

		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: <u>0047233</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>Seminary Manor</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/15</u> to <u>9/30/16</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																	
Address: <u>2345 N Seminary St</u> <u>Galesburg</u> <u>61401</u>																																																			
NumberCityZip Code																																																			
County: <u>Knox</u>																																																			
Telephone Number: <u>(309) 344-1300</u> Fax # <u>(309) 344-2473</u>																																																			
HFS ID Number: _____		Officer or Administrator of Provider Paid Preparer																																																	
Date of Initial License for Current Owners: <u>7/28/05</u>																																																			
Type of Ownership:																																																			
<table><tr><td>☒</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code <u>501 (c) (3)</u></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2"></td></tr></table>				☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code <u>501 (c) (3)</u>		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.					☐	Limited Liability Co.					☐	Trust					☐	Other _____		
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		☐	Trust																																																
		☐	Other _____																																																
In the event there are further questions about this report, please contact:		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																																																	
Name: <u>Ron Wilson</u> Telephone Number: <u>(309) 343-1550</u>																																																			
Email Address: _____																																																			

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Seminary Manor

0047233 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>121</u>	Skilled (SNF)	<u>121</u>	<u>44,286</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>121</u>	TOTALS	<u>121</u>	<u>44,286</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>6,903</u>	<u>14,887</u>	<u>12,145</u>	<u>33,935</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>6,903</u>	<u>14,887</u>	<u>12,145</u>	<u>33,935</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.63%

SEE ACCOUNTANTS' PREPARATION REPORT

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 8/01/05

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 7/28/05 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 121 and days of care provided 8,603

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.

Facility Name & ID Number Seminary Manor # 0047233 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	365,241	27,082	14,505	406,828		406,828		406,828			1
2	Food Purchase		361,857		361,857		361,857	(2,896)	358,961			2
3	Housekeeping	159,231	47,915		207,146		207,146		207,146			3
4	Laundry	50,912	12,962		63,874		63,874		63,874			4
5	Heat and Other Utilities			157,141	157,141		157,141		157,141			5
6	Maintenance	61,992	60,250	55,579	177,821		177,821		177,821			6
7	Other (specify):*											7
8	TOTAL General Services	637,376	510,066	227,225	1,374,667		1,374,667	(2,896)	1,371,771			8
	B. Health Care and Programs											
9	Medical Director			32,590	32,590		32,590		32,590			9
10	Nursing and Medical Records	2,370,903	273,524	9,599	2,654,026		2,654,026		2,654,026			10
10a	Therapy			1,197,959	1,197,959		1,197,959		1,197,959			10a
11	Activities	99,892	2,997		102,889		102,889		102,889			11
12	Social Services	59,525			59,525		59,525		59,525			12
13	CNA Training											13
14	Program Transportation			3,281	3,281		3,281		3,281			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,530,320	276,521	1,243,429	4,050,270		4,050,270		4,050,270			16
	C. General Administration											
17	Administrative	135,584			135,584		135,584		135,584			17
18	Directors Fees							4,024	4,024			18
19	Professional Services			372,122	372,122		372,122	4,417	376,539			19
20	Dues, Fees, Subscriptions & Promotions			19,211	19,211		19,211	2	19,213			20
21	Clerical & General Office Expenses	105,294	45,543	50,775	201,612		201,612	6	201,618			21
22	Employee Benefits & Payroll Taxes			548,662	548,662		548,662		548,662			22
23	Inservice Training & Education			3,579	3,579		3,579		3,579			23
24	Travel and Seminar			133	133		133		133			24
25	Other Admin. Staff Transportation			3,280	3,280		3,280		3,280			25
26	Insurance-Prop.Liab.Malpractice			43,490	43,490		43,490	18,499	61,989			26
27	Other (specify):*											27
28	TOTAL General Administration	240,878	45,543	1,041,252	1,327,673		1,327,673	26,948	1,354,621			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,408,574	832,130	2,511,906	6,752,610		6,752,610	24,052	6,776,662			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			140,659	140,659		140,659	261,035	401,694			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							370,580	370,580			32
33	Real Estate Taxes							174,000	174,000			33
34	Rent-Facility & Grounds			809,970	809,970		809,970	(809,970)				34
35	Rent-Equipment & Vehicles			15,746	15,746		15,746		15,746			35
36	Other (specify):* Mort Ins							42,334	42,334			36
37	TOTAL Ownership			966,375	966,375		966,375	37,979	1,004,354			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,100	2,100		2,100		2,100			38
39	Ancillary Service Centers		421,648		421,648		421,648		421,648			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			3,473	3,473		3,473	(3,473)				41
42	Provider Participation Fee			208,972	208,972		208,972		208,972			42
43	Other (specify):* See Att Sch 4A	47,097		422,089	469,186		469,186	(354,348)	114,838			43
44	TOTAL Special Cost Centers	47,097	421,648	636,634	1,105,379		1,105,379	(357,821)	747,558			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,455,671	1,253,778	4,114,915	8,824,364		8,824,364	(295,790)	8,528,574			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

Seminary Manor

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

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
		1	2	3	4	5	6	7	8	9	10	
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory/Expenses			49,505	49,505		49,505		49,505			
	Radiology Expenses			65,333	65,333		65,333		65,333			
	Non-Allowable Expenses	47,097		307,251	354,348		354,348	(354,348)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special C	47,097	0	422,089	469,186	0	469,186	(354,348)	114,838			

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	(2,896)	2		4
5	Telephone, TV & Radio in Resident Rooms	(13,233)	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	(1)	30		9
10	Interest and Other Investment Income	(121)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	423	43		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	(250)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(235,716)	43		24
25	Fund Raising, Advertising and Promotional	(58,725)	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	(63,960)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (374,479)		\$	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)	78,689		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 78,689		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (295,790)		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

Seminary Manor		
ID#	0047233	
Report Period Beginning:	10/1/15	
Ending:	9/30/16	

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Vending Expenses Against Income	\$ (3,473)	41	1
2	Disallow Marketing Wages	(47,097)	43	2
3	Disallow R/E Entity HUD Audit	(13,390)	19	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
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32				32
33				33
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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	(63,960)		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%	\$ 4,024	\$ 4,024	1
2	V	19	Professional Fees		Unlimited Development, Inc.	100.00%	4,417	4,417	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%	923	923	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 9,372	\$ * 9,372	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	\$	Galesburg North Seminary, LLC	N/A	\$ 13,390	\$ 13,390	15
16	V	20	Dues, Fees, Subs & Prom		Galesburg North Seminary, LLC	N/A	250	250	16
17	V	26	Property Insurance		Galesburg North Seminary, LLC	N/A	17,576	17,576	17
18	V	30	Depreciation		Galesburg North Seminary, LLC	N/A	261,036	261,036	18
19	V	32	Interest Expense	347	Galesburg North Seminary, LLC	N/A	351,793	351,446	19
20	V	32	Loan Fee Amortization		Galesburg North Seminary, LLC	N/A	19,255	19,255	20
21	V	33	Property Taxes		Galesburg North Seminary, LLC	N/A	174,000	174,000	21
22	V	34	Facility Rent	809,970	Galesburg North Seminary, LLC	N/A		(809,970)	22
23	V	36	Mortgage Insurance		Galesburg North Seminary, LLC	N/A	42,334	42,334	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			\$ 810,317			\$ 879,634	\$ * 69,317	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Seminary Manor

0047233

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

Seminary Manor

0047233

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	<u>Unlimited Development, Inc. (UDI)</u>	<u>100%</u>	<u>River Hills Manor</u>	<u>Keokuk, IA</u>				1
2	<u>Unlimited Development, Inc. (UDI)</u>	<u>100%</u>			<u>River Hills Estates</u>	<u>Keokuk, IA</u>	<u>Retirement living ce</u>	2
3	<u>Unlimited Development, Inc. (UDI)</u>	<u>100%</u>			<u>River Hills Inn</u>	<u>Keokuk, IA</u>	<u>Assisted living facili</u>	3
4	<u>Unlimited Development, Inc. (UDI)</u>	<u>100%</u>			<u>Centralia East McCorn</u>	<u>Galesburg</u>	<u>Lessor</u>	4
5	<u>Unlimited Development, Inc. (UDI)</u>	<u>100%</u>			<u>Galesburg North Semi</u>	<u>Galesburg</u>	<u>Lessor</u>	5
6	<u>Unlimited Development, Inc. (UDI)</u>	<u>100%</u>			<u>Jerseyville North State</u>	<u>Galesburg</u>	<u>Lessor</u>	6
7	<u>Unlimited Development, Inc. (UDI)</u>	<u>100%</u>			<u>Shelbyville Route 128,</u>	<u>Galesburg</u>	<u>Lessor</u>	7
8	<u>Unlimited Development, Inc. (UDI)</u>	<u>100%</u>			<u>Marion Willimason Co</u>	<u>Galesburg</u>	<u>Lessor</u>	8
9	<u>Unlimited Development, Inc. (UDI)</u>	<u>100%</u>			<u>Leroy South Buck, LL</u>	<u>Galesburg</u>	<u>Lessor</u>	9
10	<u>Unlimited Development, Inc. (UDI)</u>	<u>100%</u>			<u>2245 Seminary Street,</u>	<u>Galesburg</u>	<u>Lessor</u>	10
11	<u>Unlimited Development, Inc. (UDI)</u>	<u>100%</u>			<u>Pittsfield Lowry, LLC</u>	<u>Galesburg</u>	<u>Lessor</u>	11
12	<u>Unlimited Development, Inc. (UDI)</u>	<u>100%</u>			<u>Pekin El Camino, LLC</u>	<u>Galesburg</u>	<u>Lessor</u>	12
13	<u>Unlimited Development, Inc. (UDI)</u>	<u>100%</u>			<u>Abingdon West Marti</u>	<u>Galesburg</u>	<u>Lessor</u>	13
14	<u>Unlimited Development, Inc. (UDI)</u>	<u>100%</u>			<u>Keokuk Village Circle,</u>	<u>Galesburg</u>	<u>Lessor</u>	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								\$ 4,024	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	\$ 4,024		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	Cambridge Realty Capital						\$		\$			\$	1		
2	LTD. of Illinois		X	Facility purchase	\$40,951.77	7/1/2011		9,063,800	8,412,680	8/1/2046	4.1500	351,793	2		
3													3		
4													4		
5													5		
	Working Capital														
6													6		
7													7		
8													8		
9	TOTAL Facility Related				\$40,951.77		\$	9,063,800	\$	8,412,680			\$	351,793	9
	B. Non-Facility Related*														
10										Amortization Exp		19,255	10		
11										Int Income Offset		(468)	11		
12													12		
13													13		
14	TOTAL Non-Facility Related						\$		\$			\$	18,787	14	
15	TOTALS (line 9+line14)						\$	9,063,800	\$	8,412,680			\$	370,580	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 42,334 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.)

FACILITY NAME Seminary Manor COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0047233

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.

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,680

B. General Construction Type: Exterior BrickFrame WoodNumber of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility☒ (b) Rent from a Related Organization.☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment☒ (b) Rent equipment from a Related Organization.☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	4.33 Acres	2005	\$ 287,000	1
2					2
3	TOTALS	#VALUE!		\$ 287,000	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	121		2005		\$ 9,633,067	\$	40	\$ 240,827	\$ 240,827	\$ 2,689,233
5			2014	2014	501,672		40	12,542	12,542	26,129
6										
7										
8										
	Improvement Type**									
9	Fire Door Closers			2005	3,059	204	15	204		2,209
10	A/C, Sign, Concrete, Asphalt, Door, Dining rm addn, Alarm			2006	74,961	3,090	8-15 yrs	3,090		70,363
11	AC, Vinyl, Cabinetry, Sidewalk, Roof/deck repair, Window treatments			2007	123,842	9,177	5-15 yrs	11,802	2,625	118,156
12	Roof,Fire dampers,Condensor, Sidewalks, Sprinklers			2008	61,632	5,785	10-25 yrs	5,785		48,679
13	Prime Walls/Paint, Condensing Units/Refridgeration piping, A/C			2008	14,320	423	5-15 yrs	423		11,708
14	Handrail, Double door w/ side lights, Roof repair, Roof repair - Garage			2008	44,415	4,349	10-15 yrs	4,349		37,314
15	Lighting ple, Rplc wall/ceil, Roof Repl, Rbbr Flr, Lgt post concrete			2009	73,343	6,561	10-15 yrs	6,561		51,477
16	Prking lot poles, Prking lot (asphalt), Tile, Wtrheater, Shwr rm.			2009	89,588	8,514	8-20 yrs	8,514		66,562
17	PT addtn, Garden crt addtn, Concrete prking lot & sidewalk			2009	296,914	12,220	15-25 yrs	12,220		95,291
18	Waterheater, Waterheater			2010	7,500	750	10	750		4,531
19	Carpet - Bounce Back			2011	25,627	4,698	5	4,698		25,626
20	Seminary Manor Public BR - Floor/Wallpaper/Vanity/Faucets/Mirrors			2011	15,530	1,294	12	1,294		6,578
21	New Fan for kitchen exhaust hood			2012	2,650	265	10	265		1,170
22	Bedroom - Drywall/Tile/Covebase/Countertop/Cabinets/Paint			2012	7,925	660	12	660		2,805
23	Water heater			2012	4,888	489	10	489		1,874
24	Walk in cooler remodel- Drywall/paint/prime/tile/insulation			2012	23,065	1,922	12	1,922		7,688
25	Furnace			2013	2,600	173	15	173		591
26	AC Condensor			2013	2,850	190	15	190		649
27	Water Heater			2013	4,600	460	10	460		1,418
28	Roof			2013	12,447	1,245	10	1,245		3,735
29	Training Cntr Remodel-Kawneer Dr, 2 ADA Rmps, Deck Rmv			2013	23,582	1,965	12	1,965		5,568
30	Water Heater			2014	3,794	379	10	379		884
31	Fence-Metal			2014	7,193	1,439	5	1,439		2,998
32	Foyer Remodel-Drywll/Pnt/Rmv/Rnstll Fire Alarms/Handrails/Wllpapr/F			2014	16,400	1,367	12	1,367		2,962
33	Generator Transfer Switches			2014	10,872	1,087	10	1,087		2,265
34	PT Completion-Equipment/Supplies/Cabinet			2014	83,319	6,943	12	6,943		14,465
35	Parking Lot addition			2014	29,100		8	3,638	3,638	7,579
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 Seminary Manor

0047233

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 Wall Sconces	2014	5,278	754	7	754	\$	1,445	37
38 Landscaping	2014	\$ 5,797	\$ 580	10	\$ 580		1,208	38
39 Landscaping	2014	3,448	345	10	345		632	39
40 Cabinets-Conference Room/Kitchen	2015	2,596	173	15	173		303	40
41 Decorative Fencing	2015	7,678	307	25	307		461	41
42 Water Softener	2015	6,993	699	10	699		990	42
43 Interior Doors/Automatic Doors	2015	8,700	870	10	870		1,015	43
44 Fiber Optic Cables-Phone and Internet	2015	3,710	742	5	742		866	44
45 Fencing	2015	6,173	1,234	5	1,234		2,057	45
46 PTAC Units	2015	3,678	184	5	184		184	46
47 Water Heater	2016	3,516	117	10	117		117	47
48 Gazebo-Garden Court	2016	3,988	133	10	133		133	48
49 Nurse Station Remodel-Tile/Cabinets	2016	84,138	584	12	584		584	49
50 Shower Room A Remodel-Tub/Plumbing/Tile/Electrical	2016	124,926	868	12	868		868	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)		\$ 11,471,374	\$ 83,239		\$ 342,871	\$ 259,632	\$ 3,321,370	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	\$938,285	\$43,963	\$45,366	\$1,403	3-15 yrs	\$748,649	71
72	Current Year Purchases	125,380	13,457	13,457		5-15 Yrs	13,457	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,063,665	\$57,420	\$58,823	\$1,403		\$762,106	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	2008 Ford E450 Universal	2008	\$50,950	\$	\$	\$	4	\$50,950	76
77										77
78										78
79										79
80	TOTALS			\$50,950	\$	\$	\$		\$50,950	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)	\$12,872,989	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$140,659	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$401,694	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$261,035	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$4,134,426	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	2002 Ford F25 - 2006	\$21,200	\$	\$21,200	86
87	2006 Toyota Corolla - 2006	14,900		14,900	87
88					88
89					89
90					90
91	TOTALS	\$36,100	\$	\$36,100	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: 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. ☐ 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:				\$			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: ☐ YES ☐ NO Terms: N/A *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 15,746 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:

Seminary Manor

IDPH License ID Number:

0047233

Fiscal Year End:

9/30/16

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment Rental	10,689
Office Equipment	1,005
Other Equipment Rental	4,052
Total - Line 16	15,746

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

D. NUMBER OF CNAs TRAINED

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

COMPLETED

1. From this facility

2. From other facilities (f)

DROP-OUTS

1. From this facility

2. From other facilities (f)

TOTAL TRAINED

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

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	1,149	\$ 454,050	\$	1,149	\$ 454,050	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		207	86,133		207	86,133	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		1,336	609,759		1,336	609,759	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				421,648		421,648	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)			561	47,417		561	47,417	12
13	Other (specify): <u> </u>									13
14	TOTAL			\$	3,253	\$ 1,197,359	\$ 421,648	3,253	\$ 1,619,007	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	\$ 18,080	\$ 102,349	1
2	Cash-Patient Deposits	18,924	18,924	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 224,000)	1,641,138	1,641,138	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	121,791	167,601	6
7	Other Prepaid Expenses	1,490	1,490	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interdivision Receivable</u>	4,202,039	2,615,884	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,003,462	\$ 4,547,386	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		287,000	13
14	Buildings, at Historical Cost	1,271,808	11,471,374	14
15	Leasehold Improvements, at Historical Cost	5,797		15
16	Equipment, at Historical Cost	785,435	1,114,615	16
17	Accumulated Depreciation (book methods)	(1,064,350)	(4,134,426)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Att Sch 17A</u>		964,799	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 998,690	\$ 9,703,362	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,002,152	\$ 14,250,748	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 578,599	\$ 595,159	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,924	18,924	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	83,992	83,992	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	68,360	68,360	31
32	Accrued Real Estate Taxes(Sch.IX-B)		124,260	32
33	Accrued Interest Payable	4,940	34,034	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)	\$ 754,815	\$ 924,729	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,412,680	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Security Deposits</u>	45,013	45,013	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 45,013	\$ 8,457,693	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 799,828	\$ 9,382,422	46
47	TOTAL EQUITY(page 18, line 24)	\$ 6,202,324	\$ 4,868,326	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,002,152	\$ 14,250,748	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Seminary Manor

Period 10/1/15

Period 9/30/16

Schedule 17A

XV. Balance Sheet
Line 23 Other

	Operating	After Consolidation
Replacement Reserve		470,567
Loan Fees, Net		472,455
Real Estate Tax Escrow		15,000
Insurance Escrow		3,000
MIP Escrow		3,777
TOTAL		964,799

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,861,229	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)	\$ 5,861,228	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	341,096	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)	\$ 341,096	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)	\$ 6,202,324	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Seminary Manor

0047233

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	\$ 8,974,069	1
2	Discounts and Allowances for all Levels	(97,127)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,876,942	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	203,235	6
7	Oxygen	18,188	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 221,423	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	7,251	12
13	Barber and Beauty Care	11,135	13
14	Non-Patient Meals	2,896	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	538	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	20,983	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 42,803	23
	D. Non-Operating Revenue		
24	Contributions	15,763	24
25	Interest and Other Investment Income***	121	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15,884	26
	E. Other Revenue (specify).****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Late Fees/Processing Fees	8,408	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,408	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,165,460	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,374,667	31
32	Health Care	4,050,270	32
33	General Administration	1,327,673	33
	B. Capital Expense		
34	Ownership	966,375	34
	C. Ancillary Expense		
35	Special Cost Centers	896,407	35
36	Provider Participation Fee	208,972	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,824,364	40
41	Income before Income Taxes (line 30 minus line 40)**	341,096	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 341,096	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 857,078	44
45	Private Pay - Net Inpatient Revenue	2,428,430	45
46	Medicare - Net Inpatient Revenue	3,985,980	46
47	Other-(specify) Medicare Replacement/Managed Care	1,274,820	47
48	Other-(specify) Hospice	330,634	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,876,942	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	1,960	2,080	\$ 78,660	\$ 37.82	1
2	Assistant Director of Nursing	1,992	2,160	58,964	27.30	2
3	Registered Nurses	13,638	14,515	331,778	22.86	3
4	Licensed Practical Nurses	30,623	32,613	642,010	19.69	4
5	CNAs & Orderlies	102,840	108,041	1,221,109	11.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,751	9,372	99,892	10.66	10
11	Social Service Workers	4,680	4,953	59,525	12.02	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	35,596	37,460	365,241	9.75	15
16	Dishwashers					16
17	Maintenance Workers	5,536	5,857	61,992	10.58	17
18	Housekeepers	14,951	16,047	159,231	9.92	18
19	Laundry	5,353	5,641	50,912	9.02	19
20	Administrator	2,004	2,160	135,584	62.77	20
21	Assistant Administrator					21
22	Other Administrative	1,928	2,080	47,097	22.64	22
23	Office Manager					23
24	Clerical	8,139	8,631	105,294	12.20	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	3,467	3,655	38,382	10.50	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	241,458	255,261	\$ 3,455,671 *	\$ 13.54	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	\$ 14,505	L1, C3	35
36	Medical Director	Monthly	32,590	L9, C3	36
37	Medical Records Consultant	Monthly	2,000	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,914	L10, C3	39
40	Physical Therapy Consultant	Monthly	600	L10A, C3	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)		\$ 56,609		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	
Tracy Owens	Administrator	None	\$ 135,584	Workers' Compensation Insurance		\$ 82,171	IDPH License Fee	\$ 1,992	
				Unemployment Compensation Insurance		17,143	Advertising: Employee Recruitment	929	
				FICA Taxes		254,593	Health Care Worker Background Check		
				Employee Health Insurance		165,519	(Indicate # of checks performed 67)	1,670	
				Employee Meals			Patient Background Checks 207	5,176	
				Illinois Municipal Retirement Fund (IMRF)*					
				401k		26,612	Subscriptions	809	
				Other Employee Benefits		2,624	IHCA Dues	7,414	
							Other Licenses & Fees	1,221	
							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.)							TOTAL (agree to Sch. V, line 20, col. 8)		
						\$ 548,662	\$ 19,213		
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			G. Schedule of Travel and Seminar**		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees					
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
RFMS, Inc.	Administrative Services		\$ 171,600				Out-of-State Travel	\$	
LTC Support Services, LLC	Support Services		175,320	N/A					
RSM US LLP	Accounting Services		24,682						
Spears & Spears	Legal Services		520				In-State Travel	133	
							Seminar Expense		
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				TOTAL			(agree to Sch. V, line 24, col. 8)		
							TOTAL 133		

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

****See instructions.**

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

Yes
7,414 IHCA
- (3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

No
N/A
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
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.

\$ 52,762 Line 10
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
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.
This amount is to be recorded on line 42 of Schedule V.

\$ 208,972
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

- (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?
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.

No
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
Has any meal income been offset against related costs?

\$ 0
Yes Indicate the amount. \$ 2,896
- (16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No
\$ 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?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

Yes
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.
Attach invoices and a summary of services for all architect and appraisal fees

Yes

SEE ACCOUNTANTS' PREPARATION REPORT