FOR BHF USE

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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.

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

I. IDPH License ID Number: 0047233

Facility Name: Seminary Manor

Address: 2345 N Seminary St (Number) Galesburg (City) 61401 (Zip Code)

County: Knox

Telephone Number: (309) 344-1300 **Fax #** (309) 344-2473

HFS ID Number:

Date of Initial License for Current Owners: 7/28/05

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

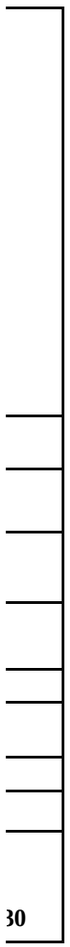
I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/14 to 9/30/15 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (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) 782-163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Facility Name & ID Number Seminary Manor # 0047233 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 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	121	Skilled (SNF)	121	44,165	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	121	TOTALS	121	44,165	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	10,844	11,922	13,491	36,257	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,844	11,922	13,491	36,257	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.09%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 8/01/05

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/28/05 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 121 and days of care provided 8,523

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 Seminary Manor # 0047233 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	334,263	32,524	10,699	377,486		377,486		377,486			1
2	Food Purchase		399,704		399,704		399,704	(4,734)	394,970			2
3	Housekeeping	174,407	46,626		221,033		221,033		221,033			3
4	Laundry	51,615	38,077		89,692		89,692		89,692			4
5	Heat and Other Utilities			163,401	163,401		163,401		163,401			5
6	Maintenance	78,408	54,148	57,259	189,815		189,815		189,815			6
7	Other (specify):*											7
8	TOTAL General Services	638,693	571,079	231,359	1,441,131		1,441,131	(4,734)	1,436,397			8
	B. Health Care and Programs											
9	Medical Director			41,250	41,250		41,250		41,250			9
10	Nursing and Medical Records	2,270,723	723,515	9,266	3,003,504		3,003,504		3,003,504			10
10a	Therapy			1,138,569	1,138,569		1,138,569		1,138,569			10a
11	Activities	100,373	2,475		102,848		102,848		102,848			11
12	Social Services	69,366			69,366		69,366		69,366			12
13	CNA Training											13
14	Program Transportation					5,778	5,778		5,778			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,440,462	725,990	1,189,085	4,355,537	5,778	4,361,315		4,361,315			16
	C. General Administration											
17	Administrative	196,145			196,145		196,145		196,145			17
18	Directors Fees							2,974	2,974			18
19	Professional Services			370,228	370,228		370,228	4,193	374,421			19
20	Dues, Fees, Subscriptions & Promotions			88,324	88,324		88,324	(68,815)	19,509			20
21	Clerical & General Office Expenses	90,759	55,215	49,257	195,231		195,231	8	195,239			21
22	Employee Benefits & Payroll Taxes			541,161	541,161		541,161		541,161			22
23	Inservice Training & Education			1,799	1,799		1,799		1,799			23
24	Travel and Seminar			876	876		876		876			24
25	Other Admin. Staff Transportation			11,555	11,555	(5,778)	5,777		5,777			25
26	Insurance-Prop.Liab.Malpractice			72,846	72,846		72,846	63,236	136,082			26
27	Other (specify):* See Att Sch V	45,302		(28,388)	16,914		16,914	(16,914)				27
28	TOTAL General Administration	332,206	55,215	1,107,658	1,495,079	(5,778)	1,489,301	(15,318)	1,473,983			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,411,361	1,352,284	2,528,102	7,291,747		7,291,747	(20,052)	7,271,695			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 Seminary Manor #0047233 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			137,986	137,986		137,986	290,612	428,598			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							353,569	353,569			32
33	Real Estate Taxes							158,040	158,040			33
34	Rent-Facility & Grounds			806,820	806,820		806,820	(806,820)				34
35	Rent-Equipment & Vehicles			5,220	5,220		5,220		5,220			35
36	Other (specify):* See Att Sch IV							19,035	19,035			36
37	TOTAL Ownership			950,026	950,026		950,026	14,436	964,462			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			90,649	90,649		90,649		90,649			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			3,997	3,997		3,997		3,997			41
42	Provider Participation Fee			226,585	226,585		226,585		226,585			42
43	Other (specify):* Outpatient Care			255	255		255		255			43
44	TOTAL Special Cost Centers			321,486	321,486		321,486		321,486			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,411,361	1,352,284	3,799,614	8,563,259		8,563,259	(5,616)	8,557,643			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 Seminary Manor # 0047233 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	(4,734)	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	(3,890)	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	(1,000)	V-27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	29,997	V-27		24
25	Fund Raising, Advertising and Promotional	(68,818)	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	(46,684)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (95,129)		$	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)	79,397		34
35	Other- Attach Schedule	10,116		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 89,513		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (5,616)		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

Seminary Manor

ID# 0047233

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 Seminary Manor # 0047233 **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 Seminary Manor # 0047233 **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	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	79,397	0	0	0	0	0	0	0	0	0	79,397	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	79,397	0	0	0	0	0	0	0	0	0	79,397	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	79,397	0	0	0	0	0	0	0	0	0	79,397	45

Facility Name & ID Number Seminary Manor # 0047233 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. [X] 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	$ 806,820	Galesburg North Seminary, LLC	N/A	$ 886,217	$ 79,397	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			$ 806,820			$ 886,217	$ * 79,397	14

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

Facility Name & ID Number Seminary Manor # 0047233 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 Seminary Manor # 0047233 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								$ 2,974	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	$ 2,974		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 Seminary Manor # 0047233 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							10,116	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					$	$		$ 10,116	25

Facility Name & ID Number Seminary Manor # 0047233 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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Cambridge Realty Capital						$	$			$	1
2	LTD. Of Illinois		X	Facility purchase	$40,951.77	7/1/2011	9,063,800	8,551,828	8/1/2046	4.1500	357,459	2
3												3
4												4
5												5
	Working Capital											
6	Miscellaneous		X									6
7	Less Interest Income		X								(3,890)	7
8												8
9	TOTAL Facility Related				$40,951.77		$ 9,063,800	$ 8,551,828			$ 353,569	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 9,063,800	$ 8,551,828			$ 353,569	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 43,012 **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 Seminary Manor # 0047233 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.**	$ 111,097	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.)		$ 153,421	2
3. Under or (over) accrual (line 2 minus line 1).		$ 42,324	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 115,716	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.		$ 158,040	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	139,846	8
	2011	141,828	9
	2012	141,923	10
	2013	147,642	11
	2014	153,421	12

This facility was purchased from an unrelated for-profit entity during 2005. 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 Seminary Manor COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0047233

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.	99-02-101-045	HAWTHORNE CENTRE SUB	$ 153,420.76	$ 153,420.76
2.		LOT 1 (EX E50 FT) BLK 1 &	$	$
3.		HAWTHORNE CENTRE RESUB	$	$
4.		NO - 5 PT LOT 6 - BEG NW	$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 153,420.76	$ 153,420.76

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 Seminary Manor # 0047233 Report Period Beginning: 10/1/14 Ending: 9/30/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,680 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	4.33 Acres	2005	$ 287,000	1
2					2
3	TOTALS	#VALUE!		$ 287,000	3

Facility Name & ID Number Seminary Manor # 0047233 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	121		2005		$ 9,633,067	$ 240,827	40	$ 240,827	$	$ 2,448,406
5			2014	2014	501,672	12,542	40	12,542		13,587
6										
7										
8										
	Improvement Type**									
9	Fire Door Closers			2005	3,059	204	15	204		2,005
10	A/C, Sign, Concrete, Asphalt, Door, Dining rm addn, Alarm			2006	74,961	6,275	8-15 yrs	6,275		67,273
11	AC, Vinyl, Cabinetry, Sidewalk, Roof/deck repair, Window treatments			2007	123,842	11,802	5-15 yrs	11,802		106,354
12	Roof,Fire dampers,Condensor, Sidewalks, Sprinklers			2008	61,632	5,786	10-25 yrs	5,786		42,894
13	Prime Walls/Paint, Condensing Units/Refridgeration piping, A/C			2008	14,320	423	5-15 yrs	423		11,285
14	Handrail, Double door w/ side lights, Roof repair, Roof repair - Garage			2008	44,415	4,348	10-15 yrs	4,348		32,965
15	Lighting ple, Rplc wall/ceil, Roof Repl, Rbbr Flr, Lgt post concrete			2009	73,343	6,561	10-15 yrs	6,561		44,916
16	Prking lot poles, Prking lot (asphalt), Tile, Wtrheater, Shwr rm.			2009	89,588	8,514	8-20 yrs	8,514		58,048
17	PT addtn, Garden crt addtn, Concrete prking lot & sidewalk			2009	296,914	12,219	15-25 yrs	12,219		83,071
18	Waterheater, Waterheater			2010	7,500	750	10	750		3,781
19	Carpet - Bounce Back			2011	25,627	5,125	5	5,125		20,928
20	Seminary Manor Public BR - Floor/Wallpaper/Vanity/Faucets/Mirrors			2011	15,530	1,294	12	1,294		5,284
21	New Fan for kitchen exhaust hood			2012	2,650	265	10	265		905
22	Bedroom - Drywall/Tile/Covebase/Countertop/Cabinets/Paint			2012	7,925	660	12	660		2,145
23	Water heater			2012	4,888	489	10	489		1,385
24	Walk in cooler remodel- Drywall/paint/prime/tile/insulation			2012	23,065	1,922	12	1,922		5,766
25	Furnace			2013	2,600	173	15	173		418
26	AC Condensor			2013	2,850	190	15	190		459
27	Water Heater			2013	4,600	460	10	460		958
28	Roof			2013	12,447	1,245	10	1,245		2,490
29	Training Cntr Remodel-Kawneer Dr, 2 ADA Rmps, Deck Rmvl			2013	23,582	1,965	12	1,965		3,603
30	Water Heater			2014	3,794	379	10	379		505
31	Fence-Metal			2014	7,193	1,439	5	1,439		1,559
32	Foyer Remodel-Drywll/Pnt/Rmv/Rnstll Fire Alarms/Handrails/Wllpapr/Fu			2014	16,400	1,367	12	1,367		1,595
33	Generator Transfer Switches			2014	10,872	1,087	10	1,087		1,178
34	PT Completion-Equipment/Supplies/Cabinets			2014	83,319	6,943	12	6,943		7,522
35	Parking Lot addition			2014	29,100	3,638	8	3,638		3,941
36	Wall Sconces			2014	5,278	691	7	691		691

*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


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Facility Name & ID Number Seminary Manor # 0047233 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	Landscaping	2014	$ 5,797	$ 580	10	$ 580	$	$ 628
38	Landscaping	2014	3,448	287	10	287		287
39	Cabinets-Conference Room/Kitchen	2015	2,596	130	15	130		130
40	Decorative Fencing	2015	7,678	154	25	154		154
41	Water Softener	2015	6,993	291	10	291		291
42	Interior Doors/Automatic Doors	2015	8,700	145	10	145		145
43	Fiber Optic Cables-Phone and Internet	2015	3,710	124	5	124		124
44	Fencing	2015	6,173	823	5	823		823
45								
46								
47								
48								
49								
50								
51								
52								
53								
54								
55								
56								
57								
58								
59								
60								
61								
62								
63								
64								
65								
66								
67								
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69								
70	TOTAL (lines 4 thru 69)		$ 11,251,128	$ 342,117		$ 342,117	$	$ 2,978,499

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

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Facility Name & ID Number Seminary Manor # 0047233 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	$ 918,345	$ 84,610	$ 84,610	$	3-15 yrs	$ 701,412	71
72	Current Year Purchases	19,940	1,871	1,871		5-15 yrs	1,871	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 938,285	$ 86,481	$ 86,481	$		$ 703,283	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	2008 Ford E450 Universal	2008	$ 50,950	$	$	$	4 yrs	$ 50,950	76
77										77
78										78
79										79
80	TOTALS			$ 50,950	$	$	$		$ 50,950	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)	$ 12,527,363	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 428,598	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 428,598	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)	$ 3,732,732	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	2002 Ford F25 - 2006	$ 21,200	$	$ 21,200	86
87	2006 Toyota Corolla - 2006	14,900		14,900	87
88					88
89					89
90					90
91	TOTALS	$ 36,100	$	$ 36,100	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Seminary Manor # 0047233 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: Galesburg North Seminary, 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: $ 5,220 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 Seminary Manor # 0047233 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 Seminary Manor # 0047233 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.

Facility Name & ID Number Seminary Manor # 0047233 **Report Period Beginning:** 10/1/14 **Ending:** 9/30/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of #NAME? (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	$ 73,424	$ 140,583	1
2	Cash-Patient Deposits	13,302	13,302	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 96,000)	1,571,241	1,571,241	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	94,140	141,566	6
7	Other Prepaid Expenses	3,482	3,482	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Att Sch VII	4,182,877	4,199,645	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,938,466	$ 6,069,819	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	0		12
13	Land	0	287,000	13
14	Buildings, at Historical Cost	5,797	10,166,789	14
15	Leasehold Improvements, at Historical Cost	1,055,239	1,084,339	15
16	Equipment, at Historical Cost	656,375	1,025,335	16
17	Accumulated Depreciation (book methods)	(923,693)	(3,768,832)	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 Sch VII	0	886,330	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 793,718	$ 9,680,961	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,732,184	$ 15,750,780	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 602,552	$ 602,552	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,302	13,302	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	78,640	78,640	30
31	Accrued Taxes Payable (excluding real estate taxes)	76,466	76,466	31
32	Accrued Real Estate Taxes(Sch.IX-B)		115,716	32
33	Accrued Interest Payable	4,940	34,515	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Interdivision Payable	0	1,041,356	36
37	See Att Sch VII	75,378	759,323	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 851,278	$ 2,721,870	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	0	8,412,681	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Security Deposits	19,677	19,677	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 19,677	$ 8,432,358	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 870,955	$ 11,154,228	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,861,229	$ 4,596,552	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,732,184	$ 15,750,780	48

***(See instructions.)**

Facility Name & ID Number Seminary Manor **#** 0047233 **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**	$ 5,254,489	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,254,489	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	606,740	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)**	$ 606,740	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)**	$ 5,861,229	24 *

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

Facility Name & ID Number Seminary Manor # 0047233 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	$ 8,897,296	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,897,296	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	205,789	6
7	Oxygen	7,347	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 213,136	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	6,718	12
13	Barber and Beauty Care	11,380	13
14	Non-Patient Meals	4,734	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	178	16
17	Sale of Drugs	19,586	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	133	19
20	Radiology and X-Ray	270	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 42,999	23
	D. Non-Operating Revenue		
24	Contributions	7,221	24
25	Interest and Other Investment Income***	3,890	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,111	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Durable Medical Equipment	4,544	28
28a	Miscellaneous Income	913	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,457	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,169,999	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,441,131	31
32	Health Care	4,355,537	32
33	General Administration	1,495,079	33
	B. Capital Expense		
34	Ownership	950,026	34
	C. Ancillary Expense		
35	Special Cost Centers	94,901	35
36	Provider Participation Fee	226,585	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,563,259	40
41	**Income before Income Taxes (line 30 minus line 40)****	606,740	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 606,740	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,414,950	44
45	Private Pay - Net Inpatient Revenue	2,278,979	45
46	Medicare - Net Inpatient Revenue	3,821,618	46
47	Other-(specify) Medicare Replacement Insurance	740,139	47
48	Other-(specify) See Att Schedule XI	641,610	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,897,296	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 Seminary Manor # 0047233 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	1,952	2,080	$ 73,534	$ 35.35	1
2	Assistant Director of Nursing	1,936	2,080	54,490	26.20	2
3	Registered Nurses	9,406	9,838	223,555	22.72	3
4	Licensed Practical Nurses	30,118	32,074	620,042	19.33	4
5	CNAs & Orderlies	101,883	106,894	1,134,642	10.61	5
6	CNA Trainees					6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides			0		8
9	Activity Director					9
10	Activity Assistants	8,967	9,840	100,373	10.20	10
11	Social Service Workers	5,316	5,636	69,366	12.31	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	35,212	37,043	334,263	9.02	15
16	Dishwashers					16
17	Maintenance Workers	8,770	9,269	78,408	8.46	17
18	Housekeepers	16,561	17,546	174,407	9.94	18
19	Laundry	5,533	5,841	51,615	8.84	19
20	Administrator	1,912	2,080	164,302	78.99	20
21	Assistant Administrator	1,916	2,080	31,843	15.31	21
22	Other Administrative	1,987	2,087	45,302	21.71	22
23	Office Manager					23
24	Clerical	8,224	8,621	90,759	10.53	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator			0		29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,824	3,961	40,947	10.34	31
32	Other Health Care(specify)	5,723	6,175	123,513	20.00	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	249,240	263,145	$ 3,411,361 *	$ 12.96	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	***	$ 10,699	1-3
36	Medical Director	***	41,250	9-3
37	Medical Records Consultant	***	1,880	10-3
38	Nurse Consultant	***	0	10-3
39	Pharmacist Consultant	***	7,211	10-3
40	Physical Therapy Consultant	***	590,954	10a-3
41	Occupational Therapy Consultant	***	431,683	10a-3
42	Respiratory Therapy Consultant	***	43,884	10a-3
43	Speech Therapy Consultant	***	72,048	10a-3
44	Activity Consultant	***		11-3
45	Social Service Consultant	***		12-3
46	Other(specify) Dental Consultant	***	175	10-3
47				
48	*** Monthly Fee			
49	TOTAL (lines 35 - 48)		$ 1,199,784	

C. CONTRACT NURSES

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

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Facility Name & ID Number Seminary Manor # 0047233 Report Period Beginning: 10/1/14 Ending: 9/30/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tracy Owens	Administrator	None	$ 164,302
Beverly Kenney	Asst Admin	None	31,843
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 196,145

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	21,625
LTC Support Services, LLC	Support Services	175,320
Templin Healthcare	Accounting Services	260
Spears & Spears	Legal Services	650
Duane Morris, LLP	Legal Services	773
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 370,228

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 84,582
Unemployment Compensation Insurance	18,115
FICA Taxes	255,897
Employee Health Insurance	143,093
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401 (k)	36,009
Other Employee Benefits	3,465
TOTAL (agree to Schedule V, line 22, col.8)	$ 541,161

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	449
Health Care Worker Background Check	
(Indicate # of checks performed 104)	1,868
Patient Background Checks 500	5,000
Advertising - Promotion	68,818
Subscriptions	3,501
IHCA Dues	6,150
Other Licenses & Fees	2,538
Indirect Costs - See Att Sch III	3
Less: Public Relations Expense	( )
Non-allowable advertising	(68,818)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,509

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	876
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)	$ 876

**See instructions.

Facility Name & ID Number Seminary Manor # 0047233 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			$		$	$	$	$	$	$	$	$	$
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20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Seminary Manor # 0047233 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? **7 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **43,560** 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. $ **226,585**
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. $ **4,734**

(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.