

		FOR BHF USE					

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**2014**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2014)**

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

<p><b>I. IDPH License ID Number:</b> <u>0047969</u></p> <p><b>Facility Name:</b> <u>Pekin Manor</u></p> <p><b>Address:</b> <u>1520 El Camino Drive</u> <u>Pekin</u> <u>61554</u>  Number City Zip Code</p> <p><b>County:</b> <u>Tazewell</u></p> <p><b>Telephone Number:</b> <u>(309) 353-1099</u> <b>Fax #</b> <u>(309) 353-1363</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>04/26/06</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input checked="" type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;"><b>IRS Exemption Code</b> <u>501 (c) (3)</u></td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Ron Wilson</u> <b>Telephone Number:</b> <u>(309) 343-1550</u>  <b>Email Address:</b> _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> <u>501 (c) (3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/13</u> to <u>9/30/14</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Matt Hails</u> (Title) <u>LTC CEO</u></td> </tr> <tr> <td style="width:20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) <u>See Preparation Report</u> (Print Name and Title) <u>McGladrey LLP</u> <u>117 E. Main St., Suite 210</u> (Firm Name &amp; Address) <u>P.O. Box 1070</u> <u>Galesburg, IL 61401</u> (Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</u></td> </tr> </table> <p align="right"><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  201 S. Grand Avenue East  Springfield, IL 62763-0001 <b>Phone # (217) 782-1630</b></p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Matt Hails</u> (Title) <u>LTC CEO</u>	Paid Preparer	(Signed) <u>See Preparation Report</u> (Print Name and Title) <u>McGladrey LLP</u> <u>117 E. Main St., Suite 210</u> (Firm Name & Address) <u>P.O. Box 1070</u> <u>Galesburg, IL 61401</u> (Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</u>
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Facility Name & ID Number Pekin Manor

# 0047969 Report Period Beginning: 10/1/13 Ending: 9/30/14

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	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	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	17,002	14,096	9,343	40,441	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,002	14,096	9,343	40,441	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.33%

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 120 and days of care provided 7,155

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: 9/30/14 Fiscal Year: 9/30/14

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

Facility Name &amp; ID Number

Pekin Manor

# 0047969

Report Period Beginning:

10/1/13

Ending:

9/30/14

**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
	<b>A. General Services</b>										
1	Dietary	311,737	35,116	6,516	353,369		353,369		353,369		1
2	Food Purchase		421,989		421,989		421,989	(1,304)	420,685		2
3	Housekeeping	177,516	65,810		243,326		243,326		243,326		3
4	Laundry	56,567	28,827	2,289	87,683		87,683		87,683		4
5	Heat and Other Utilities			130,346	130,346		130,346		130,346		5
6	Maintenance	113,881	86,620	89,268	289,769		289,769		289,769		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	659,701	638,362	228,419	1,526,482		1,526,482	(1,304)	1,525,178		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			21,000	21,000		21,000		21,000		9
10	Nursing and Medical Records	2,751,751	421,215	11,414	3,184,380		3,184,380		3,184,380		10
10a	Therapy			711,624	711,624		711,624		711,624		10a
11	Activities	95,696	3,519		99,215		99,215		99,215		11
12	Social Services	64,621			64,621		64,621		64,621		12
13	CNA Training										13
14	Program Transportation			176	176	13,612	13,788		13,788		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,912,068	424,734	744,214	4,081,016	13,612	4,094,628		4,094,628		16
	<b>C. General Administration</b>										
17	Administrative	122,331			122,331		122,331		122,331		17
18	Directors Fees							2,830	2,830		18
19	Professional Services			383,565	383,565		383,565	6,894	390,459		19
20	Dues, Fees, Subscriptions & Promotions			83,901	83,901		83,901	(68,934)	14,967		20
21	Clerical & General Office Expenses	91,837	44,907	48,948	185,692		185,692	2	185,694		21
22	Employee Benefits & Payroll Taxes			610,527	610,527		610,527		610,527		22
23	Inservice Training & Education			4,155	4,155		4,155		4,155		23
24	Travel and Seminar			42	42		42		42		24
25	Other Admin. Staff Transportation			27,223	27,223	(13,612)	13,611		13,611		25
26	Insurance-Prop.Liab.Malpractice			63,423	63,423		63,423	41,110	104,533		26
27	Other (specify):* See Att Sch V	32,155		112,692	144,847		144,847	(144,847)			27
28	<b>TOTAL General Administration</b>	246,323	44,907	1,334,476	1,625,706	(13,612)	1,612,094	(162,945)	1,449,149		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,818,092	1,108,003	2,307,109	7,233,204		7,233,204	(164,249)	7,068,955		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Pekin Manor

#0047969

Report Period Beginning:

10/1/13

Ending:

9/30/14

## 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	
	<b>D. Ownership</b>											
30	Depreciation			180,570	180,570	180,570	237,919	418,489				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						197,641	197,641				32
33	Real Estate Taxes						120,360	120,360				33
34	Rent-Facility & Grounds			563,652	563,652	563,652	(563,652)					34
35	Rent-Equipment & Vehicles			26,353	26,353	26,353		26,353				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			770,575	770,575	770,575	(7,732)	762,843				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			62,978	62,978	62,978		62,978				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			3,602	3,602	3,602		3,602				41
42	Provider Participation Fee			267,637	267,637	267,637		267,637				42
43	Other (specify):* <b>Outpatient Care</b>			2,297	2,297	2,297		2,297				43
44	<b>TOTAL Special Cost Centers</b>			336,514	336,514	336,514		336,514				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,818,092	1,108,003	3,414,198	8,340,293	8,340,293	(171,981)	8,168,312				45

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

Facility Name & ID Number Pekin Manor

# 0047969

Report Period Beginning: 10/1/13

Ending: 9/30/14

**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	(1,304)	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	(414)	V-30		9
10	Interest and Other Investment Income	(16,611)	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	(110,386)	V-27		24
25	Fund Raising, Advertising and Promotional	(68,936)	V-20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Att Sch VI	(34,698)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (232,349)</b>		<b>\$</b>	<b>30</b>

**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)	47,942		34
35	Other- Attach Schedule See Att Sch III	12,426		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 60,368</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (171,981)</b>		<b>37</b>

\*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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

BHF USE ONLY						
48		49		50		51
						52

Pekin Manor

ID# 0047969

Report Period Beginning: 10/1/13

Ending: 9/30/14

Sch. V Line  
Reference

NON-ALLOWABLE EXPENSES

Amount

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
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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	<b>Total</b>		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pekin Manor

# 0047969

Report Period Beginning:

10/1/13

Ending:

9/30/14

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	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
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	<b>TOTAL General Administration</b>	0	0	0	0	0	0	0	0	0	0	0	0	28
29	<b>TOTAL Operating Expense</b> (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 Pekin Manor# 0047969

Report Period Beginning:

10/1/13

Ending:

Summary B

9/30/14

## 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)	
	<b>D. Ownership</b>													
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	47,942	0	0	0	0	0	0	0	0	0	47,942	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	<b>TOTAL Ownership</b>	<b>0</b>	<b>47,942</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>47,942</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	0	47,942	0	0	0	0	0	0	0	0	0	47,942	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	\$ 563,652	Pekin El Camino, LLC	N/A	\$ 611,594	\$ 47,942	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		\$ 563,652			\$ 611,594	\$ * 47,942	14

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

Facility Name & ID Number

Pekin Manor

# 0047969

Report Period Beginning:

10/1/13

Ending:

9/30/14

**VII. RELATED PARTIES**

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

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

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/13 Ending: 9/30/14

## 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								\$ 2,830	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	\$ 2,830		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Pekin Manor

# 0047969

Report Period Beginning:

10/1/13

Ending: 9/30/14

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	<u>See Att Sch II &amp; III</u>							12,426	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	<b>TOTALS</b>				\$	\$		\$	12,426

**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						
		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			
	<b>A. Directly Facility Related</b>																
	<b>Long-Term</b>																
1	Cambridge Realty Capital						\$	\$			\$	1					
2	LTD. Of Illinois		X	Facility purchase	\$28,646.12	6/1/12	6,249,800	5,975,714	10/1/2041	3.5500	214,252	2					
3												3					
4												4					
5												5					
	<b>Working Capital</b>																
6	Miscellaneous		X									6					
7	Less Interest Income		X								(16,611)	7					
8												8					
9	<b>TOTAL Facility Related</b>				\$28,646.12		\$ 6,249,800	\$ 5,975,714			\$ 197,641	9					
	<b>B. Non-Facility Related*</b>																
10												10					
11												11					
12												12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 6,249,800	\$ 5,975,714			\$ 197,641	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 30,121 Line # 26

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

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

Facility Name & ID Number **Pekin Manor**# **0047969**

Report Period Beginning:

**10/1/13**

Ending:

**9/30/14****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2013 report.		\$	<b>78,590</b>		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.)		\$	<b>106,580</b>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>27,990</b>		3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>92,370</b>		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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>120,360</b>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	<b>94,873</b>	<b>8</b>	<b>FOR BHF USE ONLY</b>	
	2010	<b>97,834</b>	<b>9</b>	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2013 \$
	2011	<b>98,550</b>	<b>10</b>	<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$
	2012	<b>106,626</b>	<b>11</b>	<b>15</b>	LESS REFUND FROM LINE 6 \$
	2013	<b>106,580</b>	<b>12</b>	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$
<b>This facility was purchased from an unrelated for-profit entity during 2006. A tax exemption has not yet been obtained</b>					
<b>Amount accrued includes the taxes for 9 months based on fiscal year end. Estimate is based on prior year tax bill</b>					
<b>Taxes paid during year represents the entire 2013 bill.</b>					

**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.**

## 2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Pekin Manor COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0047969

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

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

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

(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>10-10-11-400-015</u>	<u>Sec 11 T24N R5W</u>	\$ <u>105,644.20</u>	\$ <u>105,644.20</u>
2. _____	<u>PT OF E 1/2 SE 1/2</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. <u>10-10-14-205-010</u>	<u>SEC 14 T24N R5W</u>	\$ <u>936.54</u>	\$ <u>936.54</u>
5. _____	<u>PT OF E 1/2 NE 1/4</u>	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>106,580.74</u></u>	\$ <u><u>106,580.74</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?                 YES        X   NO

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number Pekin Manor

# 0047969 Report Period Beginning:

10/1/13 Ending:

9/30/14

**X. BUILDING AND GENERAL INFORMATION:**

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

C. Does the Operating Entity?  (a) Own the Facility  (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

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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</u>	<u>6.24 Acres</u>	<u>2006</u>	<u>\$ 450,000</u>	1
2					2
3	<b>TOTALS</b>	<b>#VALUE!</b>		<b>\$ 450,000</b>	3

Facility Name &amp; ID Number Pekin Manor

# 0047969

Report Period Beginning:

10/1/13

Ending:

9/30/14

**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	120	2006	1988	\$ 7,174,313	\$ 179,363	40	\$ 179,363	\$	\$ 1,524,542	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Light Sign - Double Faced, Fire Alarm Panel	2006		43,700	4,370	10	4,370		37,557	9
10	Replace Defective Pipe for Dry System, Roof	2007		139,058	13,027	10-25 yrs	13,027		90,105	10
11	Roof Repair, Furnace Duct Repair, Sprinkler System	2008		179,648	10,561	10-25 yrs	10,561		66,348	11
12	A/C, Shower Room, Firewall, Wall/Ceiling, Kitchen Repairs	2009		78,867	6,267	5-15 yrs	6,267		38,017	12
13	Shower, Shower, Tile, AC, Carpet, Sprinkler, Sidewalks	2009		50,035	3,801	5-25 yrs	3,801		20,566	13
14	Water Heater, Landscaping/Lights	2009		12,030	1,203	10	1,203		5,815	14
15	Single Face Lighted Sign, Water Heater	2010		5,773	578	10	578		2,424	15
16	Physical Therapy Completion, Water Heater	2010		397,172	33,169	10-12 yrs	33,169		151,704	16
17	Apollo Tub Room - Sink/Mirror/Shower/Tile/Drywall/Drains/Faucets	2011		56,049	4,670	12	4,670		17,126	17
18	Water Heater	2011		4,926	492	10	492		1,683	18
19	Condensor - 5 ton	2011		2,500	167	15	167		542	19
20	Bathrm Remodel-Sink/Mirror/Walls/Tile/Floor/Curtains/Drywall/Plumb.	2011		39,773	3,315	12	3,315		10,772	20
21	Physical Therapy Remodel - Contracted Total	2011		147,137	12,261	12	12,261		42,915	21
22	Dining Room Addition (Contracted Total)	2011		183,361	15,280	12	15,280		53,480	22
23	Sprinkler System	2011		127,543	5,102	25	5,102		14,455	23
24	Sprinkler-New Tamper Switch/Relocate FDC Check Valve	2012		5,867	234	25	234		645	24
25	Kitchenette Rmdl-Sink/Vnyl Tile/Cabinet/Counter/Crnr Grds	2012		53,384	4,449	12	4,449		10,010	25
26	Nurse Station/Lounge Remodel-Paint/Vinyl/Counter/Cabinet	2012		150,956	12,579	12	12,579		28,304	26
27	Remodel-Paint/drywall/corner Plates	2012		4,570	914	5	914		1,904	27
28	Smoke Detectors-48/Pull Stations-6.5/Heat Detectors-10	2012		9,831	983	10	983		2,048	28
29	Water Heater	2012		3,717	371	10	371		774	29
30	Excavation of Lake	2012		13,885	1,389	10	1,389		3,356	30
31	Overbed Lights - 25	2012		6,266	626	10	626		1,253	31
32	Air Conditioners	2012		9,440	1,888	5	1,888		3,461	32
33	New Well for Lake	2012		7,760	931	15	517	(414)	948	33
34	Sidewalk/Landscaping	2012		3,050	204	15	204		407	34
35	Nurse Call System	2013		17,031	1,704	10	1,704		2,839	35
36										36

\*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Pekin Manor

# 0047969

Report Period Beginning:

10/1/13

Ending:

9/30/14

**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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Double Egress Doors	2013	\$ 4,730	\$ 475	10	\$ 475	\$	\$ 591	37
38	Water Heater	2013	5,147	514	10	514		600	38
39	Phone System	2013	2,637	220	10	220		220	39
40	Water Heater	2013	4,014	335	10	335		335	40
41	Storage Shed	2014	18,870	708	20	708		708	41
42	Condensor/Furnace	2014	5,800	64	15	64		64	42
43	Water Heater	2014	5,104	85	10	85		85	43
44	Pekin Manor Shower Remodel-Tile/Fixtures/Electrical/Drains	2014	66,251	460	12	460		460	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	<b>TOTAL (lines 4 thru 69)</b>		\$ 9,040,195	\$ 322,759		\$ 322,345	\$ (414)	\$ 2,137,063	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	\$ 810,175	\$ 84,383	\$ 84,383	\$	3-15 yrs	\$ 558,502	71
72	Current Year Purchases	15,764	1,109	1,109		5-10 yrs	1,109	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 825,939	\$ 85,492	\$ 85,492	\$		\$ 559,611	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	\$ 42,610	\$ 10,652	\$ 10,652	\$	4 yrs	\$ 20,417	76
77										77
78										78
79										79
80	TOTALS			\$ 42,610	\$ 10,652	\$ 10,652	\$		\$ 20,417	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 10,358,744	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 418,903	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 418,489	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (414)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,717,091	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	2003 Chevy G3500 - 2006	34,100		34,100	87
88					88
89					89
90					90
91	TOTALS	\$ 49,000	\$	\$ 49,000	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number

Pekin Manor

# 0047969

Report Period Beginning:

10/1/13

Ending:

9/30/14

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Pekin El Camino, LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

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. \_\_\_\_\_ /2015 \$ N/A

13. \_\_\_\_\_ /2016 \$ N/A

14. \_\_\_\_\_ /2017 \$ 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

by the length of the lease N/A.

N/A

N/A

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

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 26,353

Description: See Attached Schedule X

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/13 Ending: 9/30/14  
**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
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**

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

- (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	<b>TOTAL</b>			\$		\$	\$		\$	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 Pekin Manor# 0047969Report Period Beginning: 10/1/13

Ending:

9/30/14

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/14

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 177,037	\$ 231,275	1
2	Cash-Patient Deposits	12,788	12,788	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>163,000</u> )	774,351	774,351	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	124,482	143,911	6
7	Other Prepaid Expenses	331	331	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Escrow Deposits</u>		24,478	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,088,989	\$ 1,187,134	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		450,000	13
14	Buildings, at Historical Cost	13,885	7,421,032	14
15	Leasehold Improvements, at Historical Cost	1,619,163	1,619,163	15
16	Equipment, at Historical Cost	530,349	917,549	16
17	Accumulated Depreciation (book methods)	(827,519)	(2,766,850)	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>Replacement Reserve</u>		582,940	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,335,878	\$ 8,223,834	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,424,867	\$ 9,410,968	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 145,179	\$ 145,179	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,788	12,788	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	82,461	82,461	30
31	Accrued Taxes Payable (excluding real estate taxes)	92,337	92,337	31
32	Accrued Real Estate Taxes(Sch.IX-B)		92,370	32
33	Accrued Interest Payable		17,678	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Interdivision Payable</u>	3,675,428	5,734,524	36
37	<u>Current Portion of Mortgage Payable</u>		133,778	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 4,008,193	\$ 6,311,115	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,841,936	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44	<u>Security Deposits</u>	31,500	31,500	44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 31,500	\$ 5,873,436	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,039,693	\$ 12,184,551	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,614,826)	\$ (2,773,583)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,424,867	\$ 9,410,968	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (1,704,338)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ (1,704,338)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	89,512	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 89,512	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (1,614,826)	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	
<b>I. Revenue</b>		<b>Amount</b>	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 8,271,445	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,271,445	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	120,096	6
7	Oxygen	4,830	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 124,926	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,639	12
13	Barber and Beauty Care	7,375	13
14	Non-Patient Meals	1,304	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	77	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 10,395	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	1,057	24
25	Interest and Other Investment Income***	16,611	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 17,668	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Durable Medical Equipment</b>	3,128	28
28a	<b>Miscellaneous Income</b>	2,243	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 5,371	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,429,805	30

		2	
<b>II. Expenses</b>		<b>Amount</b>	
<b>A. Operating Expenses</b>			
31	General Services	1,526,482	31
32	Health Care	4,081,016	32
33	General Administration	1,625,706	33
<b>B. Capital Expense</b>			
34	Ownership	770,575	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	68,877	35
36	Provider Participation Fee	267,637	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,340,293	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	89,512	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 89,512	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 2,373,094	44
45	Private Pay - Net Inpatient Revenue	2,531,982	45
46	Medicare - Net Inpatient Revenue	2,986,739	46
47	Other-(specify) <u>Medicare Replacement Insurance</u>	104,189	47
48	Other-(specify) <u>See Att Schedule VII</u>	275,441	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 8,271,445	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Pekin Manor

# 0047969

Report Period Beginning:

10/1/13

Ending:

9/30/14

**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	1,640	1,740	\$ 59,550	\$ 34.22	1
2	Assistant Director of Nursing	1,504	1,552	45,864	29.55	2
3	Registered Nurses	12,780	13,088	332,245	25.39	3
4	Licensed Practical Nurses	30,640	32,163	725,764	22.57	4
5	CNAs & Orderlies	121,922	128,095	1,446,220	11.29	5
6	CNA Trainees					6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides			0		8
9	Activity Director			0		9
10	Activity Assistants	8,053	8,565	95,696	11.17	10
11	Social Service Workers	3,664	3,743	64,621	17.26	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	32,666	34,238	311,737	9.11	15
16	Dishwashers					16
17	Maintenance Workers	7,462	7,789	113,881	14.62	17
18	Housekeepers	17,986	18,875	177,516	9.40	18
19	Laundry	6,242	6,549	56,567	8.64	19
20	Administrator	2,072	2,072	76,253	36.80	20
21	Assistant Administrator	1,936	2,114	46,078	21.80	21
22	Other Administrative	1,560	1,642	32,155	19.58	22
23	Office Manager					23
24	Clerical	6,696	6,976	91,837	13.16	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,008	2,108	27,473	13.03	31
32	Other Health Care(specify)	5,182	5,462	114,635	20.99	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	264,013	276,771	\$ 3,818,092 *	\$ 13.80	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	***	\$ 6,516	1-3	35
36	Medical Director	***	21,000	9-3	36
37	Medical Records Consultant	***	2,350	10-3	37
38	Nurse Consultant	***	0	10-3	38
39	Pharmacist Consultant	***	8,199	10-3	39
40	Physical Therapy Consultant	***	364,349	10a-3	40
41	Occupational Therapy Consultant	***	230,918	10a-3	41
42	Respiratory Therapy Consultant	***	33,193	10a-3	42
43	Speech Therapy Consultant	***	83,164	10a-3	43
44	Activity Consultant	***		11-3	44
45	Social Service Consultant	***		12-3	45
46	Other(specify) <u>Dental Consultant</u>	***	865	10-3	46
47					47
48	<u>*** Monthly Fee</u>				48
49	TOTAL (lines 35 - 48)		\$ 750,554		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

Facility Name & ID Number Pekin Manor

Report Period Beginning: 10/1/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
Marcos Perez II	Administrator	None	\$ 76,253	Workers' Compensation Insurance	\$ 120,984	IDPH License Fee	\$	
Jenifer Horn	Asst Admin	None	5,988	Unemployment Compensation Insurance	23,297	Advertising: Employee Recruitment	1,230	
Kent DeCapp	Asst Admin	None	40,090	FICA Taxes	281,403	Health Care Worker Background Check (Indicate # of checks performed <u>47</u> )	1,401	
				Employee Health Insurance	157,318	Patient Background Checks <u>200</u>	2,000	
				Employee Meals		Advertising - Promotion	68,936	
				Illinois Municipal Retirement Fund (IMRF)*		Subscriptions	1,807	
				401 (k)	19,153	IHCA Dues	4,070	
				Other Employee Benefits	8,372	Other Licenses & Fees	4,457	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 122,331			Indirect Costs - See Att Sch III	2	
B. Administrative - Other						Less: Public Relations Expense	( )	
Description			Amount			Non-allowable advertising	(68,936)	
			\$			Yellow page advertising	( )	
						TOTAL (agree to Sch. V, line 20, col. 8)		
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 14,967		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
RFMS, Inc	Administrative Services		\$ 171,600			\$	Out-of-State Travel	\$
McGladrey LLP	Accounting Services		17,111					
LTC Support Services, LLC	Support Services		192,599				In-State Travel	
Blue Orange	Consulting Services		1,072				Staff use of personal vehicle on facility business and meals (under \$250 per travel voucher)	0
Polsinelli PC	Legal Services		237				Seminar Expense	42
Davis & Campbell L.L.C.	Legal Services		946				Less: non-allowable out-of-state travel	0
							Indirect costs - See Att Sch III	0
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 383,565	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
							TOTAL	
							\$ 42	

\* 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	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number Pekin Manor

# 0047969

Report Period Beginning:

10/1/13

Ending: 9/30/14

**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? 7 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 40,236 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. \$ 267,637  
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. \$ 1,304
- (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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details Yes-See Att Sch XI  
Attach invoices and a summary of services for all architect and appraisal fees.