

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: 0047225

Facility Name: Centralia Manor

Address: 1910 E McCord Rt161E Centralia 62801
Number City Zip Code

County: Marion

Telephone Number: (618) 533-1200 Fax # (618) 533-1257

HFS ID Number:

Date of Initial License for Current Owners: 06/29/05

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:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/15 to 9/30/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) Matt Hails
(Title) LTC CEO

Paid
Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date) _____
(Print Name and Title) Larry Templin Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP
P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ()

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' PREPARATION REPORT

Facility Name & ID Number Centralia Manor

0047225 Report Period Beginning: 10/1/15 Ending: 9/30/16

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 _____

	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>43,920</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>43,920</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>10,328</u>	<u>9,001</u>	<u>13,090</u>	<u>32,419</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>10,328</u>	<u>9,001</u>	<u>13,090</u>	<u>32,419</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.81%

D. How many bed-hold days during this year were paid by the Department? None (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 ☒ Non-allowable costs have been eliminated in Schedule V, Column 7

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 7/01/05

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 7/01/05 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 11,727

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: 9/30/2016 Fiscal Year: 9/30/2016
* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Centralia Manor # 0047225 Report Period Beginning: 10/1/15 Ending: 9/30/16

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	322,236	27,237	11,519	360,992		360,992		360,992			1
2	Food Purchase		316,961		316,961		316,961	(3,158)	313,803			2
3	Housekeeping	157,835	44,456		202,291		202,291		202,291			3
4	Laundry	65,109	10,015		75,124		75,124		75,124			4
5	Heat and Other Utilities			157,585	157,585		157,585		157,585			5
6	Maintenance	62,454	27,692	81,613	171,759		171,759		171,759			6
7	Other (specify):*											7
8	TOTAL General Services	607,634	426,361	250,717	1,284,712		1,284,712	(3,158)	1,281,554			8
	B. Health Care and Programs											
9	Medical Director			22,000	22,000		22,000		22,000			9
10	Nursing and Medical Records	2,126,992	192,979	9,800	2,329,771		2,329,771		2,329,771			10
10a	Therapy			1,196,013	1,196,013		1,196,013		1,196,013			10a
11	Activities	83,191	2,065		85,256		85,256		85,256			11
12	Social Services	49,007			49,007		49,007		49,007			12
13	CNA Training											13
14	Program Transportation			3,782	3,782		3,782		3,782			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,259,190	195,044	1,231,595	3,685,829		3,685,829		3,685,829			16
	C. General Administration											
17	Administrative	71,937			71,937		71,937		71,937			17
18	Directors Fees							3,990	3,990			18
19	Professional Services			370,164	370,164		370,164	4,380	374,544			19
20	Dues, Fees, Subscriptions & Promotions			19,771	19,771		19,771	(273)	19,498			20
21	Clerical & General Office Expenses	119,206	34,750	51,949	205,905		205,905	6	205,911			21
22	Employee Benefits & Payroll Taxes			513,834	513,834		513,834		513,834			22
23	Inservice Training & Education			7,079	7,079		7,079		7,079			23
24	Travel and Seminar			309	309		309		309			24
25	Other Admin. Staff Transportation			3,780	3,780		3,780		3,780			25
26	Insurance-Prop.Liab.Malpractice			101,740	101,740		101,740	16,313	118,053			26
27	Other (specify):*											27
28	TOTAL General Administration	191,143	34,750	1,068,626	1,294,519		1,294,519	24,416	1,318,935			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,057,967	656,155	2,550,938	6,265,060		6,265,060	21,258	6,286,318			29

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

SEE ACCOUNTANTS' PREPARATION 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			226,234	226,234		226,234	249,375	475,609			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			179	179		179	353,853	354,032			32
33	Real Estate Taxes							212,500	212,500			33
34	Rent-Facility & Grounds			902,580	902,580		902,580	(902,580)				34
35	Rent-Equipment & Vehicles			16,231	16,231		16,231		16,231			35
36	Other (specify):* Mort Ins							40,253	40,253			36
37	TOTAL Ownership			1,145,224	1,145,224		1,145,224	(46,599)	1,098,625			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,395	1,395		1,395		1,395			38
39	Ancillary Service Centers		466,856		466,856		466,856		466,856			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			4,297	4,297		4,297	(4,297)				41
42	Provider Participation Fee			183,614	183,614		183,614		183,614			42
43	Other (specify):* See Att Sch 4A	46,993		214,985	261,978		261,978	(218,950)	43,028			43
44	TOTAL Special Cost Centers	46,993	466,856	404,291	918,140		918,140	(223,247)	694,893			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,104,960	1,123,011	4,100,453	8,328,424		8,328,424	(248,588)	8,079,836			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Centralia Manor

Period Beginning 10/1/15
Period End 9/30/16

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
		1	2	3	4	5	6	7	8	9	10	
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory/Expenses			20,097	20,097		20,097		20,097			
	Radiology Expenses			22,931	22,931		22,931		22,931			
	Non-Allowable Expenses	46,993		171,957	218,950		218,950	(218,950)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special C	46,993	0	214,985	261,978	0	261,978	(218,950)	43,028			

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	(3,158)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,115)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3	30		9
10	Interest and Other Investment Income	(223)	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	(525)	20		17
18	Fines and Penalties				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	(113,646)	43		24
25	Fund Raising, Advertising and Promotional	(48,196)	43		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 Page 5A	(64,680)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (240,540)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(8,048)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (8,048)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (248,588)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Vending Expenses Against Income	\$ (4,297)	41	1
2	Disallow Marketing Wages	(46,993)	43	2
3	Disallow R/E Entity HUD Audit	(13,390)	19	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
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19				19
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21				21
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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	(64,680)		49

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 Page 6 Supplemental		
		Community Living Options, Inc. (CLO)				
		See Page 6 Supplemental for specific homes				

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	18	Director Fees	\$	Unlimited Development, Inc.	100.00%	\$ 3,990	\$ 3,990	1
2	V	19	Professional Fees		Unlimited Development, Inc.	100.00%	4,380	4,380	2
3	V	20	Dues, Licenses and Subs		Unlimited Development, Inc.	100.00%	2	2	3
4	V	21	General Admin Expense		Unlimited Development, Inc.	100.00%	6	6	4
5	V	26	Property/ Liability Insurance		Unlimited Development, Inc.	100.00%	916	916	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			\$			\$ 9,294	\$ * 9,294	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ 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)	
15	V	19	Professional Fees	\$	Centralia East McCord, LLC	N/A	\$ 13,390	\$ 13,390	15
16	V	20	Dues, Fees, Subs & Prom		Centralia East McCord, LLC	N/A	250	250	16
17	V	26	Property Insurance		Centralia East McCord, LLC	N/A	15,397	15,397	17
18	V	30	Depreciation		Centralia East McCord, LLC	N/A	249,372	249,372	18
19	V	32	Interest Expense	352	Centralia East McCord, LLC	N/A	335,097	334,745	19
20	V	32	Loan Fee Amortization		Centralia East McCord, LLC	N/A	19,331	19,331	20
21	V	33	Property Taxes		Centralia East McCord, LLC	N/A	212,500	212,500	21
22	V	34	Facility Rent	902,580	Centralia East McCord, LLC	N/A		(902,580)	22
23	V	36	Mortgage Insurance		Centralia East McCord, LLC	N/A	40,253	40,253	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 902,932			\$ 885,590	\$ * (17,342)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Centralia Manor

0047225

Report Period Beginning:

10/1/15

Ending:

9/30/16

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	Community Living Options, Inc.	100%			Allen Court	Clinton	CILA	1
2	Community Living Options, Inc.	100%	Beardstown Terrace	Beardstown				2
3	Community Living Options, Inc.	100%	Bellefontaine Place	Waterloo				3
4	Community Living Options, Inc.	100%	Braun's Terrace	Greenville				4
5	Community Living Options, Inc.	100%	Carthage Terrace	Carthage				5
6	Community Living Options, Inc.	100%	Curtiss Court	Springfield				6
7	Community Living Options, Inc.	100%	Davies Square	Pekin				7
8	Community Living Options, Inc.	100%	Douglas Terrace	Jacksonville				8
9	Community Living Options, Inc.	100%	Edwardsville Terrace	Edwardsville				9
10	Community Living Options, Inc.	100%	Effingham Terrace	Effingham				10
11	Community Living Options, Inc.	100%			Eisenhower Terrace	Jacksonville	CILA	11
12	Community Living Options, Inc.	100%	Freeburg Terrace	Freeburg				12
13	Community Living Options, Inc.	100%	Froehlich House	Galesburg				13
14	Community Living Options, Inc.	100%	Gaines Mill Place	Springfield				14
15	Community Living Options, Inc.	100%	Glenwood Terrace	Springfield				15
16	Community Living Options, Inc.	100%			Hawthorne Terrace	Galesburg	CILA	16
17	Community Living Options, Inc.	100%	Highview Terrace	Paris				17
18	Community Living Options, Inc.	100%	Jacksonville Group Homes:					18
19	Community Living Options, Inc.	100%	Anna Terrace	Jacksonville				19
20	Community Living Options, Inc.	100%	Campbell Court	Jacksonville				20
21	Community Living Options, Inc.	100%	LaFayette Terrace	Jacksonville				21
22	Community Living Options, Inc.	100%	Kepley House	Pittsfield				22
23	Community Living Options, Inc.	100%	Lawrence Place	Lincoln				23
24	Community Living Options, Inc.	100%	Lincoln Terrace	Lincoln				24
25	Community Living Options, Inc.	100%	Maple Terrace	Quincy				25
26	Community Living Options, Inc.	100%	Plonka Terrace	Galesburg				26
27	Community Living Options, Inc.	100%	Quincy Terrace	Quincy				27
28	Community Living Options, Inc.	100%	Schultz House	Danville				28
29	Community Living Options, Inc.	100%	Stevens House	Galesburg				29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Centralia Manor

0047225

Report Period Beginning:

10/1/15

Ending:

9/30/16

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	Community Living Options, Inc.	100%	Tanner Place	Paris				1
2	Community Living Options, Inc.	100%	Taylor House	Springfield				2
3	Community Living Options, Inc.	100%	Thelma Terrace	Wood River				3
4	Community Living Options, Inc.	100%	Trulson House	Galesburg				4
5	Community Living Options, Inc.	100%	Vahle Terrace	Jerseyville				5
6	Community Living Options, Inc.	100%	Walsh Terrace	Galesburg				6
7	Community Living Options, Inc.	100%	Wetherell Place	Effingham				7
8	Community Living Options, Inc.	100%	Woodriver Group Homes:					8
9	Community Living Options, Inc.	100%	Aberdeen Terrace	Alton				9
10	Community Living Options, Inc.	100%	Linton Terrace	Wood River				10
11	Community Living Options, Inc.	100%	Madison Terrace	Wood River				11
12	Community Living Options, Inc.	100%	Pershing Terrace	Wood River				12
13	Community Living Options, Inc.	100%			Audrey Court-CILA	Clinton	CILA	13
14	Unlimited Development, Inc. (UDI)	100%	Parkway Manor	Marion				14
15	Unlimited Development, Inc. (UDI)	100%			Parkway Estates	Marion	Retirement living ce	15
16	Unlimited Development, Inc. (UDI)	100%	Maryville Manor	Maryville				16
17	Unlimited Development, Inc. (UDI)	100%	Shelbyville Manor	Shelbyville				17
18	Unlimited Development, Inc. (UDI)	100%	Leroy Manor	Leroy				18
19	Unlimited Development, Inc. (UDI)	100%			Liberty Estates of Carl	Carbondale	Retirement living ce	19
20	Unlimited Development, Inc. (UDI)	100%	Care Center of Abingdon	Abingdon				20
21	Unlimited Development, Inc. (UDI)	100%	Seminary Manor	Galesburg				21
22	Unlimited Development, Inc. (UDI)	100%			Seminary Estates	Galesburg	Retirement living ce	22
23	Unlimited Development, Inc. (UDI)	100%			Hawthorne Inn of Gale	Galesburg	Assisted Living Faci	23
24	Unlimited Development, Inc. (UDI)	100%	Centralia Manor	Centralia				24
25	Unlimited Development, Inc. (UDI)	100%			Centralia Estates	Centralia Estates	Retirement living ce	25
26	Unlimited Development, Inc. (UDI)	100%	Pittsfield Manor	Pittsfield				26
27	Unlimited Development, Inc. (UDI)	100%	Pekin Manor	Pekin				27
28	Unlimited Development, Inc. (UDI)	100%			Pekin Estates	Pekin	Retirement living ce	28
29	Unlimited Development, Inc. (UDI)	100%	Jerseyville Manor	Jerseyville				29
30								30

SEE ACCOUNTANTS' PREPARATION 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	Unlimited Development, Inc. (UDI)	100%	River Hills Manor	Keokuk, IA				1
2	Unlimited Development, Inc. (UDI)	100%			River Hills Estates	Keokuk, IA	Retirement living ce	2
3	Unlimited Development, Inc. (UDI)	100%			River Hills Inn	Keokuk, IA	Assisted living facili	3
4	Unlimited Development, Inc. (UDI)	100%			Centralia East McCorn	Galesburg	Lessor	4
5	Unlimited Development, Inc. (UDI)	100%			Galesburg North Semi	Galesburg	Lessor	5
6	Unlimited Development, Inc. (UDI)	100%			Jerseyville North State	Galesburg	Lessor	6
7	Unlimited Development, Inc. (UDI)	100%			Shelbyville Route 128,	Galesburg	Lessor	7
8	Unlimited Development, Inc. (UDI)	100%			Marion Willimason Co	Galesburg	Lessor	8
9	Unlimited Development, Inc. (UDI)	100%			Leroy South Buck, LL	Galesburg	Lessor	9
10	Unlimited Development, Inc. (UDI)	100%			2245 Seminary Street,	Galesburg	Lessor	10
11	Unlimited Development, Inc. (UDI)	100%			Pittsfield Lowry, LLC	Galesburg	Lessor	11
12	Unlimited Development, Inc. (UDI)	100%			Pekin El Camino, LLC	Galesburg	Lessor	12
13	Unlimited Development, Inc. (UDI)	100%			Abingdon West Martin	Galesburg	Lessor	13
14	Unlimited Development, Inc. (UDI)	100%			Keokuk Village Circle,	Galesburg	Lessor	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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See Attached Schedule 7A								\$ 3,990	L18, C7	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	\$ 3,990		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Centralia Manor # 0047225 Report Period Beginning: 10/1/15 Ending: 9/30/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	18	Director Fees	Weighted Avail Bed Days	543,144	20	\$ 49,346	\$	43,920	\$ 3,990	1
2	19	Professional Fees	Weighted Avail Bed Days	543,144	20	54,173	\$	43,920	4,380	2
3	20	Dues, Licenses and Subs	Weighted Avail Bed Days	543,144	20	25		43,920	2	3
4	21	General Admin Expense	Weighted Avail Bed Days	543,144	20	70		43,920	6	4
5	26	Property/ Liability Insurance	Weighted Avail Bed Days	543,144	20	11,324		43,920	916	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 114,938	\$		\$ 9,294	25

SEE ACCOUNTANTS' PREPARATION REPORT

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	\$39,235.40	6/1/11	8,626,000	8,012,164	7/1/2046	4.2000	335,097		2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related				\$39,235.40		\$ 8,626,000	\$ 8,012,164			\$ 335,097		9
	B. Non-Facility Related*												
10									Amortization Exp		19,331		10
11									Int Income Offset		(575)		11
12									Misc Interest Expense		179		12
13													13
14	TOTAL Non-Facility Related						\$	\$			\$ 18,935		14
15	TOTALS (line 9+line14)						\$ 8,626,000	\$ 8,012,164			\$ 354,032		15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 40,253 Line # 36

* 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' PREPARATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2015 report.			\$	188,468 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.)	2015		\$	227,037 2
3. Under or (over) accrual (line 2 minus line 1).			\$	38,569 3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	173,931 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.			\$	212,500 7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2011	_____ 280,009	8	
	2012	_____ 276,989	9	
	2013	_____ 221,949	10	
	2014	_____ 225,618	11	
	2015	_____ 227,037	12	
This facility was purchased from an unrelated for-profit entity during 2005. A tax exemption has not yet been obtained.				
Amount accrued includes the taxes for 9 months based on fiscal year end. Estimate is based on prior year tax bill.				
Taxes paid during year represents the entire 2015 bill.				

	FOR BHF USE ONLY	
13 FROM R. E. TAX STATEMENT FOR 2015 \$		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.

SEE ACCOUNTANTS' PREPARATION REPORT

FACILITY NAME Centralia Manor COUNTY Marion

FACILITY IDPH LICENSE NUMBER 0047225

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,758

B. General Construction Type: Exterior BrickFrame WoodNumber 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:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	Facility	6.4 Acres		2005		\$ 275,000	
2							
3	TOTALS	#VALUE!				\$ 275,000	

SEE ACCOUNTANTS' PREPARATION 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		2005		\$ 9,142,000	\$	40	\$ 228,550	\$ 228,550	\$ 2,571,191
5										
6										
7										
8										
	Improvement Type**									
9	Sidewalks		2005		11,858	791	15	791		8,828
10	Parking Lot Lighting		2006		7,450	497	15	497		5,049
11	Roof		2007		5,555	556	10	556		5,046
12	Roof Replacement, Electric Sign, Shower room/VCT Rstrooms-Svc area		2008		162,223	16,222	10	16,222		134,018
13	New Roof, New Sign, Carpet, PT addition		2008		279,206	9,860	10-25 yrs	15,925	6,065	129,186
14	Air Conditioner, Water Heater, Dinning Room Remodel (Contracted Total)		2009		223,723	19,183	10-12 yrs	19,183		134,515
15	Water Heater, Window Valances, Windows		2010		36,000	2,124	5-15 yrs	2,124		22,632
16	Show Rooms/Activity Room Cabinets/Armour/Painting/Flooring/Cascade		2010		162,466	13,539	12	13,539		89,131
17	Hot Water Heater, Sprinklers		2011		25,227	1,459	10-25 yrs	1,459		7,667
18	Sprinkler System-Dry Pipe System		2011		35,800	1,432	25	1,432		6,921
19	Heatcraft Condensing Unit		2012		4,935	329	15	329		1,535
20	Fire Alarm Control Panel/Remote Annuciator/Maglock work		2012		6,300	630	10	630		2,888
21	Wood Blinds - 90		2012		5,875	1,175	5	1,175		5,091
22	AC System		2012		5,840	584	10	584		2,531
23	VCT Tile		2012		14,372	1,437	10	1,437		6,108
24	Lighted Sign 3X6 Single Faced		2012		3,200	320	10	320		1,307
25	Spectrim Crown Valance- 123		2012		50,793	10,159	5	10,159		39,788
26	Water Softener		2013		8,824	882	10	882		3,234
27	Water Heater		2013		5,989	599	10	599		2,096
28	Water Heater		2013		3,623	362	10	362		1,116
29	AC Unit		2014		5,330	1,066	5	1,066		2,487
30	Water Heater		2014		4,177	418	10	418		870
31	Water Heater		2015		5,210	521	10	521		868
32	Water Heater		2015		3,672	367	10	367		428
33	Dry Pipe Valve		2015		3,857	257	15	257		278
34	Single Face Lighted Sign		2015		4,950	495	10	495		536
35	Sprinkler Repair-Piping		2015		9,613	961	10	961		1,041
36										

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

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

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Centralia Manor

0047225

Report Period Beginning:

10/1/15

Ending:

9/30/16

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Roofing-Pauls Office Building	2015	17,559	1,756	10	1,756	\$	\$ 1,902	37
38 Landscaping/New Edging/Rock Pavers	2015	20,314	1,588	15	1,754	166	1,754	38
39 Physical Therapy Addition	2015	696,185		40	14,504	14,504	14,504	39
40 Front Doors	2016	35,428	1,472	15-20 Yrs	1,472		1,472	40
41 Water Heater	2016	9,466	631	10	631		631	41
42 Awning	2016	7,052	411	10	411		411	42
43 Asphalt Parking Lot	2016	358,554	18,675	8	18,675		18,675	43
44 Landscaping-Front of Building	2016	19,428	810	10	810		810	44
45 Building Remodel: Flooring-Tile/VCT/Carpet/Paint/Wallcoverings								45
46 Wall Lights/Chandeliers/Lamps/Bed Lights/Telephone System								46
47 Gen Contr/Plumbing/Electrical/Carpentry/Fire Sprinkler Install								47
48 Electrical Work-Nurse Station/Patient Rooms/Breakers	2016							48
49 Drapes, Poles	2016	939,643	47,868	5-10 Yrs	46,143	(1,725)	46,143	49
50 Fencing-Wrought Iron	2016	18,360	765	10	765		765	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)		\$ 12,360,057	\$ 160,201		\$ 407,761	\$ 247,560	\$ 3,273,453	70

SEE ACCOUNTANTS' PREPARATION 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	\$827,111	\$49,007	\$49,007	\$	3-15 yrs	\$607,668	71
72	Current Year Purchases	131,898	6,650	8,465	1,815		8,465	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$959,009	\$55,657	\$57,472	\$1,815		\$616,133	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2014 Braun Entervan 2263	2014	\$41,505	\$10,376	\$10,376	\$	4	\$19,023	76
77										77
78										78
79										79
80	TOTALS			\$41,505	\$10,376	\$10,376	\$		\$19,023	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)	\$13,635,571	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$226,234	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$475,609	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$249,375	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,908,609	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	2003 Chevy G3500	29,700		29,700	87
88					88
89					89
90					90
91	TOTALS	\$44,600	\$	\$44,600	91

G. Construction-in-Progress

	Description	Cost	
92	Fencing	\$1,836	92
93			93
94			94
95		\$1,836	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.

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
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.

		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:				\$			3
4	Additions							4
5								5
6								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
9. Option to Buy:

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ 16,231 Description: See Attached Schedule 14A
(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	N/A				18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: Centralia Manor
IDPH License ID Number: 0047225
Fiscal Year End: 9/30/16

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment Rental	14,256
Office Equipment	1,188
Other Equipment Rental	787
Total - Line 16	16,231

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

It is the policy of this facility to only hire certified nurses aides.
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

	Service	Schedule V Line & Column Reference	2	3	4		6	7	8	
			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	10A(3)	hrs	\$	1,341	\$ 471,824	\$	1,341	\$	471,824
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		366	158,887		366		158,887
3	Licensed Recreational Therapist		hrs							
4	Licensed Physical Therapist	10A(3)	hrs		1,595	491,631		1,595		491,631
5	Physician Care		visits							
6	Dental Care		visits							
7	Work Related Program		hrs							
8	Habilitation		hrs							
9	Pharmacy	39(2)	# of prescrpts				466,856			466,856
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
11	Academic Education		hrs							
12	Other (specify): Respiratory Therapy	10A(3)			448	73,671		448		73,671
13	Other (specify):									
14	TOTAL			\$	3,750	\$ 1,196,013	\$ 466,856	3,750	\$	1,662,869

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' PREPARATION 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	\$ 34,945	\$ 153,446	1
2	Cash-Patient Deposits	8,355	8,355	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 85,000)	1,354,288	1,355,151	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	109,195	148,683	6
7	Other Prepaid Expenses	1,990	1,990	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interdivision Receivable</u>	6,519,958	4,799,971	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 8,028,731	\$ 6,467,596	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		275,000	13
14	Buildings, at Historical Cost	2,520,329	12,360,057	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	673,773	1,000,514	16
17	Accumulated Depreciation (book methods)	(1,007,706)	(3,908,609)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	1,836	1,836	22
23	Other(specify): <u>See Sch 17A</u>		1,144,399	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,188,232	\$ 10,873,197	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,216,963	\$ 17,340,793	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 278,187	\$ 292,712	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,355	8,355	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	68,517	68,517	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	60,373	60,373	31
32	Accrued Real Estate Taxes(Sch.IX-B)		173,931	32
33	Accrued Interest Payable		24,504	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 415,432	\$ 628,392	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,012,164	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Security Deposits</u>	34,500	34,500	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 34,500	\$ 8,046,664	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 449,932	\$ 8,675,056	46
47	TOTAL EQUITY(page 18, line 24)	\$ 9,767,031	\$ 8,665,737	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,216,963	\$ 17,340,793	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Centralia Manor

Period 10/1/15

Period 9/30/16

Schedule 17A

XV. Balance Sheet
Line 23 Other

	Operating	After Consolidation
Replacement Reserve		467,066
Loan Fees, Net		476,376
Real Estate Tax Escrow		180,307
Insurance Escrow		3,001
MIP Escrow		17,649
TOTAL		1,144,399

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,648,903	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,648,904	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,118,127	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)	\$ 1,118,127	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)	\$ 9,767,031	24

*

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Centralia Manor

0047225

Report Period Beginning: 10/1/15

Ending:

9/30/16

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			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,370,250	1
2	Discounts and Allowances for all Levels	(96,524)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,273,726	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	143,384	6
7	Oxygen	9,743	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 153,127	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	8,725	12
13	Barber and Beauty Care	838	13
14	Non-Patient Meals	3,158	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	(315)	19
20	Radiology and X-Ray		20
21	Other Medical Services	6,100	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 18,506	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	223	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 223	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Late Fees/Fitness Center</u>	969	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 969	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,446,551	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,284,712	31
32	Health Care	3,685,829	32
33	General Administration	1,294,519	33
	B. Capital Expense		
34	Ownership	1,145,224	34
	C. Ancillary Expense		
35	Special Cost Centers	734,526	35
36	Provider Participation Fee	183,614	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,328,424	40
41	Income before Income Taxes (line 30 minus line 40)**	1,118,127	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,118,127	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,527,241	44
45	Private Pay - Net Inpatient Revenue	1,577,355	45
46	Medicare - Net Inpatient Revenue	5,588,148	46
47	Other-(specify) <u>Medicare Replacement/Managed Care</u>	560,637	47
48	Other-(specify) <u>Hospice</u>	20,345	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,273,726	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	1,696	1,839	\$ 54,931	\$ 29.88	1
2	Assistant Director of Nursing	1,976	2,046	52,938	25.88	2
3	Registered Nurses	14,408	15,295	310,033	20.27	3
4	Licensed Practical Nurses	28,412	29,979	529,981	17.68	4
5	CNAs & Orderlies	105,074	110,285	1,156,888	10.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,761	8,409	83,191	9.89	10
11	Social Service Workers	3,466	3,679	49,007	13.32	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,471	31,315	322,236	10.29	15
16	Dishwashers					16
17	Maintenance Workers	4,934	5,096	62,454	12.26	17
18	Housekeepers	15,939	16,628	157,835	9.49	18
19	Laundry	7,232	7,411	65,109	8.79	19
20	Administrator	1,948	2,080	71,937	34.59	20
21	Assistant Administrator					21
22	Other Administrative	2,028	2,080	46,993	22.59	22
23	Office Manager					23
24	Clerical	7,514	7,918	119,206	15.06	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	1,968	2,096	22,221	10.60	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	233,827	246,154	\$ 3,104,960 *	\$ 12.61	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	Monthly	\$ 11,519	L1, C3	35
36	Medical Director	Monthly	22,000	L9, C3	36
37	Medical Records Consultant	Monthly	1,555	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,240	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 42,314		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Jennifer Winka-Sursa	Administrator	None	\$ 71,937
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 71,937
B. Administrative - Other			
Description			Amount
N/A			\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
RFMS, Inc.	Administrative Services		\$ 171,600
LTC Support Services, LLC	Support Services		173,880
RSM US LLP	Accounting Services		24,684
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 370,164
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 77,545
Unemployment Compensation Insurance			22,181
FICA Taxes			230,323
Employee Health Insurance			171,365
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
401k			6,737
Other Employee Benefits			5,683
TOTAL (agree to Schedule V, line 22, col.8)			\$ 513,834
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
N/A			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$ 1,988
Advertising: Employee Recruitment			2,590
Health Care Worker Background Check (Indicate # of checks performed)	40		1,000
Patient Background Checks	160		4,000
Subscriptions			1,724
IHCA Dues			7,353
Other Licenses & Fees			1,116
Allocation of Home Office			2
Less: Public Relations Expense			(275)
Non-allowable advertising		()	
Yellow page advertising		()	
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 19,498
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			309
Seminar Expense			
Entertainment Expense		()	
TOTAL (agree to Sch. V, line 24, col. 8)			\$ 309

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

****See instructions.**

Facility Name & ID Number		Centralia Manor		STATE OF ILLINOIS	#	0047225	Report Period Beginning:	10/1/15	Ending:	9/30/16	Page 22
XX. GENERAL INFORMATION:											
(1)	Are nursing employees (RN,LPN,NA) represented by a union?			<u>No</u>							
(2)	Are there any dues to nursing home associations included on the cost report?			<u>Yes</u>							
	If YES, give association name and amount.			<u>7,353 IHCA</u>							
(3)	Did the nursing home make political contributions or payments to a political action organization?			<u>No</u>							
	If YES, have these costs been properly adjusted out of the cost report?			<u>N/A</u>							
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?			<u>No</u>							
	If YES, what is the capacity?			<u>N/A</u>							
(5)	Have you properly capitalized all major repairs and equipment purchases?			<u>Yes</u>							
	What was the average life used for new equipment added during this period?			<u>7.5 Yrs</u>							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$ <u>46,323</u> Line <u>10</u>							
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports?			<u>Yes</u>							
	If NO, attach a complete explanation.										
(8)	Are you presently operating under a sale and leaseback arrangement?			<u>No</u>							
	If YES, give effective date of lease.			<u>N/A</u>							
(9)	Are you presently operating under a sublease agreement?			YES <u>X</u> NO							
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?			YES <u>NO</u> <u>X</u>							
	If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.										
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.			\$ <u>183,614</u>							
	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?			<u>No</u>							
	If YES, attach an explanation of the allocation.										
SEE ACCOUNTANTS' PREPARATION REPORT											
(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?			<u>Yes</u>							
(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?			<u>No</u>							
	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 benefit on Schedule V.			\$ <u>0</u>							
	Has any meal income been offset against related costs?			<u>Yes</u>							
	Indicate the amount.			\$ <u>3,158</u>							
(16)	Travel and Transportation										
	a. Are there costs included for out-of-state travel?			<u>No</u>							
	If YES, attach a complete explanation.										
	b. Do you have a separate contract with the Department to provide medical transportation for residents?			<u>No</u>							
	If YES, please indicate the amount of income earned from such a program during this reporting period.			\$ <u>N/A</u>							
	c. What percent of all travel expense relates to transportation of nurses and patients?			<u>100% line 14</u>							
	d. Have vehicle usage logs been maintained?			<u>Yes</u>							
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?			<u>Yes</u>							
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?			<u>N/A</u>							
	g. Does the facility transport residents to and from day training?			<u>No</u>							
	Indicate the amount of income earned from providing such transportation during this reporting period.			\$ <u>N/A</u>							
(17)	Has an audit been performed by an independent certified public accounting firm?			<u>Yes</u>							
	Firm Name:			<u>RSM US LLP</u>							
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?			<u>Yes</u>							
(19)	Has a schedule for the legal fees reported on the cost report been provided by the facility?			<u>N/A</u>							
	See page 39 of the instructions for details.										
	Attach invoices and a summary of services for all architect and appraisal fees										