

Facility Name & ID Number Shelbyville Manor

0047878 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	<u>115</u>	Skilled (SNF)	<u>115</u>	<u>41,975</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>115</u>	TOTALS	<u>115</u>	<u>41,975</u>	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	<u>11,614</u>	<u>7,856</u>	<u>7,430</u>	<u>26,900</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>11,614</u>	<u>7,856</u>	<u>7,430</u>	<u>26,900</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.09%

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 02/02/06

J. Was the facility purchased or leased after January 1, 1978?
YES Date 02/01/06 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 115 and days of care provided 7,160

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

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Shelbyville Manor

0047878

Report Period Beginning:

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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	245,353	26,834	6,045	278,232		278,232	(46,567)	231,665		1
2	Food Purchase		307,041		307,041		307,041	(52,907)	254,134		2
3	Housekeeping	144,861	41,147	472	186,480		186,480	(27,557)	158,923		3
4	Laundry	57,298	29,591		86,889		86,889	(12,873)	74,016		4
5	Heat and Other Utilities			163,875	163,875		163,875	(22,966)	140,909		5
6	Maintenance	61,080	50,424	45,152	156,656		156,656	(23,210)	133,446		6
7	Other (specify):*										7
8	TOTAL General Services	508,592	455,037	215,544	1,179,173		1,179,173	(186,080)	993,093		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,865,347	319,005	9,206	2,193,558		2,193,558	(156,545)	2,037,013		10
10a	Therapy			728,162	728,162		728,162		728,162		10a
11	Activities	64,538	1,764		66,302		66,302	(441)	65,861		11
12	Social Services	25,798			25,798		25,798		25,798		12
13	CNA Training										13
14	Program Transportation			315	315	10,082	10,397		10,397		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,955,683	320,769	755,683	3,032,135	10,082	3,042,217	(156,986)	2,885,231		16
	C. General Administration										
17	Administrative	134,572			134,572		134,572		134,572		17
18	Directors Fees							2,682	2,682		18
19	Professional Services			376,596	376,596		376,596	5,108	381,704		19
20	Dues, Fees, Subscriptions & Promotions			86,741	86,741		86,741	(65,999)	20,742		20
21	Clerical & General Office Expenses	67,223	38,674	45,041	150,938		150,938	(4,036)	146,902		21
22	Employee Benefits & Payroll Taxes			469,494	469,494		469,494	(42,750)	426,744		22
23	Inservice Training & Education			7,035	7,035		7,035		7,035		23
24	Travel and Seminar			3,503	3,503		3,503		3,503		24
25	Other Admin. Staff Transportation			20,163	20,163	(10,082)	10,081	(321)	9,760		25
26	Insurance-Prop.Liab.Malpractice			44,217	44,217		44,217	26,608	70,825		26
27	Other (specify):* See Att Sch V	40,078		13,410	53,488		53,488	(53,488)			27
28	TOTAL General Administration	241,873	38,674	1,066,200	1,346,747	(10,082)	1,336,665	(132,196)	1,204,469		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,706,148	814,480	2,037,427	5,558,055		5,558,055	(475,262)	5,082,793		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

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#0047878

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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			97,337	97,337	97,337	215,972	313,309				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						125,320	125,320				32
33	Real Estate Taxes			2,800	2,800	2,800	94,350	97,150				33
34	Rent-Facility & Grounds			491,688	491,688	491,688	(491,688)					34
35	Rent-Equipment & Vehicles			14,793	14,793	14,793		14,793				35
36	Other (specify):* See Att Sch IV						12,757	12,757				36
37	TOTAL Ownership			606,618	606,618	606,618	(43,289)	563,329				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			45,518	45,518	45,518		45,518				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			182,784	182,784	182,784		182,784				42
43	Other (specify):* Outpatient Care											43
44	TOTAL Special Cost Centers			228,302	228,302	228,302		228,302				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,706,148	814,480	2,872,347	6,392,975	6,392,975	(518,551)	5,874,424				45

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

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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	(560)	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	(25,467)	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	(2,275)	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	(11,506)	V-27		24
25	Fund Raising, Advertising and Promotional	(65,172)	V-20		25
	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	(521,012)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (625,992)		\$	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)	97,096		34
35	Other- Attach Schedule See Att Sch III	10,345		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 107,441		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (518,551)		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

Shelbyville 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 Shelbyville Manor

0047878

Report Period Beginning:

10/1/12

Ending:

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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

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Summary B

9/30/13

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	97,096	0	0	0	0	0	0	0	0	0	97,096	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	97,096	0	0	0	0	0	0	0	0	0	97,096	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	97,096	0	0	0	0	0	0	0	0	0	97,096	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	\$ 491,688	Shelbyville Route 128, LLC	N/A	\$ 588,784	\$ 97,096	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		\$ 491,688			\$ 588,784	\$ * 97,096	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								\$ 2,682	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	\$ 2,682		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 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	<u>See Att Sch II & III</u>							10,345	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				\$	\$		\$	10,345

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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		8	9	10	Reporting Period Interest Expense					
		Related**					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	\$20,381.00	6/1/2012	4,313,155	4,204,382	4/1/2040	3.5500	150,787	2					
3				SNF portion								3					
4												4					
5												5					
	Working Capital																
6	Miscellaneous		X									6					
7	Less Interest Income		X								(25,467)	7					
8												8					
9	TOTAL Facility Related				\$20,381.00		\$ 4,313,155	\$ 4,204,382			\$ 125,320	9					
	B. Non-Facility Related*																
10	Cambridge Realty Capital											10					
11	LTD. Of Illinois		X	Facility purchase	\$3,597.00	6/1/2012	761,145	741,950	4/1/2040	3.5500	26,609	11					
12				ALC portion								12					
13												13					
14	TOTAL Non-Facility Related				\$3,597.00		\$ 761,145	\$ 741,950			\$ 26,609	14					
15	TOTALS (line 9+line14)						\$ 5,074,300	\$ 4,946,332			\$ 151,929	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 27,158 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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2012 report.		\$	<u>75,035</u>		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.)		\$	<u>106,616</u>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>31,581</u>		3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>82,219</u>		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.		\$	<u>113,800</u>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008	<u>97,129</u>	8	FOR BHF USE ONLY	
	2009	<u>97,779</u>	9		
	2010	<u>99,341</u>	10		
	2011	<u>95,914</u>	11		
	2012	<u>106,616</u>	12		
<u>This facility was purchased from an unrelated for-profit entity during 2006. A tax exemption has not yet been obtained</u>				13	13
<u>Amount accrued includes the taxes for 9 months based on fiscal year end. Estimate is based on prior year tax bill</u>				14	14
<u>Real estate taxes reported on Sch V 33 have been reduced by an allocation of expenses relating to ALC</u>				15	15
<u>services based on an estimated 15%. See Att Sch VI. Taxes paid during year represents the entire 2012 bill</u>				16	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Shelbyville Manor COUNTY Shelby

FACILITY IDPH LICENSE NUMBER 0047878

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</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>2013-06-17-305-001</u>	<u>W N 12TH</u>	\$ <u>106,616.14</u>	\$ <u>90,623.72</u>
2. _____	<u>SW COR SW SW 550' X 520' & 30'</u>	\$ _____	\$ _____
3. _____	<u>VAC STREET LESS .11 AC TO</u>	\$ _____	\$ _____
4. _____	<u>ST HWY 6.76 AC</u>	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>106,616.14</u></u>	\$ <u><u>90,623.72</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 Shelbyville Manor

0047878 Report Period Beginning:

10/1/12 Ending:

9/30/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,041 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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility - SNF</u>	<u>5.84 Acres</u>	<u>2006</u>	<u>\$ 195,500</u>	1
2					2
3	TOTALS	#VALUE!		\$ 195,500	3

Facility Name & ID Number Shelbyville Manor

0047878

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	115	2006	1991	\$ 5,078,282	\$ 126,962	40	\$ 126,962	\$	\$ 973,338
5									
6									
7									
8									
Improvement Type**									
9	Dry Pipe Valve and Water Softner	2006		11,205	940	10-20 yrs	940		6,590
10	Ceramic Tile Repair, Carpet, Ceramic Tile	2007		11,750	444	5-20 yrs	444		5,696
11	Roof Repair	2008		84,157	8,416	10	8,416		47,690
12	Air Handler, Water Heater, Fire Protection System	2009		21,450	2,147	10	2,147		9,487
13	Water Heater	2010		10,671	1,067	10	1,067		3,468
14	Fire Sprinkler	2011		119,000	4,760	25	4,760		11,900
15	Physical Therapy Addition (Contracted Total)	2011		762,407	63,533	12	63,533		127,067
16	Oil/Chip Parking Lot	2011		4,200	525	8	525		1,050
17	Hallway Rmdl-Vinyl tile/Base/Drywall/Handrails/Wall & Crnr Grds/AC	2011		56,356	4,696	12	4,696		9,392
18	Shower Rmdl-Exhaust fan/Fire access dr/Flr-tile/wiring/fxtrs/drains	2012		130,718	10,893	12	10,893		19,063
19	Laundry/Hallway Rmdl-Handrails/Guardrails/Vinyl Tile/Drywall/Paint	2012		138,186	11,516	12	11,516		17,274
20	Faux Wood Blinds - 14	2012		5,256	1,051	5	1,051		1,489
21	Fire Alarm System and Components	2012		8,555	784	10	784		784
22	Faux Wood Blinds	2012		5,108	936	5	936		936
23	Crown Light Boxes	2012		7,764	1,294	5	1,294		1,294
24	Faux Wood Blinds - 28	2013		4,883	325	5	325		325
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 Shelbyville Manor

0047878

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)		\$ 6,459,948	\$ 240,289		\$ 240,289	\$	\$ 1,236,843	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	\$ 583,230	\$ 60,320	\$ 60,320	\$	3-15 yrs	\$ 334,213	71
72	Current Year Purchases	62,907	3,611	3,611		10-15 yrs	3,611	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 646,137	\$ 63,931	\$ 63,931	\$		\$ 337,824	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	2012 Ford E350 Bus	2012	\$ 43,627	\$ 9,089	\$ 9,089	\$	4 yrs	\$ 9,089	76
77										77
78										78
79										79
80	TOTALS			\$ 43,627	\$ 9,089	\$ 9,089	\$		\$ 9,089	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)	\$ 7,345,212	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 313,309	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 313,309	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)	\$ 1,583,756	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	34,500			87
88	Facility ALC - 2006	896,167	22,404	171,765	88
89	Physical Therapy Add. ALC - 2011	134,542	11,212	22,424	89
90	2003 GMC G3500 Van - 2006	29,848		29,848	90
91	TOTALS	\$ 1,109,957	\$ 33,616	\$ 238,937	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Shelbyville Route 128, 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: \$ 14,793 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 Shelbyville Manor # 0047878 Report Period Beginning: 10/1/12 Ending: 9/30/13
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 prescripts							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 Shelbyville Manor# 0047878Report 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	\$ 74,767	\$ 110,615	1
2	Cash-Patient Deposits	9,571	9,571	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>34,470</u>)	960,303	960,303	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	80,987	105,473	6
7	Other Prepaid Expenses	2,459	2,459	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Att Sch VII</u>	1,888,132	1,926,526	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,016,219	\$ 3,114,947	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		230,000	13
14	Buildings, at Historical Cost		6,871,398	14
15	Leasehold Improvements, at Historical Cost	619,259	619,259	15
16	Equipment, at Historical Cost	479,679	734,512	16
17	Accumulated Depreciation (book methods)	(332,729)	(1,822,693)	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>		549,955	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 766,209	\$ 7,182,431	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,782,428	\$ 10,297,378	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 86,073	\$ 86,073	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,571	9,571	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	67,757	67,757	30
31	Accrued Taxes Payable (excluding real estate taxes)	68,802	68,802	31
32	Accrued Real Estate Taxes(Sch.IX-B)	4,200	82,219	32
33	Accrued Interest Payable		14,633	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Interdivision Payable</u>		2,047,436	36
37	<u>See Att Sch VII</u>	1,368	115,346	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 237,771	\$ 2,491,837	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,832,354	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	<u>Security Deposits</u>	51,690	51,690	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 51,690	\$ 4,884,044	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 289,461	\$ 7,375,881	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,492,967	\$ 2,921,497	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,782,428	\$ 10,297,378	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,136,729	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,136,729	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	356,238	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)	\$ 356,238	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,492,967	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	\$ 6,511,547	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,511,547	3
B. Ancillary Revenue			
4	Day Care	8,320	4
5	Other Care for Outpatients		5
6	Therapy	181,391	6
7	Oxygen	16,009	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 205,720	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	591	12
13	Barber and Beauty Care	1,200	13
14	Non-Patient Meals	560	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,067	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)	\$ 3,418	23
D. Non-Operating Revenue			
24	Contributions	710	24
25	Interest and Other Investment Income***	25,467	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 26,177	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund Income		28
28a	<u>See Att Schedule X</u>	2,351	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,351	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,749,213	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,179,173	31
32	Health Care	3,032,135	32
33	General Administration	1,346,747	33
B. Capital Expense			
34	Ownership	606,618	34
C. Ancillary Expense			
35	Special Cost Centers	45,518	35
36	Provider Participation Fee	182,784	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,392,975	40
41	Income before Income Taxes (line 30 minus line 40)**	356,238	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 356,238	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,493,331	44
45	Private Pay - Net Inpatient Revenue	1,244,751	45
46	Medicare - Net Inpatient Revenue	3,166,646	46
47	Other-(specify) <u>Assisted Living</u>	553,600	47
48	Other-(specify) <u>See Att Schedule XI</u>	53,219	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,511,547	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 Shelbyville Manor

0047878

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	\$ 71,878	\$ 34.56	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	7,752	8,335	191,704	23.00	3
4	Licensed Practical Nurses	17,978	19,331	354,923	18.36	4
5	CNAs & Orderlies	99,399	106,880	1,106,212	10.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,943	6,390	64,538	10.10	10
11	Social Service Workers	1,934	2,080	25,798	12.40	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,730	26,591	245,353	9.23	15
16	Dishwashers					16
17	Maintenance Workers	3,591	3,861	61,080	15.82	17
18	Housekeepers	15,467	16,632	144,861	8.71	18
19	Laundry	5,987	6,438	57,298	8.90	19
20	Administrator	1,934	2,080	99,345	47.76	20
21	Assistant Administrator	1,986	2,135	35,227	16.50	21
22	Other Administrative	1,803	1,939	40,078	20.67	22
23	Office Manager					23
24	Clerical	5,106	5,491	67,223	12.24	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,934	2,080	37,450	18.00	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,992	2,142	22,595	10.55	31
32	Other Health Care(specify)	3,747	4,029	80,585	20.00	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	203,217	218,514	\$ 2,706,148 *	\$ 12.38	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	***	\$ 6,045	1-3	35
36	Medical Director	***	18,000	9-3	36
37	Medical Records Consultant	***	1,880	10-3	37
38	Nurse Consultant	***	1,829	10-3	38
39	Pharmacist Consultant	***	5,360	10-3	39
40	Physical Therapy Consultant	***	333,530	10a-3	40
41	Occupational Therapy Consultant	***	246,494	10a-3	41
42	Respiratory Therapy Consultant	***	13,926	10a-3	42
43	Speech Therapy Consultant	***	134,212	10a-3	43
44	Activity Consultant	***		11-3	44
45	Social Service Consultant	***		12-3	45
46	Other(specify) <u>Dental Consultant</u>	***	137	10-3	46
47					47
48	<u>*** Monthly Fee</u>				48
49	TOTAL (lines 35 - 48)		\$ 761,413		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. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
<u>Karen Dailey</u>	<u>Administrator</u>	<u>None</u>	\$ <u>99,345</u>	<u>Workers' Compensation Insurance</u>	\$ <u>88,322</u>	<u>IDPH License Fee</u>	\$		
<u>Danielle Sanders</u>	<u>Asst Admin</u>	<u>None</u>	<u>35,227</u>	<u>Unemployment Compensation Insurance</u>	<u>29,036</u>	<u>Advertising: Employee Recruitment</u>		<u>8,239</u>	
				<u>FICA Taxes</u>	<u>204,366</u>	<u>Health Care Worker Background Check</u>			
				<u>Employee Health Insurance</u>	<u>125,598</u>	<u>(Indicate # of checks performed <u>23</u>)</u>		<u>1,346</u>	
				<u>Employee Meals</u>		<u>Patient Background Checks <u>155</u></u>		<u>1,550</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Advertising - Promotion</u>		<u>65,172</u>	
				<u>401 (k)</u>	<u>16,182</u>	<u>Subscriptions</u>		<u>2,298</u>	
				<u>Other Employee Benefits</u>	<u>5,990</u>	<u>IHCA Dues</u>		<u>4,444</u>	
						<u>Other Licenses & Fees</u>		<u>3,692</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>134,572</u>			<u>Ind Costs-Att Sch III, ALC-Att Sch VI</u>		<u>(827)</u>	
(List each licensed administrator separately.)						<u>Less: Public Relations Expense</u>	(
B. Administrative - Other						<u>Non-allowable advertising</u>		<u>(65,172)</u>	
Description			Amount			<u>Yellow page advertising</u>	(
			\$						
TOTAL (agree to Schedule V, line 17, col. 3)			\$						
(Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type		Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
<u>RFMS, Inc</u>	<u>Administrative Services</u>		\$ <u>171,600</u>	Description	Line #	Amount	Description	Amount	
<u>McGladrey LLP</u>	<u>Accounting Services</u>		<u>23,296</u>			\$	<u>Out-of-State Travel</u>	\$	
<u>LTC Support Services, LLC</u>	<u>Support Services</u>		<u>181,400</u>						
<u>Templin Healthcare Accounting</u>	<u>Accounting Services</u>		<u>251</u>				<u>In-State Travel</u>		
<u>Erickson, Davis, Murphy,</u>							<u>Staff use of personal vehicle on facility</u>		
<u>Johnson & Walsh, Ltd.</u>	<u>Legal Services</u>		<u>49</u>				<u>business and meals (under \$250 per</u>		
							<u>travel voucher)</u>	<u>0</u>	
							<u>Seminar Expense</u>	<u>3,503</u>	
							<u>Less: non-allowable out-of-state travel</u>	<u>0</u>	
							<u>Indirect costs - See Att Sch III</u>	<u>0</u>	
							<u>Entertainment Expense</u>	(
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>376,596</u>	TOTAL		\$	<u>(agree to Sch. V,</u>		
(If total legal fees exceed \$5,000, attach copy of invoices.)							<u>line 24, col. 8)</u>	\$ <u>3,503</u>	

* Attach copy of IMRF notifications

**See instructions.

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												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Shelbyville Manor# 0047878

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? 14 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 22,974 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. \$ 182,784
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. \$ 560
- (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.