

		FOR BHF USE					

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**2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)**

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>0052894</u></p> <p>Facility Name: <u>Manor Court of Carbondale</u></p> <p>Address: <u>2940 W Westridge Pl</u> <u>Carbondale</u> <u>62901</u> Number City Zip Code</p> <p>County: <u>Jackson</u></p> <p>Telephone Number: <u>(618) 457-1010</u> Fax # <u>(618) 457-9226</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>08/25/14</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501 (c) (3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</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 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	IRS Exemption Code <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>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>10/1/14</u> to <u>9/30/15</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 style="width:100%"> <tr> <td style="width:20%; vertical-align: top;"> Officer or Administrator of Provider </td> <td> (Signed) _____ (Type or Print Name) <u>Matt Hails</u> (Title) <u>LTC CEO</u> </td> </tr> <tr> <td style="width:20%; vertical-align: top;"> Paid Preparer </td> <td> (Signed) <u>See Preparation Report</u> (Print Name and Title) <u>RSM US 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="center">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>RSM US 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 type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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Facility Name & ID Number Manor Court of Carbondale

0052894 Report Period Beginning: 10/1/14 Ending: 9/30/15

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	14,612	11,421	9,981	36,014	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,612	11,421	9,981	36,014	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.22%

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 08/26/14

J. Was the facility purchased or leased after January 1, 1978?

YES Date 06/18/14 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 7,587

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: 9/30/15 Fiscal Year: 9/30/15

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

Facility Name & ID Number

Manor Court of Carbondale

0052894

Report Period Beginning:

10/1/14

Ending:

9/30/15

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	325,605	45,018	17,021	387,644		387,644		387,644		1
2	Food Purchase		438,632		438,632		438,632	(820)	437,812		2
3	Housekeeping	177,083	49,747		226,830		226,830		226,830		3
4	Laundry	67,988	31,960		99,948		99,948		99,948		4
5	Heat and Other Utilities			161,316	161,316		161,316		161,316		5
6	Maintenance	100,040	3,440	53,258	156,738		156,738		156,738		6
7	Other (specify):*										7
8	TOTAL General Services	670,716	568,797	231,595	1,471,108		1,471,108	(820)	1,470,288		8
	B. Health Care and Programs										
9	Medical Director			35,000	35,000		35,000		35,000		9
10	Nursing and Medical Records	2,394,028	544,575	10,059	2,948,662		2,948,662		2,948,662		10
10a	Therapy	664,770		28,913	693,683		693,683		693,683		10a
11	Activities	77,796	4,984		82,780		82,780		82,780		11
12	Social Services	63,743			63,743		63,743		63,743		12
13	CNA Training										13
14	Program Transportation			776	776	2,378	3,154		3,154		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,200,337	549,559	74,748	3,824,644	2,378	3,827,022		3,827,022		16
	C. General Administration										
17	Administrative	122,887			122,887		122,887		122,887		17
18	Directors Fees							2,949	2,949		18
19	Professional Services			266,117	266,117		266,117	3,877	269,994		19
20	Dues, Fees, Subscriptions & Promotions			116,027	116,027		116,027	(80,259)	35,768		20
21	Clerical & General Office Expenses	79,368	25,006	52,819	157,193		157,193	8	157,201		21
22	Employee Benefits & Payroll Taxes			653,609	653,609		653,609		653,609		22
23	Inservice Training & Education			6,480	6,480		6,480		6,480		23
24	Travel and Seminar			2,035	2,035		2,035		2,035		24
25	Other Admin. Staff Transportation			4,756	4,756	(2,378)	2,378		2,378		25
26	Insurance-Prop.Liab.Malpractice			64,680	64,680		64,680	2,147	66,827		26
27	Other (specify):* See Att Sch V	54,273		133,106	187,379		187,379	(187,379)			27
28	TOTAL General Administration	256,528	25,006	1,299,629	1,581,163	(2,378)	1,578,785	(258,657)	1,320,128		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,127,581	1,143,362	1,605,972	6,876,915		6,876,915	(259,477)	6,617,438		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

Manor Court of Carbondale

#0052894

Report Period Beginning:

10/1/14

Ending:

9/30/15

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			89,032	89,032		89,032	(4,655)	84,377			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			216,000	216,000		216,000		216,000			33
34	Rent-Facility & Grounds			1,290,000	1,290,000		1,290,000		1,290,000			34
35	Rent-Equipment & Vehicles			33,639	33,639		33,639		33,639			35
36	Other (specify):*											36
37	TOTAL Ownership			1,628,671	1,628,671		1,628,671	(4,655)	1,624,016			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			24,036	24,036		24,036		24,036			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			230,742	230,742		230,742		230,742			42
43	Other (specify):* Outpatient Care			2,143	2,143		2,143		2,143			43
44	TOTAL Special Cost Centers			256,921	256,921		256,921		256,921			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,127,581	1,143,362	3,491,564	8,762,507		8,762,507	(264,132)	8,498,375			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 Manor Court of Carbondale

0052894

Report Period Beginning: 10/1/14

Ending: 9/30/15

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	(820)	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		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	(133,106)	V-27		24
25	Fund Raising, Advertising and Promotional	(80,262)	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	(59,976)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (274,164)		\$	30

BHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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)			34
35	Other- Attach Schedule	10,032		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 10,032		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (264,132)		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

Manor Court of Carbondale

ID# 0052894

Report Period Beginning: 10/1/14

Ending: 9/30/15

Sch. V Line Reference

NON-ALLOWABLE EXPENSES

Amount

Reference

1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manor Court of Carbondale# 0052894

Report Period Beginning:

10/1/14

Ending:

9/30/15

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

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

STATE OF ILLINOIS

Facility Name & ID Number Manor Court of Carbondale# 0052894

Report Period Beginning:

10/1/14

Ending:

Summary B

9/30/15

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	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	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		\$	LTC Support Services, LLC		\$	\$	1
2	V							2
3	V			See 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		\$			\$	\$ *	14

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

Facility Name & ID Number

Manor Court of Carbondale

0052894

Report Period Beginning:

10/1/14

Ending:

9/30/15

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 Manor Court of Carbondale # 0052894 Report Period Beginning: 10/1/14 Ending: 9/30/15

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								\$ 2,949	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	\$ 2,949		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 Manor Court of Carbondale

0052894

Report Period Beginning:

10/1/14

Ending: 9/30/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1					\$	\$		\$	1	
2	See Att Sch II & III							10,032	2	
3									3	
4									4	
5									5	
6									6	
7									7	
8									8	
9									9	
10									10	
11									11	
12									12	
13									13	
14									14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS				\$	\$		\$	10,032	25

Facility Name & ID Number

Manor Court of Carbondale

0052894

Report Period Beginning:

10/1/14

Ending:

9/30/15

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			
	A. Directly Facility Related																
	Long-Term																
1							\$	\$			\$						
2																	
3																	
4																	
5																	
	Working Capital																
6																	
7																	
8																	
9	TOTAL Facility Related						\$	\$			\$						
	B. Non-Facility Related*																
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$	\$			\$						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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 Manor Court of Carbondale# 0052894

Report Period Beginning:

10/1/14

Ending:

9/30/15

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 2014 report.		\$	<u>10,000</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>3,539</u>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(6,461)</u>		3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>226,708</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.)		\$	<u>(4,247)</u>		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>216,000</u>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	_____	8	FOR BHF USE ONLY	
	2011	_____	9	13	FROM R. E. TAX STATEMENT FOR 2014 \$ 13
	2012	_____	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2013	_____	11	15	LESS REFUND FROM LINE 6 \$ 15
	2014	<u>7,079</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
<u>This facility is owned by an unrelated for-profit, therefore a tax exemption has not been granted. Amount accrued includes the tax: for 6 months of 2014 and 9 months of 2015 based on fiscal year end. Estimate is based on similar sized facilities. Taxes paid during year represents half of the 2014 bill. The facility paid the other half after year end, however the facility was only responsible for the tax starting 8/6/14 per lease agreement. The \$4,247 listed in line 6 represents the refund of taxes for the time period 1/1/14 - 8/5/14.</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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manor Court of Carbondale COUNTY Jackson
 FACILITY IDPH LICENSE NUMBER 0052894
 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 2014 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 2014.

(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>15-18-376-074</u>	<u>LOT 19 LIBERTY VILLAGE</u>	\$ <u>7,078.94</u>	\$ <u>7,078.94</u>
2. _____	<u>SECTION 1-A 3.42 AC 18-9-1</u>	\$ _____	\$ _____
3. _____	<u>PC 3 SL 063</u>	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>7,078.94</u></u>	\$ <u><u>7,078.94</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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 61,679 B. General Construction Type: Exterior Brick/Vinyl Siding 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				\$	1
2					2
3	TOTALS			\$	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	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	4	
5									5	
6									6	
7									7	
8									8	
Improvement Type**										
9	Double Faced Lighted Sign	2014	2014	5,980	598	10	598		698	9
10	Workstations-Cubicle/Desk/Storage Cabinets	2014	2014	55,904	5,592	10	5,592		6,226	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	

*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 Manor Court of Carbondale

0052894

Report Period Beginning:

10/1/14

Ending:

9/30/15

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)	\$ 61,884	\$ 6,190		\$ 6,190	\$	\$ 6,924	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	\$ 370,419	\$ 52,072	\$ 52,072	\$	3-15 yrs	\$ 58,498	71
72	Current Year Purchases	103,653	13,332	13,332		3-15 yrs	13,332	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 474,072	\$ 65,404	\$ 65,404	\$		\$ 71,830	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	2014 Starcraft Allstar 8929	2014	\$ 51,133	\$ 12,783	\$ 12,783	\$	4	\$ 15,979	76
77										77
78										78
79										79
80	TOTALS			\$ 51,133	\$ 12,783	\$ 12,783	\$		\$ 15,979	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)	\$ 587,089	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 84,377	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 84,377	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)	\$ 94,733	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	2014 Toyota Corolla-5939 - 2014	\$ 18,621	\$ 4,655	\$ 5,043	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 18,621	\$ 4,655	\$ 5,043	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: Edwin Enterprises, 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>2014</u>	<u>120</u>	<u>6/8/14</u>	\$ <u>1,290,000</u>	<u>10</u>	<u>5</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		120		\$ 1,290,000			7

10. Effective dates of current rental agreement:

Beginning 8/6/14

Ending 8/6/24

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

Fiscal Year Ending Annual Rent

12. 9/30/2016 \$ 1,290,000

13. 9/30/2017 \$ 1,290,000

14. 9/30/2018 \$ 1,290,000

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: Appraised Value *

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: \$ 33,639 Description: See Attached Schedule VII

(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 Manor Court of Carbondale # 0052894 Report Period Beginning: 10/1/14 Ending: 9/30/15
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		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist		hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist		hrs							4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy		# of prescrpts							9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):									13	
14	TOTAL			\$		\$	\$		\$	14	

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

Facility Name & ID Number Manor Court of Carbondale# 0052894Report Period Beginning: 10/1/14Ending: 9/30/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/15

(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	\$ 45,127	\$	1
2	Cash-Patient Deposits	21,225		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>118,000</u>)	1,901,642		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	119,490		6
7	Other Prepaid Expenses	1,914		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	0		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,089,398	\$ 0	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	0		12
13	Land	0		13
14	Buildings, at Historical Cost	0		14
15	Leasehold Improvements, at Historical Cost	61,884		15
16	Equipment, at Historical Cost	543,826		16
17	Accumulated Depreciation (book methods)	(99,776)		17
18	Deferred Charges	0		18
19	Organization & Pre-Operating Costs	0		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	0		20
21	Restricted Funds	0		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	0		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 505,934	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,595,332	\$ 0	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 228,772	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,225		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	69,695		30
31	Accrued Taxes Payable (excluding real estate taxes)	109,480		31
32	Accrued Real Estate Taxes(Sch.IX-B)	226,708		32
33	Accrued Interest Payable	0		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Interdivision Payable</u>	3,364,795		36
37		0		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,020,675	\$ 0	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	0		40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44	<u>Security Deposits</u>	47,830		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 47,830	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,068,505	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,473,173)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,595,332	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (758,597)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (758,597)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(714,576)	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)	\$ (714,576)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,473,173)	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	\$ 7,902,123	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,902,123	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	129,217	6
7	Oxygen	8,610	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 137,827	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		12
13	Barber and Beauty Care	265	13
14	Non-Patient Meals	820	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,085	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,223	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,223	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Durable Medical Equipment	2,673	28
28a	Miscellaneous Income		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,673	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,047,931	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,471,108	31
32	Health Care	3,824,644	32
33	General Administration	1,581,163	33
B. Capital Expense			
34	Ownership	1,628,671	34
C. Ancillary Expense			
35	Special Cost Centers	26,179	35
36	Provider Participation Fee	230,742	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,762,507	40
41	Income before Income Taxes (line 30 minus line 40)**	(714,576)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (714,576)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,882,753	44
45	Private Pay - Net Inpatient Revenue	2,049,204	45
46	Medicare - Net Inpatient Revenue	3,196,052	46
47	Other-(specify) <u>Medicare Replacement Insurance</u>	90,569	47
48	Other-(specify) <u>See Att Schedule X</u>	683,545	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,902,123	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 Manor Court of Carbondale

0052894

Report Period Beginning:

10/1/14

Ending:

9/30/15

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	2,008	2,080	\$ 72,120	\$ 34.67	1
2	Assistant Director of Nursing	1,182	1,209	33,203	27.46	2
3	Registered Nurses	19,822	20,120	487,205	24.21	3
4	Licensed Practical Nurses	24,751	24,996	435,218	17.41	4
5	CNAs & Orderlies	105,247	106,921	1,188,427	11.12	5
6	CNA Trainees					6
7	Licensed Therapist	10,105	10,290	412,430	40.08	7
8	Rehab/Therapy Aides	10,295	10,414	252,340	24.23	8
9	Activity Director					9
10	Activity Assistants	8,139	8,316	77,796	9.35	10
11	Social Service Workers	4,050	4,265	63,743	14.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	38,298	39,394	325,605	8.27	15
16	Dishwashers					16
17	Maintenance Workers	6,532	6,798	100,040	14.72	17
18	Housekeepers	18,165	18,581	177,083	9.53	18
19	Laundry	7,237	7,405	67,988	9.18	19
20	Administrator	1,912	2,044	87,468	42.79	20
21	Assistant Administrator	1,912	1,978	35,419	17.91	21
22	Other Administrative	1,936	2,080	54,273	26.09	22
23	Office Manager					23
24	Clerical	7,123	7,273	79,368	10.91	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	3,212	3,366	37,995	11.29	31
32	Other Health Care(specify)	6,719	6,835	139,860	20.46	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	278,645	284,365	\$ 4,127,581 *	\$ 14.52	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	***	\$ 17,021	1-3	35
36	Medical Director	***	35,000	9-3	36
37	Medical Records Consultant	***	2,274	10-3	37
38	Nurse Consultant	***	0	10-3	38
39	Pharmacist Consultant	***	7,605	10-3	39
40	Physical Therapy Consultant	***	0	10a-3	40
41	Occupational Therapy Consultant	***	0	10a-3	41
42	Respiratory Therapy Consultant	***	28,913	10a-3	42
43	Speech Therapy Consultant	***	0	10a-3	43
44	Activity Consultant	***		11-3	44
45	Social Service Consultant	***		12-3	45
46	Other(specify) <u>Dental Consultant</u>	***	180	10-3	46
47					47
48	*** <u>Monthly Fee</u>				48
49	TOTAL (lines 35 - 48)		\$ 90,993		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
Sandra McCoy	Administrator	None	\$ 87,468	Workers' Compensation Insurance	\$ 154,162	IDPH License Fee	\$		
Rebecca McPherson	Asst Admin	None	17,239	Unemployment Compensation Insurance	46,545	Advertising: Employee Recruitment		21,661	
Brenda Barnett	Asst Admin	None	18,180	FICA Taxes	303,560	Health Care Worker Background Check			
				Employee Health Insurance	113,701	(Indicate # of checks performed <u>124</u>)		2,181	
				Employee Meals		Patient Background Checks	<u>329</u>	3,290	
				Illinois Municipal Retirement Fund (IMRF)*		Advertising - Promotion		80,262	
				401 (k)	13,511	Subscriptions		801	
				Other Employee Benefits	22,130	IHCA Dues		5,130	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 122,887			Other Licenses & Fees		2,702	
(List each licensed administrator separately.)						Indirect Costs - See Att Sch III		3	
B. Administrative - Other						Less: Public Relations Expense	(
Description			Amount			Non-allowable advertising		(80,262)	
			\$			Yellow page advertising	(
TOTAL (agree to Schedule V, line 17, col. 3)			\$		TOTAL (agree to Schedule V, line 22, col.8)	\$ 653,609		TOTAL (agree to Sch. V, line 20, col. 8)	\$ 35,768
(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		\$ 128,700			\$	Out-of-State Travel	\$	
RSM US LLP	Accounting Services		4,178						
LTC Support Services, LLC	Support Services		130,410				In-State Travel		
Templin Healthcare	Accounting Services		1,781				Staff use of personal vehicle on facility		
Duane Morris, LLP	Legal Services		1,048				business and meals (under \$250 per		
							travel voucher)	0	
							Seminar Expense	2,035	
							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)			\$ 266,117	TOTAL		\$	(agree to Sch. V, line 24, col. 8)		
(For legal fee disclosure, see page 39 of instructions)							TOTAL	\$ 2,035	

* Attach copy of IMRF notifications

**See instructions.

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

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

Facility Name & ID Number Manor Court of Carbondale

0052894

Report Period Beginning: 10/1/14

Ending: 9/30/15

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? 9 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 62,061 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. \$ 230,742
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. \$ 820
- (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: RSM US 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.