FOR BHF USE

LL1

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0047969

Facility Name: Pekin Manor

Address: 1520 El Camino Drive (Number) Pekin (City) 61554 (Zip Code)

County: Tazewell

Telephone Number: (309) 353-1099 **Fax #** (309) 353-1363

HFS ID Number:

Date of Initial License for Current Owners: 04/26/06

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 (c) (3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			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 10/1/11 to 9/30/12 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) Ben Perkins
(Title) Director of Operations

Paid Preparer

(Signed) See Preparation Report (Date)
(Print Name and Title) McGladrey LLP, 117 E. Main St., Suite 210
(Firm Name & Address) P.O. Box 1070, Galesburg, IL 61401
(Telephone) (309) 342-1175 Fax # (309) 342-7816

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**

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/11 Ending: 9/30/12

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,920	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	120	TOTALS	120	43,920	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	14,669	10,336	8,208	33,213	8
9	SNF/PED					9
10	ICF		0			10
11	ICF/DD					11
12	SC		0			12
13	DD 16 OR LESS					13
14	TOTALS	14,669	10,336	8,208	33,213	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.62%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/26/06

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/06 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 120 and days of care provided 6,159

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 9/30/12 Fiscal Year: 9/30/12

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

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/11 Ending: 9/30/12

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	270,372	33,870	6,300	310,542		310,542		310,542			1
2	Food Purchase		352,368		352,368		352,368	(61)	352,307			2
3	Housekeeping	128,018	51,184		179,202		179,202		179,202			3
4	Laundry	21,312	20,169		41,481		41,481		41,481			4
5	Heat and Other Utilities			120,426	120,426		120,426		120,426			5
6	Maintenance	102,275	114,183	75,391	291,849		291,849		291,849			6
7	Other (specify):*											7
8	TOTAL General Services	521,977	571,774	202,117	1,295,868		1,295,868	(61)	1,295,807			8
	B. Health Care and Programs											
9	Medical Director			17,250	17,250		17,250		17,250			9
10	Nursing and Medical Records	2,002,810	333,668	8,205	2,344,683		2,344,683		2,344,683			10
10a	Therapy			469,597	469,597		469,597		469,597			10a
11	Activities	78,465	8,308		86,773		86,773		86,773			11
12	Social Services	35,490			35,490		35,490		35,490			12
13	CNA Training											13
14	Program Transportation					8,450	8,450		8,450			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,116,765	341,976	495,052	2,953,793	8,450	2,962,243		2,962,243			16
	C. General Administration											
17	Administrative	130,369			130,369		130,369		130,369			17
18	Directors Fees							3,597	3,597			18
19	Professional Services			382,897	382,897		382,897	(7,202)	375,695			19
20	Dues, Fees, Subscriptions & Promotions			40,399	40,399		40,399	(29,931)	10,468			20
21	Clerical & General Office Expenses	75,650	45,742	34,628	156,020		156,020	574	156,594			21
22	Employee Benefits & Payroll Taxes			525,834	525,834		525,834		525,834			22
23	Inservice Training & Education			2,657	2,657		2,657		2,657			23
24	Travel and Seminar			720	720		720		720			24
25	Other Admin. Staff Transportation			16,899	16,899	(8,450)	8,449		8,449			25
26	Insurance-Prop.Liab.Malpractice			75,363	75,363		75,363	41,970	117,333			26
27	Other (specify):* See Att Sch V	41,841		143,252	185,093		185,093	(185,093)				27
28	TOTAL General Administration	247,860	45,742	1,222,649	1,516,251	(8,450)	1,507,801	(176,085)	1,331,716			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,886,602	959,492	1,919,818	5,765,912		5,765,912	(176,146)	5,589,766			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Pekin Manor #0047969 **Report Period Beginning:** 10/1/11 **Ending:** 9/30/12

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			140,191	140,191		140,191	238,308	378,499			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							309,170	309,170			32
33	Real Estate Taxes							99,600	99,600			33
34	Rent-Facility & Grounds			667,904	667,904		667,904	(667,904)				34
35	Rent-Equipment & Vehicles			3,131	3,131		3,131		3,131			35
36	Other (specify):* See Att Sch IV							6,112	6,112			36
37	**TOTAL Ownership**			811,226	811,226		811,226	(14,714)	796,512			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			41,810	41,810		41,810		41,810			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			2,860	2,860		2,860		2,860			41
42	Provider Participation Fee			319,375	319,375		319,375		319,375			42
43	Other (specify):* Outpatient Care			5,137	5,137		5,137		5,137			43
44	**TOTAL Special Cost Centers**			369,182	369,182		369,182		369,182			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,886,602	959,492	3,100,226	6,946,320		6,946,320	(190,860)	6,755,460			45

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

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/11 Ending: 9/30/12

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	(61)	V-2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		V-30		9
10	Interest and Other Investment Income	(6,619)	V-32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties		V-21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(141,205)	V-27		24
25	Fund Raising, Advertising and Promotional	(29,969)	V-20		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 Att Sch VI	(54,419)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (232,273)		$	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)	31,371		34
35	Other- Attach Schedule **See Att Sch III**	10,042		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 41,413		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (190,860)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Pekin Manor

ID# 0047969

Report Period Beginning: 10/1/11

Ending: 9/30/12

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

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pekin Manor # 0047969 **Report Period Beginning:** 10/1/11 **Ending:** 9/30/12

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

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

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Pekin Manor # 0047969 **Report Period Beginning:** 10/1/11 **Ending:** 9/30/12

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	31,371	0	0	0	0	0	0	0	0	0	31,371	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	31,371	0	0	0	0	0	0	0	0	0	31,371	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	31,371	0	0	0	0	0	0	0	0	0	31,371	45

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/11 Ending: 9/30/12

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
None	N/A	Unlimited Development, Inc (UDI)		See Attached Schedule I		
		Community Living Options, Inc. (CLO)				
		See Attached Schedule I for specific homes & other CLO subsidiaries				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Facility Rent	$ 667,904	Pekin El Camino, LLC	N/A	$ 699,275	$ 31,371	1
2	V								2
3	V				See Att Schedule IV and Preparation Report				3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 667,904			$ 699,275	$ * 31,371	14

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

Facility Name & ID Number Pekin Manor # 0047969 **Report Period Beginning:** 10/1/11 **Ending:** 9/30/12

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/11 Ending: 9/30/12

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See Attached Schedule II & III								$ 3,597	18-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 3,597		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

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/11 Ending: 9/30/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2		See Att Sch II & III							10,042	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 10,042	25

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/11 Ending: 9/30/12

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Cambridge Realty Capital						$	$			$	1
2	LTD. Of Illinois		X	Facility purchase	$28,646.12	6/1/12	6,249,800	6,229,456	10/1/2041	3.5500	315,789	2
3												3
4												4
5												5
	Working Capital											
6	Miscellaneous		X									6
7	Less Interest Income		X								(6,619)	7
8												8
9	TOTAL Facility Related				$28,646.12		$ 6,249,800	$ 6,229,456			$ 309,170	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,249,800	$ 6,229,456			$ 309,170	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 31,565 Line # 26

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

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

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/11 Ending: 9/30/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 71,966	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 98,550	2
3. Under or (over) accrual (line 2 minus line 1).		$ 26,584	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 73,016	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 99,600	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	90,864	8
	2008	92,828	9
	2009	94,873	10
	2010	97,834	11
	2011	98,550	12

This facility was purchased from an unrelated for-profit entity during 2006. A tax exemption has not yet been obtained
Amount accrued includes the taxes for 9 months based on fiscal year end. Estimate is based on prior year tax bill
Taxes paid during year represents the entire 2011 bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Pekin Manor COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0047969

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

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

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-10-11-400-015	Sec 11 T24N R5W	$ 97,684.78	$ 97,684.78
2.		PT OF E 1/2 SE 1/2	$	$
3.			$	$
4.	10-10-14-205-010	SEC 14 T24N R5W	$ 865.98	$ 865.98
5.		PT OF E 1/2 NE 1/4	$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 98,550.76	$ 98,550.76

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/11 Ending: 9/30/12

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,948 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [X] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	6.24 Acres	2006	$ 450,000	1
2					2
3	TOTALS	#VALUE!		$ 450,000	3

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/11 Ending: 9/30/12

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		2006	1988	$ 7,174,313	$ 179,353	40	$ 179,353	$	$ 1,165,821	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Light Sign - Double Faced, Fire Alarm Panel			2006	43,700	4,370	10	4,370		28,817	9
10	Replace Defective Pipe for Dry System, Roof			2007	139,058	13,027	10-25 yrs	13,027		64,051	10
11	Roof Repair, Furnace Duct Repair, Sprinkler System			2008	179,648	10,560	10-25 yrs	10,560		45,226	11
12	A/C Unit			2009	5,890	1,178	5	1,178		4,221	12
13	Shower Room Repairs			2009	27,671	1,845	15	1,845		6,611	13
14	Installed Firewall (Sheet Rock)			2009	15,586	1,558	10	1,558		5,455	14
15	Wall/Ceiling Repairs & Paint			2009	11,772	1,177	10	1,177		4,120	15
16	Kitchen Wall & Floor Repairs			2009	17,948	1,196	15	1,196		4,387	16
17	Shower Room Tile			2009	2,587	129	20	129		452	17
18	Shower Room (Tile & Paint)			2009	11,694	779	15	779		2,663	18
19	Tile (Shower Room Walls)			2009	2,967	148	20	148		507	19
20	Air Conditioners			2009	2,680	536	5	536		1,742	20
21	Carpet - Main Entry Offices/Hall			2009	4,500	900	5	900		2,775	21
22	Sprinkler System			2009	7,197	288	25	288		936	22
23	Sidewalks - SW Corners/Exit/Courtyard			2009	18,410	1,227	15	1,227		3,682	23
24	Water Heater			2009	4,750	475	10	475		1,346	24
25	Landscaping/Lights in Center Courtyard			2009	7,280	728	10	728		2,063	25
26	Single Face Lighted Sign			2010	2,734	273	10	273		660	26
27	Physical Therapy Completion			2010	392,863	32,739	12	32,739		84,575	27
28	Water Heater			2010	3,039	304	10	304		608	28
29	Water Heater			2010	4,309	431	10	431		790	29
30	Apollo Tub Room - Sink/Mirror/Shower/Tile/Drywall/Drains/Faucets			2011	56,049	4,671	12	4,671		7,785	30
31	Water Heater			2011	4,926	493	10	493		698	31
32	Condensor - 5 ton			2011	2,500	166	15	166		208	32
33	Bathrm Remodel-Sink/Mirror/Walls/Tile/Floor/Curtains/Drywall/Plumb			2011	39,773	3,314	12	3,314		4,143	33
34	Physical Therapy Remodel - Contracted Total			2011	147,137	12,261	12	12,261		18,392	34
35	Dining Room Addition (Contracted Total)			2011	183,361	15,280	12	15,280		22,920	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

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/11 Ending: 9/30/12

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	Sprinkler System	2011	$ 127,543	$ 4,251	25	$ 4,251	$	$ 4,251	37
38	Sprinkler-New Tamper Switch/Relocate FDC Check Valve	2012	5,867	176	25	176		176	38
39	Kitchenette Rmdl-Sink/Vnyl Tile/Cabinet/Counter/Crnr Grds	2012	53,384	1,112	12	1,112		1,112	39
40	Nurse Station/Lounge Remodel-Paint/Vinyl/Counter/Cabinet	2012	150,956	3,145	12	3,145		3,145	40
41	Remodel-Paint/drywall/corner Plates	2012	4,570	76	5	76		76	41
42	Smoke Detectors-48/Pull Stations-6.5/Heat Detectors-10	2012	9,831	82	10	82		82	42
43	Water Heater	2012	3,717	31	10	31		31	43
44	Excavation of Lake	2012	13,885	579	10	579		579	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)		$ 8,884,095	$ 298,858		$ 298,858	$	$ 1,495,106	70

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

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/11 Ending: 9/30/12

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	$ 678,663	$ 74,657	$ 74,657	$	5-15 yrs	$ 386,464	71
72	Current Year Purchases	71,125	4,984	4,984		5-15 yrs	4,984	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 749,788	$ 79,641	$ 79,641	$		$ 391,448	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2003 Chevy G3500	2006	$ 34,100	$	$	$	4 yrs	$ 34,100	76
77										77
78										78
79										79
80	TOTALS			$ 34,100	$	$	$		$ 34,100	80

E. Summary of Care-Related Assets

		1 Reference	2 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)	$ 10,117,983	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 378,499	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 378,499	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,920,654	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	2006 Toyota Corolla - 2006	$ 14,900	$	$ 14,900	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 14,900	$	$ 14,900	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/11 Ending: 9/30/12

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Pekin El Camino, LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [X] 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:				$ See Attached			3
4	Additions				Schedule IV			4
5					Related Party			5
6					Lease			6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
   This amount was calculated by dividing the total amount to be amortized N/A
   by the length of the lease N/A .

9. Option to Buy: [ ] YES [ ] NO Terms: N/A *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2013	$ N/A
13.	/2014	$ N/A
14.	/2015	$ 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: $ 3,131 Description: See Attached Schedule XII
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* 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.

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/11 Ending: 9/30/12

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

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

STATE OF ILLINOIS

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/11 Ending: 9/30/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/12 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 46,321	$ 267,064	1
2	Cash-Patient Deposits	12,005	12,005	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 114,264)	1,338,911	1,338,911	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	115,980	132,281	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Att Sch VII		22,541	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,513,217	$ 1,772,802	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		450,000	13
14	Buildings, at Historical Cost	13,885	7,421,032	14
15	Leasehold Improvements, at Historical Cost	1,463,063	1,463,063	15
16	Equipment, at Historical Cost	411,588	798,788	16
17	Accumulated Depreciation (book methods)	(472,864)	(1,935,554)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Att Sch VII		490,504	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,415,672	$ 8,687,833	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,928,889	$ 10,460,635	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 153,825	$ 261,892	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,005	12,005	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	59,936	59,936	30
31	Accrued Taxes Payable (excluding real estate taxes)	102,074	102,074	31
32	Accrued Real Estate Taxes(Sch.IX-B)		73,016	32
33	Accrued Interest Payable		18,429	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Interdivision Payable	4,135,286	6,279,116	36
37	Current portion of long term payable		124,622	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,463,126	$ 6,931,090	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,104,834	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Security Deposits	46,054	46,054	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 46,054	$ 6,150,888	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,509,180	$ 13,081,978	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,580,291)	$ (2,621,343)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,928,889	$ 10,460,635	48

***(See instructions.)**

Facility Name & ID Number Pekin Manor **#** 0047969 **Report Period Beginning:** 10/1/11 **Ending:** 9/30/12

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,282,072)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,282,072)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(298,219)	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)**	$ (298,219)	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)**	$ (1,580,291)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/11 Ending: 9/30/12

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,484,627	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,484,627	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	135,445	6
7	Oxygen	1,938	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 137,383	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	3,515	12
13	Barber and Beauty Care	5,257	13
14	Non-Patient Meals	61	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	192	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 9,025	23
	D. Non-Operating Revenue		
24	Contributions	1,588	24
25	Interest and Other Investment Income***	6,619	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,207	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund Income		28
28a	See Att Schdule X	8,859	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,859	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,648,101	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,295,868	31
32	Health Care	2,953,793	32
33	General Administration	1,516,251	33
	B. Capital Expense		
34	Ownership	811,226	34
	C. Ancillary Expense		
35	Special Cost Centers	49,807	35
36	Provider Participation Fee	319,375	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,946,320	40
41	**Income before Income Taxes (line 30 minus line 40)****	(298,219)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (298,219)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,023,121	44
45	Private Pay - Net Inpatient Revenue	1,779,856	45
46	Medicare - Net Inpatient Revenue	2,396,416	46
47	Other-(specify)		47
48	Other-(specify) See Att Sch XI	285,234	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,484,627	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.**

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/11 Ending: 9/30/12

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,965	2,090	$ 62,392	$ 29.85	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	5,248	5,583	132,589	23.75	3
4	Licensed Practical Nurses	30,358	32,296	689,190	21.34	4
5	CNAs & Orderlies	85,957	91,444	1,019,601	11.15	5
6	CNA Trainees					6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides			0		8
9	Activity Director			0		9
10	Activity Assistants	6,906	7,346	78,465	10.68	10
11	Social Service Workers	1,871	1,990	35,490	17.83	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,334	24,823	270,372	10.89	15
16	Dishwashers					16
17	Maintenance Workers	7,573	8,057	102,275	12.69	17
18	Housekeepers	13,238	14,083	128,018	9.09	18
19	Laundry	2,362	2,513	21,312	8.48	19
20	Administrator	1,956	2,080	105,288	50.62	20
21	Assistant Administrator	1,043	1,110	25,081	22.60	21
22	Other Administrative	2,045	2,176	41,841	19.23	22
23	Office Manager					23
24	Clerical	5,461	5,809	75,650	13.02	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	1,222	1,300	15,923	12.25	31
32	Other Health Care(specify)	3,824	4,068	83,115	20.43	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	194,363	206,768	$ 2,886,602 *	$ 13.96	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	***	$ 6,300	1-3	35
36	Medical Director	***	17,250	9-3	36
37	Medical Records Consultant	***	1,760	10-3	37
38	Nurse Consultant	***	0	10-3	38
39	Pharmacist Consultant	***	6,445	10-3	39
40	Physical Therapy Consultant	***	197,687	10a-3	40
41	Occupational Therapy Consultant	***	185,355	10a-3	41
42	Respiratory Therapy Consultant	***	0	10a-3	42
43	Speech Therapy Consultant	***	86,555	10a-3	43
44	Activity Consultant	***		11-3	44
45	Social Service Consultant	***		12-3	45
46	Other(specify)	***	0	10-3	46
47					47
48	*** Monthly Fee				48
49	TOTAL (lines 35 - 48)		$ 501,352		49

C. CONTRACT NURSES

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

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/11 Ending: 9/30/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Benjamin Perkins	Administrator	None	$ 105,288
Nicole Friend	Asst Admin	None	16,042
Kent DeCapp	Asst Admin	None	9,039
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 130,369

B. Administrative - Other

Description	Amount
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
RFMS, Inc	Administrative Services	$ 171,600
McGladrey LLP	Accounting Services	8,000
LTC Support Services, LLC	Support Services	154,200
Polsinelli Shughart P.C.	Legal Services	7,919
Davis & Campbell LLC	Legal Services	37,645
Singleton Law Firm, P.C.	Legal Services	65
Quinn Johnston	Legal Services	1,743
Michael T. Mahoney, Ltd.	Collection Services	1,725
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 382,897

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 119,553
Unemployment Compensation Insurance	56,270
FICA Taxes	211,329
Employee Health Insurance	114,602
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401 (k)	11,461
Other Employee Benefits	12,619
TOTAL (agree to Schedule V, line 22, col.8)	$ 525,834

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,439
Health Care Worker Background Check (Indicate # of checks performed 19)	532
Patient Background Checks 183	1,830
Advertising - Promotion	29,969
Subscriptions	1,255
IHCA Dues	4,495
Other Licenses & Fees	879
Indirect Costs - See Att Sch III	38
Less: Public Relations Expense	( )
Non-allowable advertising	(29,969)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,468

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Staff use of personal vehicle on facility business and meals (under $250 per travel voucher)	0
Seminar Expense	720
Less: non-allowable out-of-state travel	0
Indirect costs - See Att Sch III	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 720

**See instructions.

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/11 Ending: 9/30/12

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/11 Ending: 9/30/12

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **See Page 21 section F**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes - IHCA dues** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **52,036** Line **10**

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

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **319,375**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **61**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **McGladrey LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.