

		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: 0047597

Facility Name: Jerseyville Manor

Address: 1251 North State St Jerseyville 62052
Number City Zip Code

County: Jersey

Telephone Number: (618) 498-6441 Fax # (618) 498-9025

HFS ID Number:

Date of Initial License for Current Owners: 09/28/05

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 Jerseyville Manor

0047597 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>160</u>	Skilled (SNF)	<u>160</u>	<u>58,560</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>160</u>	TOTALS	<u>160</u>	<u>58,560</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>26,286</u>	<u>13,890</u>	<u>7,745</u>	<u>47,921</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>26,286</u>	<u>13,890</u>	<u>7,745</u>	<u>47,921</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.83%

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 10/01/05

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 9/28/05 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 160 and days of care provided 6,955

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 Jerseyville Manor # 0047597 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	306,830	28,442	12,958	348,230		348,230		348,230			1
2	Food Purchase		435,134		435,134		435,134	(2,416)	432,718			2
3	Housekeeping	189,769	59,545		249,314		249,314		249,314			3
4	Laundry	83,133	29,146		112,279		112,279		112,279			4
5	Heat and Other Utilities			166,933	166,933		166,933		166,933			5
6	Maintenance	88,284	44,672	73,968	206,924		206,924		206,924			6
7	Other (specify):*											7
8	TOTAL General Services	668,016	596,939	253,859	1,518,814		1,518,814	(2,416)	1,516,398			8
	B. Health Care and Programs											
9	Medical Director			14,700	14,700		14,700		14,700			9
10	Nursing and Medical Records	2,875,058	246,957	18,439	3,140,454		3,140,454		3,140,454			10
10a	Therapy			1,221,651	1,221,651		1,221,651		1,221,651			10a
11	Activities	109,225	4,233		113,458		113,458		113,458			11
12	Social Services	66,412			66,412		66,412		66,412			12
13	CNA Training											13
14	Program Transportation			6,225	6,225		6,225		6,225			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,050,695	251,190	1,261,015	4,562,900		4,562,900		4,562,900			16
	C. General Administration											
17	Administrative	117,407			117,407		117,407		117,407			17
18	Directors Fees							5,320	5,320			18
19	Professional Services			405,671	405,671		405,671	8,406	414,077			19
20	Dues, Fees, Subscriptions & Promotions			22,647	22,647		22,647	(522)	22,125			20
21	Clerical & General Office Expenses	122,265	38,052	77,782	238,099		238,099	7	238,106			21
22	Employee Benefits & Payroll Taxes			604,420	604,420		604,420		604,420			22
23	Inservice Training & Education			3,779	3,779		3,779		3,779			23
24	Travel and Seminar			58	58		58		58			24
25	Other Admin. Staff Transportation			6,223	6,223		6,223		6,223			25
26	Insurance-Prop.Liab.Malpractice			95,494	95,494		95,494	16,414	111,908			26
27	Other (specify):*											27
28	TOTAL General Administration	239,672	38,052	1,216,074	1,493,798		1,493,798	29,625	1,523,423			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,958,383	886,181	2,730,948	7,575,512		7,575,512	27,209	7,602,721			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			117,864	117,864		117,864	407,593	525,457			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			682	682		682	138,610	139,292			32
33	Real Estate Taxes			1,135	1,135		1,135	140,220	141,355			33
34	Rent-Facility & Grounds			838,644	838,644		838,644	(838,644)				34
35	Rent-Equipment & Vehicles			12,721	12,721		12,721		12,721			35
36	Other (specify):* Mort Ins							19,534	19,534			36
37	TOTAL Ownership			971,046	971,046		971,046	(132,687)	838,359			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		274,267		274,267		274,267		274,267			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			332,109	332,109		332,109		332,109			42
43	Other (specify):* See Att Sch 4A	54,309		250,455	304,764		304,764	(271,587)	33,177			43
44	TOTAL Special Cost Centers	54,309	274,267	582,564	911,140		911,140	(271,587)	639,553			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,012,692	1,160,448	4,284,558	9,457,698		9,457,698	(377,065)	9,080,633			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

Jerseyville 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):*			25,552	25,552		25,552		25,552			
	Laboratory/Expenses			7,625	7,625		7,625		7,625			
	Radiology Expenses				0		0		0			
	Non-Allowable Expenses	54,309		218,325	272,634		272,634	(272,634)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special C	54,309	0	251,502	305,811	0	305,811	(272,634)	33,177			

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	(2,416)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,639)	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	4	30		9
10	Interest and Other Investment Income	(34)	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	(775)	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	(5,839)	43		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(152,253)	43		24
25	Fund Raising, Advertising and Promotional	(53,547)	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	(409,450)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (629,949)		\$	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)	252,884		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 252,884		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (377,065)		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			Sch. V Line	
		Amount	Reference	
1	Disallow Related Party Interest Expense	\$ (344,316)	32	1
2	Disallow Marketing Wages	(54,309)	43	2
3	Disallow R/E Entity HUD Audit	(13,390)	19	3
4	Record Legal Fees from UDI-Direct Cost	2,565	19	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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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	(409,450)		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%	\$ 5,320	\$ 5,320	1
2	V	19	Professional Fees		Unlimited Development, Inc.	100.00%	5,841	5,841	2
3	V	20	Dues, Licenses and Subs		Unlimited Development, Inc.	100.00%	3	3	3
4	V	21	General Admin Expense		Unlimited Development, Inc.	100.00%	7	7	4
5	V	26	Property/ Liability Insurance		Unlimited Development, Inc.	100.00%	1,221	1,221	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			\$			\$ 12,392	\$ * 12,392	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	\$	Jerseyville North State, LLC	N/A	\$ 13,390	\$ 13,390	15
16	V	20	Dues, Fees, Subs & Prom		Jerseyville North State, LLC	N/A	250	250	16
17	V	26	Property Insurance		Jerseyville North State, LLC	N/A	15,193	15,193	17
18	V	30	Depreciation		Jerseyville North State, LLC	N/A	407,589	407,589	18
19	V	32	Interest Expense	264	Jerseyville North State, LLC	N/A	483,224	482,960	19
20	V	33	Property Taxes		Jerseyville North State, LLC	N/A	140,220	140,220	20
21	V	34	Facility Rent	838,644	Jerseyville North State, LLC	N/A		(838,644)	21
22	V	36	Mortgage Insurance		Jerseyville North State, LLC	N/A	19,534	19,534	22
23	V								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			\$ 838,908			\$ 1,079,400	\$ * 240,492	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Jerseyville Manor

0047597

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

Jerseyville Manor

0047597

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 Marti	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								\$ 5,320	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	\$ 5,320		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 Jerseyville Manor # 0047597 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	\$	58,560	\$ 5,320	1
2	19	Professional Fees	Weighted Avail Bed Days	543,144	20	54,173	\$	58,560	5,841	2
3	20	Dues, Licenses and Subs	Weighted Avail Bed Days	543,144	20	25		58,560	3	3
4	21	General Admin Expense	Weighted Avail Bed Days	543,144	20	70		58,560	7	4
5	26	Property/ Liability Insurance	Weighted Avail Bed Days	543,144	20	11,324		58,560	1,221	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	\$		\$ 12,392	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	\$17,694.29	5/1/12		4,173,100	3,879,122	3/1/2046	3.5500	138,908	2		
3													3		
4	Community Living												4		
5	Options, Inc.	X		Wing addition		8/1/2009		5,738,601	5,738,601	7/1/2039	6.0000	344,316	5		
	Working Capital														
6													6		
7													7		
8													8		
9	TOTAL Facility Related				\$17,694.29		\$	9,911,701	\$	9,617,723			\$	483,224	9
	B. Non-Facility Related*														
10														10	
11									Int Income Offset			(298)	11		
12									Disallow Related Party Int Exp			(344,316)	12		
13									Misc. Interest Expense			682	13		
14	TOTAL Non-Facility Related						\$		\$			\$	(343,932)	14	
15	TOTALS (line 9+line14)						\$	9,911,701	\$	9,617,723			\$	139,292	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 19,534 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.)

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Jerseyville Manor COUNTY Jersey

FACILITY IDPH LICENSE NUMBER 0047597

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 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.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 04-127-014-00	S17 T8 R11 UNPLATTED	\$ 138,124.82	\$ 138,124.82
2.	PARCELS PT SE 1/4 (TRACT	\$	\$
3.	1 - SURVEY IN PLAT CAB 1/54B)	\$	\$
4. 04-127-015-00	S17 T8 R11 UNPLATTED	\$ 890.60	\$ 890.60
5.	PARCELS PT SE 1/4 (PT TRACT	\$	\$
6.	2 PLAT CAB 1/54B)	\$	\$
7. 04-017-009-00	S17 T8 R11 TRACT IN SE1/4	\$ 244.02	\$ 244.02
8.	SE 1/4 9-04 85K, 10-00 75K	\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 139,259.44	\$ 139,259.44

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,306

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:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	3.5 Acres	2005	\$ 160,000	1
2	Facility Addition	.88 Acres	2008	14,025	2
3	TOTALS	#VALUE!		\$ 174,025	3

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	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	92		2005		\$ 4,578,867	\$	40	\$ 114,472	\$ 114,472	\$ 1,268,729	4
5	68		2008		4,926,175		25	197,047	197,047	1,576,376	5
6											6
7											7
8											8
	Improvement Type**										
9	Attic Insulation		2005		5,952	397	15	397		4,365	9
10	Parking Lot Lighting		2006		5,355	357	15	357		3,749	10
11	Furnace, Wall Paper/Paint Dining/Kitchen/Beauty Shop		2008		13,072	168	5-15 yrs	168		11,956	11
12	Floor Scrubber, Elec Sign, Prking Lot, Renten Pnd, Sidwlks		2008		398,166	4,474	5-20 yrs	41,133	36,659	338,622	12
13	Landscaping, Fence		2008		47,677		10-15 yrs	4,486	4,486	35,891	13
14	Electric Install, Recliner Wheelchairs, Baskets		2008		37,076	2,852	13	2,852		22,578	14
15	Dish Truck, Steamable, Convect. Steamer, Wiring Convec Over		2008		15,149	1,515	10	1,515		11,867	15
16	Roof		2008		116,316	11,632	10	11,632		92,084	16
17	Paint & Wallpaper, Paint & Wallpaper, Fence		2008		16,441	332	5-8 yrs	332		16,386	17
18	Wndw Decs, Duct work, Veranda, outsd lights, Jrsyvle Parking Lot		2009		265,075	21,135	5-15 yrs	21,135		221,277	18
19	Water heater		2010		4,760	476	10	476		2,856	19
20	Generator, Water heater, lobby remodel (Contracted Total)		2011		39,722	3,639	5-12 yrs.	3,639		21,809	20
21	Bathroom #1- Fixtures/Plumbing/Toilet/Drywall/Cabinets/Tile Floor/Pain		2012		68,090	5,674	12	5,674		22,223	21
22	Bathroom #2- Drywall/Plumbing/Fixtures/Cabinets/Tile Floor/Toilet/ Gra		2012		59,732	4,978	12	4,978		19,496	22
23	Bathroom #3- Fixtures/Plumbing/Toilet/Cabinets/Paint/ Drywall		2012		29,696	2,475	12	2,475		9,693	23
24	Bathroom #4- Fixtures/Drywall/Paint/Cabinets/Toilet/Tile Floor/ Grab Ba		2012		30,269	2,522	12	2,522		9,878	24
25	Water heater		2014		10,185	1,019	10	1,019		2,801	25
26	Water heater		2014		5,204	520	10	520		1,431	26
27	Exterior Double Doors		2014		5,641	564	10	564		1,363	27
28	Courtyard Doors		2014		2,615	174	15	174		421	28
29	Hollow Metal Doors		2014		4,937	247	20	247		597	29
30	Water Softener		2014		3,539	354	10	354		796	30
31	Concrete-Parking Lot		2014		52,000	3,467	15	3,467		7,223	31
32	Concrete Driveway		2015		25,040	1,669	15	1,669		2,225	32
33	Furnace/AC		2015		6,800	680	10	680		850	33
34	Carpet Therapy Room		2015		2,791	558	5	558		605	34
35	Therapy Room Addition		2015		582,659			12,139	12,139	12,139	35
36											36

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

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

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

Facility Name & ID Number Jerseyville Manor

0047597

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 Quarry Tile-Kitchen/VCT-Hall/Breakroom/Office/3 Bathrooms	2015	9,804	449	20	449	\$	\$ 449	37
38 Seal Parking Lot	2016	5,058	316	8	316		316	38
39 Kitchen Remodel-Tile/Cabinets/Counter Tops/Fixtures/Plumbing	2016	152,555	5,297	12	5,297		5,297	39
40 A/C Unit; Coil	2016	10,100	168	5	168		168	40
41 A/C Unit; Coil, Furnace, Condenser-Roof Top Unit	2016	10,250	57	15	57		57	41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 11,546,768	\$ 78,165		\$ 442,968	\$ 364,803	\$ 3,726,573	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	\$961,819	\$21,636	\$63,580	\$41,944	3-15 yrs	\$767,814	71
72	Current Year Purchases	78,543	7,581	8,427	846	5-15 Yrs	8,427	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,040,362	\$29,217	\$72,007	\$42,790		\$776,241	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2014 Braun Entervan	2014	\$41,928	\$10,482	\$10,482		4	\$25,331	76
77										77
78										78
79										79
80	TOTALS			\$41,928	\$10,482	\$10,482			\$25,331	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)	\$12,803,083	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$117,864	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$525,457	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$407,593	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$4,528,145	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	2005 Ford E350 - 2005	\$47,110	\$	\$47,110	86
87	2006 Toyota Corolla - 2006	15,288		15,288	87
88	2003 GMC G3500 Van - 2006	29,848		29,848	88
89					89
90					90
91	TOTALS	\$92,246	\$	\$92,246	91

G. Construction-in-Progress

	Description	Cost	
92	Remodel & Live Life Upgrades	\$38,032	92
93			93
94			94
95		\$38,032	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. 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:				\$			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 . N/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: \$12,721 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: Jerseyville Manor
IDPH License ID Number: 0047597
Fiscal Year End: 9/30/16

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment Rental	10,629
Office Equipment	549
Other Equipment Rental	1,543
Total - Line 16	12,721

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	\$	1,452	\$ 444,938	\$	1,452	\$	444,938
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		757	237,523		757		237,523
3	Licensed Recreational Therapist		hrs							
4	Licensed Physical Therapist	10A(3)	hrs		1,399	509,406		1,399		509,406
5	Physician Care		visits							
6	Dental Care		visits							
7	Work Related Program		hrs							
8	Habilitation		hrs							
9	Pharmacy	39(2)	# of prescrpts				274,267			274,267
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
11	Academic Education		hrs							
12	Other (specify): Respiratory Therapy	10A(3)			626	29,784		626		29,784
13	Other (specify):									
14	TOTAL			\$	4,234	\$ 1,221,651	\$ 274,267	4,234	\$	1,495,918

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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 58,550	\$ 364,882	1
2	Cash-Patient Deposits	23,723	23,723	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 163,000)	2,342,957	2,346,445	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	139,398	161,815	6
7	Other Prepaid Expenses	2,980	2,980	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interdivision Receivable	7,151,313	6,384,118	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 9,718,921	\$ 9,283,963	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		174,025	13
14	Buildings, at Historical Cost	1,066,034	11,546,768	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	508,861	1,082,290	16
17	Accumulated Depreciation (book methods)	(861,486)	(4,528,145)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	38,032	38,032	22
23	Other(specify): See Att Sch 17A		365,243	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 751,441	\$ 8,678,213	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,470,362	\$ 17,962,176	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 161,160	\$ 175,505	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,723	23,723	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	101,430	101,430	30
	Accrued Taxes Payable (excluding real estate taxes)	113,840	113,840	31
32	Accrued Real Estate Taxes(Sch.IX-B)		101,647	32
33	Accrued Interest Payable		183,634	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)	\$ 400,153	\$ 699,779	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,617,723	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Security Deposits	45,000	45,000	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 45,000	\$ 9,662,723	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 445,153	\$ 10,362,502	46
47	TOTAL EQUITY(page 18, line 24)	\$ 10,025,209	\$ 7,599,674	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,470,362	\$ 17,962,176	48

Jerseyville Manor

Period 10/1/15

Period 9/30/16

Schedule 17A

XV. Balance Sheet
Line 23 Other

	Operating	After Consolidation
Replacement Reserve		346,749
Real Estate Tax Escrow		12,000
Insurance Escrow		3,000
MIP Escrow		3,494
TOTAL		365,243

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$9,062,508	1
2	Restatements (describe):		2
3	Post Closing Entries	(55,215)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$9,007,293	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,017,916	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)	\$1,017,916	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$10,025,209	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Jerseyville Manor

0047597

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	\$ 9,929,800	1
2	Discounts and Allowances for all Levels	(69,420)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,860,380	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	581,716	6
7	Oxygen	390	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 582,106	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	2,125	12
13	Barber and Beauty Care	3,779	13
14	Non-Patient Meals	291	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,978	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 9,173	23
	D. Non-Operating Revenue		
24	Contributions	220	24
25	Interest and Other Investment Income***	34	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 254	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Late Fees/Maintenance Fees	23,701	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 23,701	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,475,614	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,518,814	31
32	Health Care	4,562,900	32
33	General Administration	1,493,798	33
	B. Capital Expense		
34	Ownership	971,046	34
	C. Ancillary Expense		
35	Special Cost Centers	579,031	35
36	Provider Participation Fee	332,109	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,457,698	40
41	Income before Income Taxes (line 30 minus line 40)**	1,017,916	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,017,916	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,668,523	44
45	Private Pay - Net Inpatient Revenue	2,135,099	45
46	Medicare - Net Inpatient Revenue	3,574,368	46
47	Other-(specify) Medicare Replacement/Managed Care	384,308	47
48	Other-(specify) Hospice	98,082	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,860,380	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	1,976	2,052	\$ 80,864	\$ 39.42	1
2	Assistant Director of Nursing	1,976	2,075	51,204	24.68	2
3	Registered Nurses	26,950	28,379	677,514	23.87	3
4	Licensed Practical Nurses	22,227	23,300	462,331	19.84	4
5	CNAs & Orderlies	132,493	139,294	1,581,946	11.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,824	10,501	109,225	10.40	10
11	Social Service Workers	3,887	4,179	66,412	15.89	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	28,720	30,150	306,830	10.18	15
16	Dishwashers					16
17	Maintenance Workers	5,812	6,296	88,284	14.02	17
18	Housekeepers	18,551	19,798	189,769	9.59	18
19	Laundry	8,718	9,293	83,133	8.95	19
20	Administrator	1,972	2,160	117,407	54.36	20
21	Assistant Administrator					21
22	Other Administrative	1,920	2,080	54,309	26.11	22
23	Office Manager					23
24	Clerical	7,107	7,644	122,265	15.99	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	1,658	1,708	21,199	12.41	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	273,791	288,906	\$ 4,012,692 *	\$ 13.89	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 12,958	L1, C3	35
36	Medical Director	Monthly	14,700	L9, C3	36
37	Medical Records Consultant	Monthly	2,500	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,757	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)		\$ 40,915		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Dana Bainter	Administrator	None	\$ 117,407
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 117,407
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		206,940
RSM US LLP	Accounting Services		24,949
Polsinelli Shughart PC	Legal Services		2,182
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 405,671
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 94,548
Unemployment Compensation Insurance			5,723
FICA Taxes			294,758
Employee Health Insurance			186,810
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
401k			14,762
Other Employee Benefits			7,819
TOTAL (agree to Schedule V, line 22, col.8)			\$ 604,420
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			\$ 1,992
Advertising: Employee Recruitment			745
Health Care Worker Background Check (Indicate # of checks performed 40)			1,000
Patient Background Checks			1,970
Subscriptions			3,146
IHCA Dues			9,804
Other Licenses & Fees			3,990
Allocation from Home Office			3
Less: Public Relations Expense			(525)
Non-allowable advertising			()
Yellow page advertising			()
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 22,125
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			58
Seminar Expense			
Entertainment Expense			()
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 58

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

****See instructions.**

XX. GENERAL INFORMATION:

STATE OF ILLINOIS

0047597

Report Period Beginning:

10/1/15

Ending:

Page 22

9/30/16

- (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?
If YES, give association name and amount. 9,804 IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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?
What was the average life used for new equipment added during this period? Yes
10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 100,762 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.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 332,109
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.

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? 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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,416
- (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? 100% line 14
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: RSM US LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees