

		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>I. IDPH License ID Number: <u>0047878</u></p> <p>Facility Name: <u>Shelbyville Manor</u></p> <p>Address: <u>1111 W North 12th St</u> <u>Shelbyville</u> <u>62565</u> <small>Number City Zip Code</small></p> <p>County: <u>Shelby</u></p> <p>Telephone Number: <u>(217) 774-2111</u> Fax # <u>(217) 774-2209</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>02/02/2006</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501 (c) (3)</u> </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Ron Wilson</u> Telephone Number: <u>(309) 343-1550</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501 (c) (3)</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</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 & 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"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </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>
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501 (c) (3)</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
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>							

Facility Name & ID Number Shelbyville Manor

0047878 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 3/17/14

	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	115	Skilled (SNF)	109	40,787	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	115	TOTALS	109	40,787	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	11,423	10,476	7,355	29,254	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,423	10,476	7,355	29,254	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.72%

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 109 and days of care provided 6,767

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	255,184	24,033	9,357	288,574		288,574	(49,676)	238,898		1
2	Food Purchase		319,673		319,673		319,673	(57,039)	262,634		2
3	Housekeeping	149,796	33,170	779	183,745		183,745	(27,774)	155,971		3
4	Laundry	67,441	28,932	240	96,613		96,613	(14,630)	81,983		4
5	Heat and Other Utilities			190,351	190,351		190,351	(27,309)	163,042		5
6	Maintenance	67,408	46,415	49,106	162,929		162,929	(24,733)	138,196		6
7	Other (specify):*										7
8	TOTAL General Services	539,829	452,223	249,833	1,241,885		1,241,885	(201,161)	1,040,724		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	2,023,570	330,163	7,697	2,361,430		2,361,430	(202,845)	2,158,585		10
10a	Therapy			754,615	754,615		754,615		754,615		10a
11	Activities	69,369	2,496		71,865		71,865	(624)	71,241		11
12	Social Services	38,667			38,667		38,667		38,667		12
13	CNA Training										13
14	Program Transportation			464	464	11,904	12,368		12,368		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,131,606	332,659	780,776	3,245,041	11,904	3,256,945	(203,469)	3,053,476		16
	C. General Administration										
17	Administrative	127,188			127,188		127,188		127,188		17
18	Directors Fees							2,635	2,635		18
19	Professional Services			377,037	377,037		377,037	6,641	383,678		19
20	Dues, Fees, Subscriptions & Promotions			83,071	83,071		83,071	(62,032)	21,039		20
21	Clerical & General Office Expenses	70,396	40,871	47,901	159,168		159,168	(2,250)	156,918		21
22	Employee Benefits & Payroll Taxes			495,243	495,243		495,243	(49,539)	445,704		22
23	Inservice Training & Education			8,718	8,718		8,718		8,718		23
24	Travel and Seminar			2,727	2,727		2,727		2,727		24
25	Other Admin. Staff Transportation			23,808	23,808	(11,904)	11,904	(583)	11,321		25
26	Insurance-Prop.Liab.Malpractice			48,860	48,860		48,860	24,224	73,084		26
27	Other (specify):* See Att Sch V	44,666		154,799	199,465		199,465	(199,465)			27
28	TOTAL General Administration	242,250	40,871	1,242,164	1,525,285	(11,904)	1,513,381	(280,369)	1,233,012		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,913,685	825,753	2,272,773	6,012,211		6,012,211	(684,999)	5,327,212		29

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			106,830	106,830		106,830	215,977	322,807			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							127,183	127,183			32
33	Real Estate Taxes							92,412	92,412			33
34	Rent-Facility & Grounds			491,688	491,688		491,688	(491,688)				34
35	Rent-Equipment & Vehicles			13,455	13,455		13,455		13,455			35
36	Other (specify):* See Att Sch IV							13,279	13,279			36
37	TOTAL Ownership			611,973	611,973		611,973	(42,837)	569,136			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			46,163	46,163		46,163		46,163			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			244	244		244		244			41
42	Provider Participation Fee			197,678	197,678		197,678		197,678			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			244,085	244,085		244,085		244,085			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,913,685	825,753	3,128,831	6,868,269		6,868,269	(727,836)	6,140,433			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 Shelbyville Manor

0047878

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	(331)	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	(20,220)	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	(152,676)	V-27		24
25	Fund Raising, Advertising and Promotional	(61,038)	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	(594,839)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (829,104)		\$	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)	89,696		34
35	Other- Attach Schedule See Att Sch III	11,572		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 101,268		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (727,836)		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

ID# 0047878

Report Period Beginning: 10/1/13

Ending: 9/30/14

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:

10/1/13

Ending:

9/30/14

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

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

STATE OF ILLINOIS

Facility Name & ID Number Shelbyville Manor

0047878

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)	
	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	89,696	0	0	0	0	0	0	0	0	0	89,696	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	89,696	0	0	0	0	0	0	0	0	0	89,696	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	89,696	0	0	0	0	0	0	0	0	0	89,696	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	\$ 581,384	\$ 89,696	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			\$ 581,384	\$ * 89,696	14

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

Facility Name & ID Number

Shelbyville Manor

0047878

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 Shelbyville Manor # 0047878 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	2	3	4	5	6		7		8	
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	See Attached Schedule II & III							\$ 2,635	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	\$ 2,635		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 Shelbyville Manor

0047878

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	See Att Sch II & III							11,572	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				\$	\$		\$	11,572

Facility Name & ID Number

Shelbyville Manor

0047878

Report Period Beginning:

10/1/13

Ending:

9/30/14

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	4,107,501	4/1/2040	3.5500	147,403	2					
3				SNF portion								3					
4												4					
5												5					
	Working Capital																
6	Miscellaneous		X									6					
7	Less Interest Income		X								(20,220)	7					
8												8					
9	TOTAL Facility Related				\$20,381.00		\$ 4,313,155	\$ 4,107,501			\$ 127,183	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	724,853	4/1/2040	3.5500	26,012	11					
12				ALC portion								12					
13												13					
14	TOTAL Non-Facility Related				\$3,597.00		\$ 761,145	\$ 724,853			\$ 26,012	14					
15	TOTALS (line 9+line14)						\$ 5,074,300	\$ 4,832,354			\$ 153,195	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 24,377 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 2013 report.		\$	<u>82,219</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>106,531</u>	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>24,312</u>	3	
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>84,408</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>108,720</u>	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	<u>97,779</u>	8	FOR BHF USE ONLY	
	2010	<u>99,341</u>	9	13	FROM R. E. TAX STATEMENT FOR 2013 \$ 13
	2011	<u>95,914</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2012	<u>106,616</u>	11	15	LESS REFUND FROM LINE 6 \$ 15
	2013	<u>106,531</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
<u>This facility was purchased from an unrelated for-profit entity during 2006. A tax exemption has not yet been obtained</u>					
<u>Amount accrued includes the taxes for 9 months based on fiscal year end. Estimate is based on prior year tax bill</u>					
<u>Real estate taxes reported on Sch V 33 have been reduced by an allocation of expenses relating to ALC</u>					
<u>services based on an estimated 15%. See Att Sch VI. Taxes paid during year represents the entire 2013 bill</u>					

NOTES:

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

2013 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 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</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>106,530.90</u>	\$ <u>90,551.26</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>106,530.90</u></u>	\$ <u><u>90,551.26</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 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 Shelbyville Manor

0047878 Report Period Beginning:

10/1/13 Ending:

9/30/14

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

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	Accumulated Depreciation
4	109	2006	1991	\$ 5,078,282	\$ 126,957	40	\$ 126,957	\$ 1,100,295
5								
6								
7								
8								
Improvement Type**								
9	Dry Pipe Valve and Water Softner	2006		11,205	939	10-20 yrs	939	7,529
10	Ceramic Tile Repair, Carpet, Ceramic Tile	2007		11,750	443	5-20 yrs	443	6,139
11	Roof Repair	2008		84,157	8,415	10	8,415	56,105
12	Air Handler, Water Heater, Fire Protection System	2009		21,450	2,145	10	2,145	11,632
13	Water Heater	2010		10,671	1,067	10	1,067	4,535
14	Fire Sprinkler	2011		119,000	4,760	25	4,760	16,660
15	Physical Therapy Addition (Contracted Total)	2011		762,407	63,534	12	63,534	190,601
16	Oil/Chip Parking Lot	2011		4,200	525	8	525	1,575
17	Hallway Rmdl-Vinyl tile/Base/Drywall/Handrails/Wall & Crnr Grds/AC	2011		56,356	4,696	12	4,696	14,088
18	Shower Rmdl-Exhaust fan/Fire access dr/Flr-tile/wiring/fxtrs/drains	2012		130,718	10,893	12	10,893	29,956
19	Laundry/Hallway Rmdl-Handrails/Guardrails/Vinyl Tile/Drywall/Paint	2012		138,186	11,516	12	11,516	28,790
20	Faux Wood Blinds - 14	2012		5,256	1,051	5	1,051	2,540
21	Fire Alarm System and Components	2012		8,555	856	10	856	1,640
22	Faux Wood Blinds	2012		5,108	1,022	5	1,022	1,958
23	Crown Light Boxes	2012		7,764	1,553	5	1,553	2,847
24	Faux Wood Blinds - 28	2013		4,883	976	5	976	1,301
25	Water Heater	2013		8,780	878	10	878	878
26	Doors	2014		16,820	841	10	841	841
27	Storage Building/Garage	2014		2,700	60	15	60	60
28	Sprinkler Pipe	2014		9,620	214	15	214	214
29	Condensor/Air Handler	2014		3,380	19	15	19	19
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:

10/1/13

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		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)		\$ 6,501,248	\$ 243,360		\$ 243,360	\$	\$ 1,480,203	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	\$ 646,137	\$ 63,538	\$ 63,538	\$	3-15 yrs	\$ 401,362	71
72	Current Year Purchases	69,635	5,002	5,002		5-12 yrs	5,002	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 715,772	\$ 68,540	\$ 68,540	\$		\$ 406,364	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	\$ 10,907	\$ 10,907	\$	4 yrs	\$ 19,996	76
77										77
78										78
79										79
80	TOTALS			\$ 43,627	\$ 10,907	\$ 10,907	\$		\$ 19,996	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)	\$ 7,456,147	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 322,807	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 322,807	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)	\$ 1,906,563	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	22,405	194,170	88
89	Physical Therapy Add. ALC - 2011	134,542	11,212	33,636	89
90	2003 GMC G3500 Van - 2006	29,848		29,848	90
91	TOTALS	\$ 1,109,957	\$ 33,617	\$ 272,554	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. _____ /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: \$ 13,455 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: 10/1/13 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>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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)		Total Units (Column 2 + 4)		Total Cost (Col. 3 + 5 + 6)					
			Units of Service	Cost	Units	Cost										
1	Licensed Occupational Therapist		hrs	\$		\$		\$								1
2	Licensed Speech and Language Development Therapist		hrs													2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist		hrs													4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# of 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

0047878

Report 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*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 64,904	\$ 104,824	1
2	Cash-Patient Deposits	11,459	11,459	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>160,000</u>)	1,500,654	1,500,654	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	98,395	118,918	6
7	Other Prepaid Expenses	4,448	4,448	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Att Sch VII</u>	1,913,624	1,943,587	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,593,484	\$ 3,683,890	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	660,559	660,559	15
16	Equipment, at Historical Cost	549,314	804,147	16
17	Accumulated Depreciation (book methods)	(439,559)	(2,179,117)	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>		576,245	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 770,314	\$ 6,963,232	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,363,798	\$ 10,647,122	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 86,635	\$ 86,635	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,459	11,459	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	78,068	78,068	30
31	Accrued Taxes Payable (excluding real estate taxes)	70,034	70,034	31
32	Accrued Real Estate Taxes(Sch.IX-B)	4,200	84,408	32
33	Accrued Interest Payable		14,296	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Interdivision Payable</u>		2,029,843	36
37	<u>Current Portion of Long Term Payable</u>		118,091	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 250,396	\$ 2,492,834	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,714,264	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44	<u>Security Deposits</u>	55,500	55,500	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 55,500	\$ 4,769,764	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 305,896	\$ 7,262,598	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,057,902	\$ 3,384,524	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,363,798	\$ 10,647,122	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,492,967	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,492,967	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	564,935	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)	\$ 564,935	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)	\$ 4,057,902	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	\$ 7,191,992	1	
2	Discounts and Allowances for all Levels	()	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,191,992	3	
B. Ancillary Revenue				
4	Day Care	3,170	4	
5	Other Care for Outpatients		5	
6	Therapy	188,891	6	
7	Oxygen	14,203	7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 206,264	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	641	12	
13	Barber and Beauty Care	200	13	
14	Non-Patient Meals	331	14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	9,797	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory	1,195	19	
20	Radiology and X-Ray	240	20	
21	Other Medical Services		21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 12,404	23	
D. Non-Operating Revenue				
24	Contributions	50	24	
25	Interest and Other Investment Income***	20,220	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 20,270	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28	Durable Medical Equipment	1,178	28	
28a	Miscellaneous Income	1,096	28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,274	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,433,204	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	1,241,885	31	
32	Health Care	3,245,041	32	
33	General Administration	1,525,285	33	
B. Capital Expense				
34	Ownership	611,973	34	
C. Ancillary Expense				
35	Special Cost Centers	46,407	35	
36	Provider Participation Fee	197,678	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,868,269	40	
41	Income before Income Taxes (line 30 minus line 40)**	564,935	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 564,935	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,627,237	44
45	Private Pay - Net Inpatient Revenue	1,741,710	45
46	Medicare - Net Inpatient Revenue	2,965,358	46
47	Other-(specify) <u>Assisted Living</u>	636,665	47
48	Other-(specify) <u>See Att Schedule XI</u>	221,022	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,191,992	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:

10/1/13

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	1,944	2,080	\$ 74,754	\$ 35.94	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	6,240	6,429	156,560	24.35	3
4	Licensed Practical Nurses	23,904	25,210	472,724	18.75	4
5	CNAs & Orderlies	110,086	115,127	1,188,296	10.32	5
6	CNA Trainees					6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides			0		8
9	Activity Director			0		9
10	Activity Assistants	6,701	7,046	69,369	9.85	10
11	Social Service Workers	3,067	3,211	38,667	12.04	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,168	27,858	255,184	9.16	15
16	Dishwashers					16
17	Maintenance Workers	3,894	4,233	67,408	15.92	17
18	Housekeepers	13,742	14,412	149,796	10.39	18
19	Laundry	7,051	7,428	67,441	9.08	19
20	Administrator	1,880	2,080	91,914	44.19	20
21	Assistant Administrator	1,953	2,150	35,274	16.41	21
22	Other Administrative	2,016	2,080	44,666	21.47	22
23	Office Manager					23
24	Clerical	7,182	7,637	70,396	9.22	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,920	2,080	39,631	19.05	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,917	2,093	21,902	10.46	31
32	Other Health Care(specify)	3,863	4,067	69,703	17.14	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	223,528	235,221	\$ 2,913,685 *	\$ 12.39	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	***	\$ 9,357	1-3	35
36	Medical Director	***	18,000	9-3	36
37	Medical Records Consultant	***	1,880	10-3	37
38	Nurse Consultant	***	0	10-3	38
39	Pharmacist Consultant	***	5,767	10-3	39
40	Physical Therapy Consultant	***	371,112	10a-3	40
41	Occupational Therapy Consultant	***	273,222	10a-3	41
42	Respiratory Therapy Consultant	***	20,970	10a-3	42
43	Speech Therapy Consultant	***	89,311	10a-3	43
44	Activity Consultant	***		11-3	44
45	Social Service Consultant	***		12-3	45
46	Other(specify) <u>Dental Consultant</u>	***	50	10-3	46
47					47
48	<u>*** Monthly Fee</u>				48
49	TOTAL (lines 35 - 48)		\$ 789,669		49

C. CONTRACT NURSES

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

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
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:

10/1/13

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? 8 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 22,280 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. \$ 197,678
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. \$ 331
- (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. N/A
Attach invoices and a summary of services for all architect and appraisal fees.