

		FOR BHF USE					

LL1

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: 0050427

Facility Name: Manor Court of Maryville

Address: 6955 State Route 162 Maryville 62062
Number City Zip Code

County: Madison

Telephone Number: (618) 288-3800 Fax # (618) 288-1106

HFS ID Number:

Date of Initial License for Current Owners: 10/01/2006

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501 (c) (3)

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Ron Wilson Telephone Number: (309) 343-1550
Email Address:

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 Manor Court of Maryville

0050427 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>132</u>	Skilled (SNF)	<u>132</u>	<u>48,312</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>132</u>	TOTALS	<u>132</u>	<u>48,312</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>18,501</u>	<u>12,527</u>	<u>10,598</u>	<u>41,626</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>18,501</u>	<u>12,527</u>	<u>10,598</u>	<u>41,626</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.16%

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 1/25/11

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 1/1/11 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 132 and days of care provided 7,459

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Maryville # 0050427 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	323,639	30,045	10,857	364,541		364,541		364,541			1
2	Food Purchase		374,386		374,386		374,386	(826)	373,560			2
3	Housekeeping	163,745	54,533		218,278		218,278		218,278			3
4	Laundry	80,468	25,000		105,468		105,468	(195)	105,273			4
5	Heat and Other Utilities			207,433	207,433		207,433		207,433			5
6	Maintenance	90,803	27,973	71,290	190,066		190,066		190,066			6
7	Other (specify):*											7
8	TOTAL General Services	658,655	511,937	289,580	1,460,172		1,460,172	(1,021)	1,459,151			8
	B. Health Care and Programs											
9	Medical Director			52,500	52,500		52,500		52,500			9
10	Nursing and Medical Records	2,803,176	294,028	15,781	3,112,985		3,112,985		3,112,985			10
10a	Therapy	975,825		17,500	993,325		993,325		993,325			10a
11	Activities	84,391	2,898		87,289		87,289		87,289			11
12	Social Services	111,479			111,479		111,479		111,479			12
13	CNA Training											13
14	Program Transportation			5,300	5,300		5,300		5,300			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,974,871	296,926	91,081	4,362,878		4,362,878		4,362,878			16
	C. General Administration											
17	Administrative	113,251			113,251		113,251		113,251			17
18	Directors Fees							4,389	4,389			18
19	Professional Services			378,914	378,914		378,914	4,820	383,734			19
20	Dues, Fees, Subscriptions & Promotions			24,141	24,141		24,141	2	24,143			20
21	Clerical & General Office Expenses	138,001	38,420	55,247	231,668		231,668	6	231,674			21
22	Employee Benefits & Payroll Taxes			783,630	783,630		783,630		783,630			22
23	Inservice Training & Education			12,337	12,337		12,337		12,337			23
24	Travel and Seminar			1,071	1,071		1,071		1,071			24
25	Other Admin. Staff Transportation			5,297	5,297		5,297		5,297			25
26	Insurance-Prop.Liab.Malpractice			195,540	195,540		195,540	1,007	196,547			26
27	Other (specify):*											27
28	TOTAL General Administration	251,252	38,420	1,456,177	1,745,849		1,745,849	10,224	1,756,073			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,884,778	847,283	1,836,838	7,568,899		7,568,899	9,203	7,578,102			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			47,204	47,204		47,204	(4,265)	42,939			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			107,750	107,750		107,750		107,750			33
34	Rent-Facility & Grounds			998,794	998,794		998,794		998,794			34
35	Rent-Equipment & Vehicles			39,124	39,124		39,124		39,124			35
36	Other (specify):* Mort Ins											36
37	TOTAL Ownership			1,192,872	1,192,872		1,192,872	(4,265)	1,188,607			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			17,556	17,556		17,556		17,556			38
39	Ancillary Service Centers		375,553	235	375,788		375,788		375,788			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			142	142		142	(142)				41
42	Provider Participation Fee			269,027	269,027		269,027		269,027			42
43	Other (specify):* See Att Sch 4A	125,856		810,803	936,659		936,659	(861,467)	75,192			43
44	TOTAL Special Cost Centers	125,856	375,553	1,097,763	1,599,172		1,599,172	(861,609)	737,563			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,010,634	1,222,836	4,127,473	10,360,943		10,360,943	(856,671)	9,504,272			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

Manor Court of Maryville

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			32,011	32,011		32,011		32,011			
	Radiology Expenses			43,181	43,181		43,181		43,181			
	Non-Allowable Expenses	125,856		735,611	861,467		861,467	(861,467)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special C	125,856	0	810,803	936,659	0	936,659	(861,467)	75,192			

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	(826)	2		4
5	Telephone, TV & Radio in Resident Rooms	(11,837)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(195)	4		8
9	Non-Straightline Depreciation	(4,265)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				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	(611,738)	43		24
25	Fund Raising, Advertising and Promotional	(112,036)	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	(125,998)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (866,895)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	10,224		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 10,224		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (856,671)		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	Offset Vending Expenses Against Income	\$ (142)	41	1
2	Disallow Marketing Wages	(125,856)	43	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
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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	(125,998)		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%	\$ 4,389	\$ 4,389	1
2	V	19	Professional Fees		Unlimited Development, Inc.	100.00%	4,820	4,820	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%	1,007	1,007	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			\$			\$ 10,224	\$ * 10,224	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Manor Court of Maryville

0050427

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

Manor Court of Maryville

0050427

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								\$ 4,389	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	\$ 4,389		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

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												\$	1
2	N/A												2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$	\$			\$		9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$	\$			\$		14
15	TOTALS (line 9+line14)						\$	\$			\$		15

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

* 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.)

FACILITY NAME Manor Court of Maryville COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0050427

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.

- A. Square Feet: 72,233
- 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. (X) (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? (X) (a) Own the Equipment (b) Rent equipment from a Related Organization. (X) (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 (X)
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				\$	1
2					2
3	TOTALS			\$	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	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					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Sign		2010		44,512	4,451	10	4,451		27,819
10	Water Filtration System		2012		8,588	859	10	859		4,080
11	Water Softener		2014		7,902	790	10	790		2,040
12	Workstation-Counters/Cabinets/Chair		2014		3,834	320	12	320		586
13	Compressr/Inverter Assembly		2016		7,384	98	15	98		98
14	Carpet-Nurse Station, Office, Garden Court Sitting Area		2016		5,452	182	5	182		182
15	A/C Units/Condenser		2016		8,253	96	5-15 Yrs	96		96
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*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 Manor Court of Maryville

0050427

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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37							\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
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)		\$ 85,925	\$ 6,796		\$ 6,796	\$	\$ 34,901	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	\$ 397,481	\$ 27,579	\$ 27,579	\$	3-15 yrs	\$ 300,747	71
72	Current Year Purchases	62,717	8,564	8,564		5-10 Yrs	8,564	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 460,198	\$ 36,143	\$ 36,143	\$		\$ 309,311	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	2005 Ford E350 Universal	2006	\$ 47,110	\$	\$	\$	4	\$ 47,110
77									77
78									78
79									79
80	TOTALS			\$ 47,110	\$	\$	\$		\$ 47,110

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)			\$	593,233
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	42,939
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	42,939
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	391,322

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	2013 Toyota Corolla - 2013	\$ 17,060	\$ 4,265	\$ 14,928	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 17,060	\$ 4,265	\$ 14,928	91

G. Construction-in-Progress			
	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: LB Properties, Inc.
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES

NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	2010	120	1/1/2011	\$ 998,794	15	10	3
4	Additions		12					4
5								5
6								6
7	TOTAL		132		\$ 998,794			7

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

This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A.

N/A
9. Option to Buy:

YES

X

 NO Terms: N/A *

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

15. Is Movable equipment rental included in building rental?

YES

NO
16. Rental Amount for movable equipment: \$ 39,124 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

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

C. CONTRACTUAL INCOME

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)	\$			

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

HFS 3745 (N-4-99)

IL478-2471

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A(1)	12,448	hrs	\$ 375,000		\$	\$	12,448	\$ 375,000	1
2	Licensed Speech and Language Development Therapist	10A(1)	3,006	hrs	120,964				3,006	120,964	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A(1)	13,236	hrs	381,033				13,236	381,033	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39(2)		# of prescrpts				375,553		375,553	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	10A(3)				73	17,500		73	17,500	12
13	Other (specify): <u>Therapy Coordinator</u>	10A(1)	2,072		98,828				2,072	98,828	13
14	TOTAL				\$ 975,825	73	\$ 17,500	\$ 375,553	30,835	\$ 1,368,878	14

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

SEE ACCOUNTANTS' 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	\$ 309,076	\$ 309,076	1
2	Cash-Patient Deposits	28,158	28,158	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 711,000)	2,271,250	2,271,250	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	161,547	161,547	6
7	Other Prepaid Expenses	6,370	6,370	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,776,401	\$ 2,776,401	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	85,925	85,925	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	524,369	507,308	16
17	Accumulated Depreciation (book methods)	(406,247)	(391,322)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify) Non Care Assets		2,132	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 204,047	\$ 204,043	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,980,448	\$ 2,980,444	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 311,890	\$ 311,890	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,158	28,158	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	98,605	98,605	30
31	Accrued Taxes Payable (excluding real estate taxes)	94,100	94,100	31
32	Accrued Real Estate Taxes(Sch.IX-B)	100,966	100,966	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Interdivision Payable	5,739,369	5,739,369	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,373,088	\$ 6,373,088	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Security Deposits	47,353	47,353	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 47,353	\$ 47,353	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,420,441	\$ 6,420,441	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,439,993)	\$ (3,439,997)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,980,448	\$ 2,980,444	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,107,824)	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)	\$ (3,107,825)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(332,168)	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)	\$ (332,168)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (3,439,993)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Maryville

0050427

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	\$ 10,059,938	1
2	Discounts and Allowances for all Levels	(252,339)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,807,599	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	179,909	6
7	Oxygen	14,222	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 194,131	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	871	12
13	Barber and Beauty Care	2,685	13
14	Non-Patient Meals	826	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	649	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	76	20
21	Other Medical Services	12,925	21
22	Laundry	195	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 18,227	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	624	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 624	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Late Fees	8,194	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,194	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,028,775	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,460,172	31
32	Health Care	4,362,878	32
33	General Administration	1,745,849	33
	B. Capital Expense		
34	Ownership	1,192,872	34
	C. Ancillary Expense		
35	Special Cost Centers	1,330,145	35
36	Provider Participation Fee	269,027	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,360,943	40
41	Income before Income Taxes (line 30 minus line 40)**	(332,168)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (332,168)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,649,958	44
45	Private Pay - Net Inpatient Revenue	2,058,642	45
46	Medicare - Net Inpatient Revenue	3,585,985	46
47	Other-(specify) Medicare Replacement/Managed Care	1,115,955	47
48	Other-(specify) Hospice	397,059	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,807,599	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	1,796	1,889	\$ 69,986	\$ 37.05	1
2	Assistant Director of Nursing	1,784	1,808	52,410	28.99	2
3	Registered Nurses	22,426	23,264	564,310	24.26	3
4	Licensed Practical Nurses	30,368	31,597	649,963	20.57	4
5	CNAs & Orderlies	121,172	126,097	1,442,029	11.44	5
6	CNA Trainees					6
7	Licensed Therapist	28,980	30,762	975,825	31.72	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,915	7,541	84,391	11.19	10
11	Social Service Workers	5,918	6,235	111,479	17.88	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	32,232	33,536	323,639	9.65	15
16	Dishwashers					16
17	Maintenance Workers	5,836	6,291	90,803	14.43	17
18	Housekeepers	17,438	18,042	163,745	9.08	18
19	Laundry	8,582	9,114	80,468	8.83	19
20	Administrator	2,008	2,080	113,251	54.45	20
21	Assistant Administrator					21
22	Other Administrative	3,680	3,960	125,856	31.78	22
23	Office Manager					23
24	Clerical	8,895	9,406	138,001	14.67	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	1,974	2,094	24,478	11.69	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	300,004	313,715	\$ 5,010,634 *	\$ 15.97	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	\$ 10,857	L1, C3	35
36	Medical Director	Monthly	52,500	L9, C3	36
37	Medical Records Consultant	Monthly	2,000	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,079	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)		\$ 74,436		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				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount	Description	Amount		
Johnny Law	Administrator	None	\$ 113,251	Workers' Compensation Insurance	\$ 118,745	IDPH License Fee	\$ 1,989		
				Unemployment Compensation Insurance	32,067	Advertising: Employee Recruitment	1,011		
				FICA Taxes	370,787	Health Care Worker Background Check			
				Employee Health Insurance	215,713	(Indicate # of checks performed 81)	2,029		
				Employee Meals		Patient Background Checks 125	3,130		
				Illinois Municipal Retirement Fund (IMRF)*					
				401k	36,242	Subscriptions	5,204		
				Other Employee Benefits	10,076	IHCA Dues	8,088		
						Other Licenses & Fees	2,690		
						Allocation from Home Office	2		
						Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 113,251		TOTAL (agree to Sch. V, line 20, col. 8)		\$ 24,143	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**
Description			Amount	Description	Line #	Amount	Description	Amount	
N/A			\$	N/A			Out-of-State Travel	\$	
							In-State Travel	1,071	

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

****See instructions.**

Facility Name & ID Number		Manor Court of Maryville		STATE OF ILLINOIS	#	0050427	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>8,088 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>47,715</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 NO <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>269,027</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.										
(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>826</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>Yes</u>							
	See page 39 of the instructions for details.										
	Attach invoices and a summary of services for all architect and appraisal fees										

SEE ACCOUNTANTS' PREPARATION REPORT