C. Ancillary Expense			
35 Special Cost Centers	48,735	35	
36 Provider Participation Fee	248,884	36	
D. Other Expenses (specify):			
37		37	
38		38	
39		39	
40 TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,864,364	40	
41 Income before Income Taxes (line 30 minus line 40)**	542,999	41	
42 Income Taxes		42	
43 NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 542,999	43	

	1		2
III. Net Inpatient Revenue detailed by Payer Source	Amount		
44 Medicaid - Net Inpatient Revenue	\$ 2,070,840	44	
45 Private Pay - Net Inpatient Revenue	898,486	45	
46 Medicare - Net Inpatient Revenue	2,564,718	46	
47 Other-(specify) <u>Assisted Living</u>	672,715	47	
48 Other-(specify) <u>See Att Sch XII</u>	831	48	
49 TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,207,590	49	

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

** Does this agree with taxable income (loss) per Federal Income

Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

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	1,974	2,099	\$ 72,432	\$ 34.51	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	8,930	9,501	200,841	21.14	3
4	Licensed Practical Nurses	14,869	15,818	262,902	16.62	4
5	CNAs & Orderlies	85,568	91,030	933,966	10.26	5
6	CNA Trainees					6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides			0		8
9	Activity Director			0		9
10	Activity Assistants	7,055	7,505	71,933	9.58	10
11	Social Service Workers	1,088	1,158	13,893	12.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,324	24,812	228,552	9.21	15
16	Dishwashers					16
17	Maintenance Workers	2,094	2,228	39,322	17.65	17
18	Housekeepers	11,953	12,716	126,365	9.94	18
19	Laundry	5,950	6,329	55,952	8.84	19
20	Administrator	1,956	2,080	102,500	49.28	20
21	Assistant Administrator	2,062	2,194	35,104	16.00	21
22	Other Administrative	2,477	2,635	44,348	16.83	22
23	Office Manager					23
24	Clerical	5,496	5,847	64,883	11.10	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,979	2,106	37,122	17.63	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,956	2,081	21,329	10.25	31
32	Other Health Care(specify)	4,495	4,782	75,504	15.79	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	183,226	194,921	\$ 2,386,948 *	\$ 12.25	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	***	\$ 4,027	1-3	35
36	Medical Director	***	16,800	9-3	36
37	Medical Records Consultant	***	1,810	10-3	37
38	Nurse Consultant	***	0	10-3	38
39	Pharmacist Consultant	***	5,293	10-3	39
40	Physical Therapy Consultant	***	232,103	10a-3	40
41	Occupational Therapy Consultant	***	188,198	10a-3	41
42	Respiratory Therapy Consultant	***	0	10a-3	42
43	Speech Therapy Consultant	***	116,675	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	*** Monthly Fee				48
49	TOTAL (lines 35 - 48)		\$ 564,906		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

* 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		
Karen Dailey	Administrator	None	\$ 102,500	Workers' Compensation Insurance		\$ 95,453	IDPH License Fee		\$		
Angela Towle	Asst Admin	None	12,853	Unemployment Compensation Insurance		17,963	Advertising: Employee Recruitment		3,868		
Danielle Sanders	Asst Admin	None	22,251	FICA Taxes		176,627	Health Care Worker Background Check				
				Employee Health Insurance		102,529	(Indicate # of checks performed 80)		2,233		
				Employee Meals			Patient Background Checks	133	1,330		
				Illinois Municipal Retirement Fund (IMRF)*			Advertising - Promotion		71,418		
				401 (k)		6,385	Subscriptions		1,324		
				Other Employee Benefits		8,259	IHCA Dues		4,307		
							Other Licenses & Fees		1,251		
							Ind Costs-Att Sch III, ALC-Att Sch XI		(439)		
							Less: Public Relations Expense	(			
							Non-allowable advertising		(71,418)		
							Yellow page advertising	(			
TOTAL (agree to Schedule V, line 17, col. 1)							TOTAL (agree to Sch. V,		\$		
(List each licensed administrator separately.)			\$ 137,604				line 20, col. 8)		13,874		
B. Administrative - Other											
Description			Amount								
			\$								
TOTAL (agree to Schedule V, line 17, col. 3)			\$								
(Attach a copy of any management service agreement)											
C. Professional Services				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 LLP	Accounting Services		8,000								
LTC Support Services, LLC	Support Services		149,940								
Bennett Law Office	Collection Services		229				In-State Travel				
Polsinelli Shughart PC	Legal Services		1,488				Staff use of personal vehicle on facility				
Drinkerbiddle & Reath LLP	Legal Services		19,159				business and meals (under \$250 per				
Singleton Law Firm, P.C.	Legal Services		65				travel voucher)		0		
							Seminar Expense		477		
							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)				TOTAL		\$	(agree to Sch. V,				
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 350,481				line 24, col. 8)		\$ 477		

*** Attach copy of IMRF notifications**

****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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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?

7 yrs

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

27,585

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.

\$

248,884

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.

\$

180

(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 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.