

Facility Name & ID Number Pittsfield Manor

0047944 Report Period Beginning: 10/1/12 Ending: 9/30/13

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	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	89	Skilled (SNF)	89	32,485	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	89	TOTALS	89	32,485	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	9,837	9,358	3,096	22,291	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,837	9,358	3,096	22,291	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.62%

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

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 04/26/06

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 89 and days of care provided 2,748

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 9/30/13 Fiscal Year: 9/30/13

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

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	222,284	32,634	3,758	258,676		258,676	(35,860)	222,816		1
2	Food Purchase		265,865		265,865		265,865	(37,940)	227,925		2
3	Housekeeping	91,725	58,694		150,419		150,419	(29,813)	120,606		3
4	Laundry	49,860	32,154		82,014		82,014	(16,255)	65,759		4
5	Heat and Other Utilities			121,815	121,815		121,815	(23,363)	98,452		5
6	Maintenance	64,595	32,455	38,859	135,909		135,909	(26,938)	108,971		6
7	Other (specify):*										7
8	TOTAL General Services	428,464	421,802	164,432	1,014,698		1,014,698	(170,169)	844,529		8
	B. Health Care and Programs										
9	Medical Director			14,400	14,400		14,400		14,400		9
10	Nursing and Medical Records	1,595,984	230,125	6,568	1,832,677		1,832,677	(150,868)	1,681,809		10
10a	Therapy			345,169	345,169		345,169		345,169		10a
11	Activities	61,530	4,322		65,852		65,852	(16,465)	49,387		11
12	Social Services	27,965			27,965		27,965		27,965		12
13	CNA Training			125	125		125		125		13
14	Program Transportation					3,985	3,985		3,985		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,685,479	234,447	366,262	2,286,188	3,985	2,290,173	(167,333)	2,122,840		16
	C. General Administration										
17	Administrative	106,420			106,420		106,420		106,420		17
18	Directors Fees							2,076	2,076		18
19	Professional Services			297,977	297,977		297,977	3,953	301,930		19
20	Dues, Fees, Subscriptions & Promotions			55,905	55,905		55,905	(42,985)	12,920		20
21	Clerical & General Office Expenses	53,439	37,138	35,781	126,358		126,358	(1,730)	124,628		21
22	Employee Benefits & Payroll Taxes			409,543	409,543		409,543	(42,395)	367,148		22
23	Inservice Training & Education			6,212	6,212		6,212		6,212		23
24	Travel and Seminar			2,805	2,805		2,805		2,805		24
25	Other Admin. Staff Transportation			7,969	7,969	(3,985)	3,984	(302)	3,682		25
26	Insurance-Prop.Liab.Malpractice			41,147	41,147		41,147	24,207	65,354		26
27	Other (specify):* See Att Sch V	29,045		125,126	154,171		154,171	(154,171)			27
28	TOTAL General Administration	188,904	37,138	982,465	1,208,507	(3,985)	1,204,522	(211,347)	993,175		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,302,847	693,387	1,513,159	4,509,393		4,509,393	(548,849)	3,960,544		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			70,775	70,775		70,775	161,774	232,549			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							137,950	137,950			32
33	Real Estate Taxes							61,440	61,440			33
34	Rent-Facility & Grounds			485,700	485,700		485,700	(485,700)				34
35	Rent-Equipment & Vehicles			3,500	3,500		3,500		3,500			35
36	Other (specify):* See Att Sch IV											36
37	TOTAL Ownership			559,975	559,975		559,975	(124,536)	435,439			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			11,692	11,692		11,692		11,692			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			22	22		22		22			41
42	Provider Participation Fee			167,354	167,354		167,354		167,354			42
43	Other (specify):* Outpatient Care											43
44	TOTAL Special Cost Centers			179,068	179,068		179,068		179,068			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,302,847	693,387	2,252,202	5,248,436		5,248,436	(673,385)	4,575,051			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 Pittsfield Manor

0047944

Report Period Beginning: 10/1/12

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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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(540)	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	(21,768)	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	(123,652)	V-27		24
25	Fund Raising, Advertising and Promotional	(42,105)	V-20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Att Sch VI	(516,257)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (704,322)		\$	30

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	2	
		Amount	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)	22,931		34
35	Other- Attach Schedule See Att Sch III	8,006		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 30,937		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (673,385)		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY						
48		49		50		51
						52

Pittsfield Manor

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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 Pittsfield Manor# 0047944

Report Period Beginning:

10/1/12

Ending:

9/30/13

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
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

Facility Name & ID Number Pittsfield Manor

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Ending:

Summary B

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

	Capital Expense	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)	
	D. Ownership													
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	22,931	0	0	0	0	0	0	0	0	0	22,931	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	22,931	0	0	0	0	0	0	0	0	0	22,931	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	0	22,931	0	0	0	0	0	0	0	0	0	22,931	45

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. 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Facility Rent	\$ 485,700	Pittsfield Lowry, LLC	N/A	\$ 508,631	\$ 22,931	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		\$ 485,700			\$ 508,631	\$ * 22,931	14

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

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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

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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 II & III								\$ 2,076	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	\$ 2,076		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

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	See Att Sch II & III							8,006	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				\$	\$		\$	8,006

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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	Name of Lender	2		3	4	5	6		7	8	9	10						
			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	\$19,553.00	5/1/2012	4,557,600	4,464,641	6/1/2045	3.5500	159,718	2						
3					SNF portion								3						
4													4						
5													5						
		Working Capital																	
6		Miscellaneous		X									6						
7		Less Interest Income		X								(21,768)	7						
8													8						
9		TOTAL Facility Related				\$19,553.00		\$ 4,557,600	\$ 4,464,641			\$ 137,950	9						
		B. Non-Facility Related*																	
10		Cambridge Realty Capital											10						
11		LTD. Of Illinois		X	Facility purchase	\$4,888.00	5/1/2012	1,139,400	1,116,160	6/1/2045	3.5500	39,929	11						
12					ALC portion								12						
13													13						
14		TOTAL Non-Facility Related				\$4,888.00		\$ 1,139,400	\$ 1,116,160			\$ 39,929	14						
15		TOTALS (line 9+line14)						\$ 5,697,000	\$ 5,580,801			\$ 177,879	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 30,493 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 Pittsfield Manor# 0047944

Report Period Beginning:

10/1/12

Ending:

9/30/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	62,119	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.)		\$	75,850			2
3. Under or (over) accrual (line 2 minus line 1).		\$	13,731			3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	63,069			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.		\$	76,800			7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2008	<u>74,860</u>	8	FOR BHF USE ONLY	
		2009	<u>77,806</u>	9	13	FROM R. E. TAX STATEMENT FOR 2012 \$
		2010	<u>76,734</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$
		2011	<u>76,716</u>	11	15	LESS REFUND FROM LINE 6 \$
		2012	<u>75,850</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$
<u>This facility was purchased from an unrelated for-profit entity during 2006. A tax exemption has not yet been obtained</u>						
<u>Amount accrued includes the taxes for 9 months based on fiscal year end. Estimate is based on prior year tax bill</u>						
<u>Real estate taxes reported on Sch V line 33 have ben reduced by an allocation of expenses relating to ALC</u>						
<u>services based on an estimated 20%. See Att Sch VI. Taxes paid during year represents the entire 2012 bill</u>						

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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Pittsfield Manor COUNTY Pike

FACILITY IDPH LICENSE NUMBER 0047944

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 2012 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 2012.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>54-130-01</u>	<u>RNG/BLK:2 TWP:54 SEC/LOT:3</u>	\$ <u>75,230.92</u>	\$ <u>60,184.74</u>
2. _____	<u>PT LOT 1,2,3 EX. SW COR 2</u>	\$ _____	\$ _____
3. _____	<u>NORRIS SD E SIDE SEC</u>	\$ _____	\$ _____
4. _____	<u>25-PITTSF (EX OUTLOT 1)</u>	\$ _____	\$ _____
5. _____	<u>TD041006B723P127#06-1203</u>	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. <u>54-130-01A</u>	<u>RNG/BLK:2 TWP:54 SECT/LOT:3</u>	\$ <u>619.38</u>	\$ <u>495.50</u>
8. _____	<u>OUTLOT 1(PITTSVILLE</u>	\$ _____	\$ _____
9. _____	<u>VILLAGE) NORRIS SD E SIDE</u>	\$ _____	\$ _____
10. _____	<u>SEC 25-PITTSF</u>	\$ _____	\$ _____
TOTALS		\$ <u><u>75,850.30</u></u>	\$ <u><u>60,680.24</u></u>

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? X YES 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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 Pittsfield Manor

0047944 Report Period Beginning:

10/1/12 Ending:

9/30/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 41,400 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility - SNF</u>	<u>2.6 Acres</u>	<u>2006</u>	<u>\$ 144,000</u>	<u>1</u>
2	<u>Facility - SNF</u>	<u>.06 Acres</u>	<u>2013</u>	<u>1,662</u>	<u>2</u>
3	TOTALS	#VALUE!		\$ 145,662	3

Facility Name & ID Number **Pittsfield Manor**

0047944

Report Period Beginning:

10/1/12

Ending:

9/30/13

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	89	2006	1990	\$ 5,262,410	\$ 131,560	40	\$ 131,560	\$	\$ 986,704
5									
6									
7									
8									
Improvement Type**									
9	Landscaping	2006		4,720	472	10	472		3,540
10	Water Heaters, Replaced Sheetrock Ceilings (gypsum)	2008		12,251	1,225	10	1,225		6,234
11	Shtrock wlls/repl ceiling/repl tiles, Wall light/bdside tbls/chairs/nightstand	2008		98,212	7,141	10-15 yrs	7,141		35,406
12	Wtr Heatr/Roof/Frnce & A/C/Gttrs/Fire sprinklers	2009		372,840	27,022	10-25 yrs	27,022		124,220
13	Sprinkler System/Carpet/Carpet/Carpeting	2009		22,969	3,806	5-25 yrs	3,806		15,124
14	Parker Tub Rm-Sink,Mirror,toilet,shwr walls,flr,drywall,drains,plumbing	2011		44,775	3,731	12	3,731		8,706
15	Parking Lot Overlay and Sealcoat	2011		52,770	6,596	8	6,596		13,192
16	Hallway-Handrails/whlchair guards/covebs/paint/light/insulation/wall gua	2012		57,129	4,761	12	4,761		7,538
17	Water Heater	2012		3,691	369	10	369		369
18	Water Softener	2012		2,522	252	10	252		252
19	Water Heater	2012		3,760	345	10	345		345
20	Cable TV System	2013		5,014	251	10	251		251
21	Water Softener	2013		2,633	22	10	22		22
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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 **Pittsfield Manor**

0047944

Report Period Beginning:

10/1/12

Ending:

9/30/13

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			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,945,696	\$ 187,553		\$ 187,553	\$	\$ 1,201,903	70

**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	\$ 458,509	\$ 44,394	\$ 44,394	\$	5-15 yrs	\$ 295,666	71
72	Current Year Purchases	16,503	602	602		5-12 yrs	602	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 475,012	\$ 44,996	\$ 44,996	\$		\$ 296,268	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 GMC G350 Van	2006	\$ 29,848	\$	\$	\$	4 yrs	\$ 29,848	76
77										77
78										78
79										79
80	TOTALS			\$ 29,848	\$	\$	\$		\$ 29,848	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)	\$ 6,596,218	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 232,549	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 232,549	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)	\$ 1,528,019	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	Land ALC - 2006	36,000			87
88	Facility ALC - 2006	1,315,602	32,890	246,675	88
89					89
90					90
91	TOTALS	\$ 1,366,502	\$ 32,890	\$ 261,575	91

G. Construction-in-Progress

	Description	Cost	
92	PT Addition	\$ 18,986	92
93			93
94			94
95		\$ 18,986	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Pittsfield Lowry, 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. 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:				\$ <u>See Attached</u>			3
4	Additions				<u>Schedule IV</u>			4
5					<u>Related Party</u>			5
6					<u>Lease</u>			6
7	TOTAL				\$			7

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. _____ /2014 \$ N/A

13. _____ /2015 \$ N/A

14. _____ /2016 \$ N/A

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 N/A

by the length of the lease 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: \$ 3,500 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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.)

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		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.

Facility Name & ID Number Pittsfield Manor

0047944

Report Period Beginning: 10/1/12

Ending:

9/30/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/13 (last day of reporting year)

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	\$ 30,334	\$ 40,274	1
2	Cash-Patient Deposits	5,974	5,974	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>168,110</u>)	758,254	758,254	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	72,449	96,190	6
7	Other Prepaid Expenses	3,568	3,568	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Att Sch VII</u>	18,780	76,610	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 889,359	\$ 980,870	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		181,662	13
14	Buildings, at Historical Cost		6,578,012	14
15	Leasehold Improvements, at Historical Cost	683,286	683,286	15
16	Equipment, at Historical Cost	217,627	519,760	16
17	Accumulated Depreciation (book methods)	(329,616)	(1,789,594)	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): <u>See Att Sch VII</u>	18,986	384,609	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 590,283	\$ 6,557,735	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,479,642	\$ 7,538,605	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 83,455	\$ 83,455	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,974	5,974	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	62,341	62,341	30
31	Accrued Taxes Payable (excluding real estate taxes)	64,744	64,744	31
32	Accrued Real Estate Taxes(Sch.IX-B)		63,069	32
33	Accrued Interest Payable		16,510	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Interdivision Payable</u>	1,516,187	3,034,047	36
37	<u>Current portion of long term payable</u>		96,738	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,732,701	\$ 3,426,878	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,484,063	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44	<u>Security Deposits</u>	39,236	39,236	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 39,236	\$ 5,523,299	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,771,937	\$ 8,950,177	46
47	TOTAL EQUITY(page 18, line 24)	\$ (292,295)	\$ (1,411,572)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,479,642	\$ 7,538,605	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 519,039	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 519,039	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(811,334)	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)	\$ (811,334)	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)	\$ (292,295)	24 *

* This must agree with page 17, line 47.

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	\$ 4,253,170	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,253,170	3
B. Ancillary Revenue			
4	Day Care	7,000	4
5	Other Care for Outpatients		5
6	Therapy	135,895	6
7	Oxygen	3,498	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 146,393	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,342	12
13	Barber and Beauty Care	4,395	13
14	Non-Patient Meals	540	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 7,277	23
D. Non-Operating Revenue			
24	Contributions	1,357	24
25	Interest and Other Investment Income***	21,768	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 23,125	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund Income		28
28a	<u>See Att Schedule X</u>	7,137	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,137	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,437,102	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,014,698	31
32	Health Care	2,286,188	32
33	General Administration	1,208,507	33
B. Capital Expense			
34	Ownership	559,975	34
C. Ancillary Expense			
35	Special Cost Centers	11,714	35
36	Provider Participation Fee	167,354	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,248,436	40
41	Income before Income Taxes (line 30 minus line 40)**	(811,334)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (811,334)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,180,821	44
45	Private Pay - Net Inpatient Revenue	1,474,873	45
46	Medicare - Net Inpatient Revenue	1,174,299	46
47	Other-(specify) <u>Assisted Living</u>	370,385	47
48	Other-(specify) <u>See Att Schedule XI</u>	52,792	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,253,170	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 Pittsfield Manor

0047944

Report Period Beginning:

10/1/12

Ending:

9/30/13

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	1,934	2,080	\$ 73,070	\$ 35.13	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	8,994	9,671	208,798	21.59	3
4	Licensed Practical Nurses	15,326	16,479	297,778	18.07	4
5	CNAs & Orderlies	81,711	87,861	897,940	10.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,884	6,327	61,530	9.72	10
11	Social Service Workers	1,934	2,080	27,965	13.44	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,362	24,045	222,284	9.24	15
16	Dishwashers					16
17	Maintenance Workers	5,117	5,502	64,595	11.74	17
18	Housekeepers	9,154	9,843	91,725	9.32	18
19	Laundry	5,324	5,724	49,860	8.71	19
20	Administrator	1,934	2,080	69,767	33.54	20
21	Assistant Administrator	1,934	2,080	36,653	17.62	21
22	Other Administrative	1,934	2,080	29,045	13.96	22
23	Office Manager					23
24	Clerical	4,850	5,215	53,439	10.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,006	2,157	35,587	16.50	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,904	2,048	20,480	10.00	31
32	Other Health Care(specify)	3,341	3,593	62,331	17.35	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	175,643	188,865	\$ 2,302,847 *	\$ 12.19	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	***	\$ 3,758	1-3	35
36	Medical Director	***	14,400	9-3	36
37	Medical Records Consultant	***	2,154	10-3	37
38	Nurse Consultant	***	49	10-3	38
39	Pharmacist Consultant	***	4,365	10-3	39
40	Physical Therapy Consultant	***	147,665	10a-3	40
41	Occupational Therapy Consultant	***	125,646	10a-3	41
42	Respiratory Therapy Consultant	***		10a-3	42
43	Speech Therapy Consultant	***	71,858	10a-3	43
44	Activity Consultant	***		11-3	44
45	Social Service Consultant	***		12-3	45
46	Other(specify)	***		10-3	46
47					47
48	*** Monthly Fee				48
49	TOTAL (lines 35 - 48)		\$ 369,895		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	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

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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
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14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Pittsfield Manor

0047944

Report Period Beginning:

10/1/12

Ending: 9/30/13

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. \$ 18,940 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. \$ 167,354
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. \$ 540
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.