FOR BHF USE

LL1

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.

I. IDPH License ID Number: 0047969

Facility Name: Pekin Manor

Address: 1520 El Camino Drive (Number) Pekin (City) 61554 (Zip Code)

County: Tazewell

Telephone Number: (309) 353-1099 **Fax #** (309) 353-1363

HFS ID Number:

Date of Initial License for Current Owners: 4/26/06

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 (c) (3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Ron Wilson **Telephone Number:** (309) 343-1550
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/14 to 9/30/15 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Matt Hails
(Title) LTC CEO

Paid Preparer

(Signed) See Preparation Report (Date)
(Print Name and Title) RSM US LLP, 117 E. Main St., Suite 210
(Firm Name & Address) P.O. Box 1070, Galesburg, IL 61401
(Telephone) (309) 342-1175 Fax # (309) 342-7816

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**

Facility Name & ID Number Pekin Manor # 0047969 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 12/01/14

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	130	46,840	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	130	46,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,822	13,774	9,666	39,262	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,822	13,774	9,666	39,262	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.82%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 4/26/06

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/1/06 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 130 and days of care provided 6,863

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] 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 Pekin Manor # 0047969 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 Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	356,614	33,090	8,507	398,211		398,211		398,211			1
2	Food Purchase		409,983		409,983		409,983	(947)	409,036			2
3	Housekeeping	172,443	45,172		217,615		217,615		217,615			3
4	Laundry	47,638	33,714		81,352		81,352		81,352			4
5	Heat and Other Utilities			145,929	145,929		145,929		145,929			5
6	Maintenance	140,454	65,722	76,957	283,133		283,133		283,133			6
7	Other (specify):*											7
8	TOTAL General Services	717,149	587,681	231,393	1,536,223		1,536,223	(947)	1,535,276			8
	B. Health Care and Programs											
9	Medical Director			22,500	22,500		22,500		22,500			9
10	Nursing and Medical Records	2,733,119	484,969	10,513	3,228,601		3,228,601		3,228,601			10
10a	Therapy			759,284	759,284		759,284		759,284			10a
11	Activities	84,943	4,391		89,334		89,334		89,334			11
12	Social Services	77,087			77,087		77,087		77,087			12
13	CNA Training											13
14	Program Transportation					8,156	8,156		8,156			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,895,149	489,360	792,297	4,176,806	8,156	4,184,962		4,184,962			16
	C. General Administration											
17	Administrative	119,286			119,286		119,286		119,286			17
18	Directors Fees							2,950	2,950			18
19	Professional Services			373,699	373,699		373,699	2,616	376,315			19
20	Dues, Fees, Subscriptions & Promotions			75,073	75,073		75,073	(55,209)	19,864			20
21	Clerical & General Office Expenses	111,054	45,252	56,043	212,349		212,349	(1,422)	210,927			21
22	Employee Benefits & Payroll Taxes			632,038	632,038		632,038		632,038			22
23	Inservice Training & Education			2,301	2,301		2,301		2,301			23
24	Travel and Seminar			824	824		824		824			24
25	Other Admin. Staff Transportation			16,312	16,312	(8,156)	8,156		8,156			25
26	Insurance-Prop.Liab.Malpractice			40,856	40,856		40,856	39,809	80,665			26
27	Other (specify):* See Att Sch V	38,489		108,391	146,880		146,880	(146,880)				27
28	TOTAL General Administration	268,829	45,252	1,305,537	1,619,618	(8,156)	1,611,462	(158,136)	1,453,326			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,881,127	1,122,293	2,329,227	7,332,647		7,332,647	(159,083)	7,173,564			29

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

Facility Name & ID Number **Pekin Manor** **#0047969** **Report Period Beginning:** **10/1/14** **Ending:** **9/30/15**

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			177,412	177,412		177,412	237,628	415,040			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							209,219	209,219			32
33	Real Estate Taxes							124,559	124,559			33
34	Rent-Facility & Grounds			563,652	563,652		563,652	(563,652)				34
35	Rent-Equipment & Vehicles			20,267	20,267		20,267		20,267			35
36	Other (specify):*											36
37	**TOTAL Ownership**			761,331	761,331		761,331	7,754	769,085			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			67,615	67,615		67,615		67,615			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			3,602	3,602		3,602		3,602			41
42	Provider Participation Fee			263,203	263,203		263,203		263,203			42
43	Other (specify):* **Outpatient Care**			1,325	1,325		1,325		1,325			43
44	**TOTAL Special Cost Centers**			335,745	335,745		335,745		335,745			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,881,127	1,122,293	3,426,303	8,429,723		8,429,723	(151,329)	8,278,394			45

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

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/14 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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(947)	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	(680)	V-30		9
10	Interest and Other Investment Income	(360)	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	(1,430)	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	(107,788)	V-27		24
25	Fund Raising, Advertising and Promotional	(55,212)	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	(41,401)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (207,818)		$	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 Amount	2 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)	46,456		34
35	Other- Attach Schedule	10,033		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 56,489		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (151,329)		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 Yes	2 No	3 Amount	4 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

STATE OF ILLINOIS **Page 5A**

Pekin Manor

ID# 0047969

Report Period Beginning: 10/1/14

Ending: 9/30/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line 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 Pekin Manor # 0047969 **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 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

Summary B

Facility Name & ID Number Pekin Manor # 0047969 **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

	Capital Expense D. Ownership	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)	
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	46,456	0	0	0	0	0	0	0	0	0	46,456	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	46,456	0	0	0	0	0	0	0	0	0	46,456	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
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	46,456	0	0	0	0	0	0	0	0	0	46,456	45

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/14 Ending: 9/30/15

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Facility Rent	$ 563,652	Pekin El Camino, LLC	N/A	$ 610,108	$ 46,456	1
2	V								2
3	V				See Att Schedule IV and Preparation Report				3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 563,652			$ 610,108	$ * 46,456	14

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

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/14 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 Pekin Manor # 0047969 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See Attached Schedule II & III								$ 2,950	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	$ 2,950		13

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

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

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/14 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 [X] NO [ ]

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

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

	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							10,033	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					$	$		$ 10,033	25

Facility Name & ID Number Pekin Manor # 0047969 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	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Cambridge Realty Capital						$	$			$	1
2	LTD. Of Illinois		X	Facility purchase	$28,646.12	6/1/12	6,249,800	5,841,936	10/1/2041	3.5500	209,579	2
3												3
4												4
5												5
	Working Capital											
6	Miscellaneous		X									6
7	Less Interest Income		X								(360)	7
8												8
9	TOTAL Facility Related				$28,646.12		$ 6,249,800	$ 5,841,936			$ 209,219	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,249,800	$ 5,841,936			$ 209,219	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 29,456 Line # 26

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

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

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/14 Ending: 9/30/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 92,370	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.)		$ 108,662	2
3. Under or (over) accrual (line 2 minus line 1).		$ 16,292	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 108,267	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.		$ 124,559	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	97,834	8
	2011	98,550	9
	2012	106,626	10
	2013	106,580	11
	2014	108,662	12

This facility was purchased from an unrelated for-profit entity during 2006. A tax exemption has not yet been obtained
Amount accrued includes the taxes for 9 months based on fiscal year end. Estimate is based on prior year tax bill
Taxes paid during year represents the entire 2014 bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Pekin Manor COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0047969

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

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

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

Enter the tax index number and real estate tax assessed for 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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-10-11-400-015	Sec 11 T24N R5W	$ 107,706.94	$ 107,706.94
2.		PT OF E 1/2 SE 1/2 4.77 AC	$	$
3.			$	$
4.	10-10-14-205-010	SEC 14 T24N R5W	$ 954.82	$ 954.82
5.		PT OF E 1/2 NE 1/4 1.47 AC	$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 108,661.76	$ 108,661.76

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.

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/14 Ending: 9/30/15

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	6.24 Acres	2006	$ 450,000	1
2					2
3	TOTALS	#VALUE!		$ 450,000	3

Facility Name & ID Number Pekin Manor # 0047969 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	130		2006	1988	$ 7,174,313	$ 179,352	40	$ 179,352	$	$ 1,703,894	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Light Sign - Double Faced, Fire Alarm Panel			2006	43,700	4,370	10	4,370		41,927	9
10	Replace Defective Pipe for Dry System, Roof			2007	139,058	13,027	10-25 yrs	13,027		103,132	10
11	Roof Repair, Furnace Duct Repair, Sprinkler System			2008	179,648	10,561	10-25 yrs	10,561		76,909	11
12	A/C, Shower Room, Firewall, Wall/Ceiling, Kitchen Repairs			2009	78,867	5,778	5-15 yrs	5,778		43,795	12
13	Shower, Shower, Tile, AC, Carpet, Sprinkler, Sidewalks			2009	50,035	2,572	5-25 yrs	2,572		23,138	13
14	Water Heater, Landscaping/Lights			2009	12,030	1,203	10	1,203		7,018	14
15	Single Face Lighted Sign, Water Heater			2010	5,773	578	10	578		3,002	15
16	Physical Therapy Completion, Water Heater			2010	397,172	33,170	10-12 yrs	33,170		184,874	16
17	Apollo Tub Room - Sink/Mirror/Shower/Tile/Drywall/Drains/Faucets			2011	56,049	4,671	12	4,671		21,797	17
18	Water Heater, Condensor, Bathroom remodel			2011	47,199	3,974	10-15 yrs	3,974		16,971	18
19	PT Remodel, Dining Room, Sprinkler			2011	458,041	32,643	12-25 yrs	32,643		143,493	19
20	Sprinkler-New Tamper Switch/Relocate FDC Check Valve			2012	5,867	235	25	235		880	20
21	Kitchenette Rmdl-Sink/Vnyl Tile/Cabinet/Counter/Crnr Grds			2012	53,384	4,449	12	4,449		14,459	21
22	Nurse Station/Lounge Remodel-Paint/Vinyl/Counter/Cabinet			2012	150,956	12,580	12	12,580		40,884	22
23	Remodel-Paint/drywall/corner Plates			2012	4,570	914	5	914		2,818	23
24	Smoke Detectors-48/Pull Stations-6.5/Heat Detectors-10			2012	9,831	983	10	983		3,031	24
25	Water Heater			2012	3,717	372	10	372		1,146	25
26	Excavation of Lake			2012	13,885	1,389	10	1,389		4,745	26
27	Overbed Lights - 25			2012	6,266	627	10	627		1,880	27
28	Air Conditioners			2012	9,440	1,888	5	1,888		5,349	28
29	New Well for Lake			2012	7,760	931	15	517	(414)	1,465	29
30	Sidewalk/Landscaping			2012	3,050	203	15	203		610	30
31	Nurse Call System			2013	17,031	1,703	10	1,703		4,542	31
32	Double Egress Doors			2013	4,730	473	10	473		1,064	32
33	Water Heater			2013	5,147	515	10	515		1,115	33
34	Phone System			2013	2,637	264	10	264		484	34
35	Water Heater			2013	4,014	401	10	401		736	35
36	Storage Shed			2014	18,870	943	20	943		1,651	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/14 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Condensor/Furnance	2014	$ 5,800	$ 387	15	$ 387	$	$ 451	37
38	Water Heater	2014	5,104	510	10	510		595	38
39	Pekin Manor Shower Remodel-Tile/Fixtures/Electrical/Drains	2014	66,251	5,521	12	5,521		5,981	39
40	Roof	2014	2,900	532	10	266	(266)	266	40
41	Landscaping	2014	22,225	2,223	10	2,223		2,223	41
42	Water Heater	2015	3,550	207	10	207		207	42
43	Water Heater	2015	6,420	321	10	321		321	43
44	Ceramic Tile-Service Cooridor	2015	3,242	81	20	81		81	44
45	Concrete-Parking Lot	2015	3,300	18	15	18		18	45
46	Relocate Water Lines from Floor to Overhead	2015	62,335	208	25	208		208	46
47	Soffits - West Cooridor	2015	43,300	361	10	361		361	47
48	Parking Lot Lights	2015	11,850	100	10	100		100	48
49	100 Hall Remodekl-Tile/Fire Alarm/Carpet/Fixtures/Cabinets	2015	54,280	377	12	377		377	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)		$ 9,253,597	$ 331,615		$ 330,935	$ (680)	$ 2,467,998	70

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

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/14 Ending: 9/30/15

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	$ 825,939	$ 71,976	$ 71,976	$	3-15 yrs	$ 631,587	71
72	Current Year Purchases	16,848	1,476	1,476		5-12 yrs	1,476	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 842,787	$ 73,452	$ 73,452	$		$ 633,063	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2012 Ford E350 Bus	2012	$ 42,610	$ 10,653	$ 10,653	$	4 yrs	$ 31,070	76
77										77
78										78
79										79
80	TOTALS			$ 42,610	$ 10,653	$ 10,653	$		$ 31,070	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,588,994	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 415,720	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 415,040	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (680)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,132,131	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	2006 Toyota Corolla - 2006	$ 14,900	$	$ 14,900	86
87	2003 Chevy G3500 - 2006	34,100		34,100	87
88					88
89					89
90					90
91	TOTALS	$ 49,000	$	$ 49,000	91

G. Construction-in-Progress

	Description	Cost	
92	Shower Remodel	$ 26,674	92
93			93
94			94
95		$ 26,674	95

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

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

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/14 Ending: 9/30/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Pekin El Camino, LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [X] 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:				$ See Attached			3
4	Additions				Schedule IV			4
5					Related Party			5
6					Lease			6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
   This amount was calculated by dividing the total amount to be amortized N/A
   by the length of the lease N/A .

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

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.	/2016	$ N/A
13.	/2017	$ N/A
14.	/2018	$ 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: $ 20,267 Description: See Attached Schedule X
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/14 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/14 Ending: 9/30/15

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	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 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.

STATE OF ILLINOIS

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/14 Ending: 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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 266,326	$ 309,785	1
2	Cash-Patient Deposits	7,077	7,077	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 87,000)	483,352	483,352	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	107,724	134,705	6
7	Other Prepaid Expenses	2,320	2,320	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Att Schedule VII	347,026	373,263	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,213,825	$ 1,310,502	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	0		12
13	Land	0	450,000	13
14	Buildings, at Historical Cost	36,110	7,443,257	14
15	Leasehold Improvements, at Historical Cost	1,810,340	1,810,340	15
16	Equipment, at Historical Cost	547,197	934,397	16
17	Accumulated Depreciation (book methods)	(1,004,931)	(3,182,570)	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): See Att Schedule VII	26,674	542,163	23
24	**TOTAL Long-T \ (sum of lines 11 thru 23)**	$ 1,415,390	$ 7,997,587	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,629,215	$ 9,308,089	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 522,425	$ 522,425	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,077	7,077	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	63,384	63,384	30
31	Accrued Taxes Payable (excluding real estate taxes)	88,199	88,199	31
32	Accrued Real Estate Taxes(Sch.IX-B)	0	108,267	32
33	Accrued Interest Payable	0	17,283	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Interdivision Payable	3,553,583	5,482,679	36
37	Current Portion of Mortgage Payable	0	138,606	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,234,668	$ 6,427,920	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	0	5,703,330	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Security Deposits	37,860	37,860	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 37,860	$ 5,741,190	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,272,528	$ 12,169,110	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,643,313)	$ (2,861,021)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,629,215	$ 9,308,089	48

*(See instructions.)

Facility Name & ID Number Pekin Manor **#** 0047969 **Report Period Beginning:** 10/1/14 **Ending:** 9/30/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,614,826)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,614,826)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(28,487)	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)**	$ (28,487)	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)**	$ (1,643,313)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/14 Ending: 9/30/15

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,322,378	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,322,378	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	65,192	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 65,192	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,513	12
13	Barber and Beauty Care	6,787	13
14	Non-Patient Meals	947	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)**	$ 10,247	23
	D. Non-Operating Revenue		
24	Contributions	75	24
25	Interest and Other Investment Income***	360	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 435	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Durable Medical Equipment	2,804	28
28a	Miscellaneous Income	180	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,984	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,401,236	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,536,223	31
32	Health Care	4,176,806	32
33	General Administration	1,619,618	33
	B. Capital Expense		
34	Ownership	761,331	34
	C. Ancillary Expense		
35	Special Cost Centers	72,542	35
36	Provider Participation Fee	263,203	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,429,723	40
41	**Income before Income Taxes (line 30 minus line 40)****	(28,487)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (28,487)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,065,569	44
45	Private Pay - Net Inpatient Revenue	2,562,643	45
46	Medicare - Net Inpatient Revenue	3,047,815	46
47	Other-(specify) Medicare Replacement Insurance	83,958	47
48	Other-(specify) See Att Sch XII	562,393	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,322,378	49

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

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

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

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

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/14 Ending: 9/30/15

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,968	2,080	$ 72,996	$ 35.09	1
2	Assistant Director of Nursing	2,020	2,080	57,759	27.77	2
3	Registered Nurses	13,792	14,331	358,183	24.99	3
4	Licensed Practical Nurses	31,702	33,225	747,202	22.49	4
5	CNAs & Orderlies	114,590	120,101	1,349,870	11.24	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,361	7,958	84,943	10.67	10
11	Social Service Workers	3,925	4,121	77,087	18.71	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	37,735	39,884	356,614	8.94	15
16	Dishwashers					16
17	Maintenance Workers	9,207	9,644	140,454	14.56	17
18	Housekeepers	17,262	18,291	172,443	9.43	18
19	Laundry	5,173	5,428	47,638	8.78	19
20	Administrator	1,984	2,219	86,306	38.89	20
21	Assistant Administrator	1,744	1,920	32,980	17.18	21
22	Other Administrative	1,788	1,974	38,489	19.50	22
23	Office Manager					23
24	Clerical	7,164	7,599	111,054	14.61	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	1,915	2,071	26,135	12.62	31
32	Other Health Care(specify)	5,554	5,761	120,974	21.00	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	264,884	278,687	$ 3,881,127 *	$ 13.93	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	***	$ 8,507	1-3	35
36	Medical Director	***	22,500	9-3	36
37	Medical Records Consultant	***	1,880	10-3	37
38	Nurse Consultant	***	0	10-3	38
39	Pharmacist Consultant	***	8,051	10-3	39
40	Physical Therapy Consultant	***	372,458	10a-3	40
41	Occupational Therapy Consultant	***	234,581	10a-3	41
42	Respiratory Therapy Consultant	***	46,223	10a-3	42
43	Speech Therapy Consultant	***	106,022	10a-3	43
44	Activity Consultant	***		11-3	44
45	Social Service Consultant	***		12-3	45
46	Other(specify) Dental Consultant	***	582	10-3	46
47					47
48	*** Monthly Fee				48
49	TOTAL (lines 35 - 48)		$ 800,804		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Marcos Perez II	Administrator	None	$ 7,140
Jenifer Horn	Asst Admin	None	32,980
Brandy Cooper	Administrator	None	79,166
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 119,286

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
RFMS, Inc	Administrative Services	$ 171,600
RSM US LLP	Accounting Services	22,431
LTC Support Services, LLC	Support Services	177,360
Blue Orange	Consulting Services	0
Davis & Campbell LLC	Legal Services	1,235
Duane Morris, LLP	Legal Services	1,073
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 373,699

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 103,393
Unemployment Compensation Insurance	38,200
FICA Taxes	294,731
Employee Health Insurance	166,120
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401 (k)	22,516
Other Employee Benefits	7,078
TOTAL (agree to Schedule V, line 22, col.8)	$ 632,038

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,233
Health Care Worker Background Check	
(Indicate # of checks performed 68)	1,515
Patient Background Checks 278	2,800
Advertising - Promotion	55,212
Subscriptions	1,401
IHCA Dues	6,528
Other Licenses & Fees	3,384
Indirect Costs - See Att Sch III	3
Less: Public Relations Expense	( )
Non-allowable advertising	(55,212)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,864

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Staff use of personal vehicle on facility	
business and meals (under $250 per	
travel voucher)	0
Seminar Expense	824
Less: non-allowable out-of-state travel	0
Indirect costs - See Att Sch III	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 824

**See instructions.

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/14 Ending: 9/30/15

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	Amount of Expense Amortized Per Year								
					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 Pekin Manor # 0047969 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? **8 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **55,563** 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. $ **263,203**
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. $ **947**

(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 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 XII**
Attach invoices and a summary of services for all architect and appraisal fees.