FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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 10/1/15 to 9/30/16 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 ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/15 Ending: 9/30/16

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 _____

	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	130	Skilled (SNF)	130	47,580	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	130	TOTALS	130	47,580	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	14,081	15,697	6,971	36,749	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,081	15,697	6,971	36,749	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.24%

D. How many bed-hold days during this year were paid by the Department?
None (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] Non-allowable costs have been eliminated in Schedule V, Column 7

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 6,093

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: 9/30/2016 Fiscal Year: 9/30/2016

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/15 Ending: 9/30/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	331,524	33,903	12,367	377,794		377,794		377,794			1
2	Food Purchase		378,235		378,235		378,235	(1,431)	376,804			2
3	Housekeeping	169,716	44,528		214,244		214,244		214,244			3
4	Laundry	50,151	16,064		66,215		66,215		66,215			4
5	Heat and Other Utilities			136,123	136,123		136,123		136,123			5
6	Maintenance	174,062	51,454	78,218	303,734		303,734		303,734			6
7	Other (specify):*											7
8	TOTAL General Services	725,453	524,184	226,708	1,476,345		1,476,345	(1,431)	1,474,914			8
	B. Health Care and Programs											
9	Medical Director			19,500	19,500		19,500		19,500			9
10	Nursing and Medical Records	2,504,973	234,123	22,764	2,761,860		2,761,860		2,761,860			10
10a	Therapy			681,847	681,847		681,847		681,847			10a
11	Activities	93,914	5,681		99,595		99,595		99,595			11
12	Social Services	72,339			72,339		72,339		72,339			12
13	CNA Training											13
14	Program Transportation			5,189	5,189		5,189		5,189			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,671,226	239,804	729,300	3,640,330		3,640,330		3,640,330			16
	C. General Administration											
17	Administrative	92,548			92,548		92,548		92,548			17
18	Directors Fees							4,323	4,323			18
19	Professional Services			381,394	381,394		381,394	4,746	386,140			19
20	Dues, Fees, Subscriptions & Promotions			19,585	19,585		19,585	2	19,587			20
21	Clerical & General Office Expenses	131,689	40,633	55,743	228,065		228,065	6	228,071			21
22	Employee Benefits & Payroll Taxes			585,711	585,711		585,711		585,711			22
23	Inservice Training & Education			2,158	2,158		2,158		2,158			23
24	Travel and Seminar			71	71		71		71			24
25	Other Admin. Staff Transportation			5,187	5,187		5,187		5,187			25
26	Insurance-Prop.Liab.Malpractice			28,130	28,130		28,130	8,690	36,820			26
27	Other (specify):*											27
28	TOTAL General Administration	224,237	40,633	1,077,979	1,342,849		1,342,849	17,767	1,360,616			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,620,916	804,621	2,033,987	6,459,524		6,459,524	16,336	6,475,860			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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: 10/1/15 Ending: 9/30/16

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			192,742	192,742		192,742	218,945	411,687			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14	14		14	204,254	204,268			32
33	Real Estate Taxes							84,990	84,990			33
34	Rent-Facility & Grounds			563,652	563,652		563,652	(563,652)				34
35	Rent-Equipment & Vehicles			9,695	9,695		9,695		9,695			35
36	Other (specify):* Mort Ins							28,780	28,780			36
37	**TOTAL Ownership**			766,103	766,103		766,103	(26,683)	739,420			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			7,595	7,595		7,595		7,595			38
39	Ancillary Service Centers		234,998		234,998		234,998		234,998			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			2,626	2,626		2,626	(1,408)	1,218			41
42	Provider Participation Fee			253,015	253,015		253,015		253,015			42
43	Other (specify):* See Att Sch 4A	48,361		186,934	235,295		235,295	(176,506)	58,789			43
44	**TOTAL Special Cost Centers**	48,361	234,998	450,170	733,529		733,529	(177,914)	555,615			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,669,277	1,039,619	3,250,260	7,959,156		7,959,156	(188,261)	7,770,895			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Pekin Manor

Period Beginning 10/1/15
Period End 9/30/16

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory/Expenses			43,288	43,288		43,288		43,288			
	Radiology Expenses			15,501	15,501		15,501		15,501			
	Non-Allowable Expenses	48,361		128,145	176,506		176,506	(176,506)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special C	48,361	0	186,934	235,295	0	235,295	(176,506)	58,789			

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/15 Ending: 9/30/16

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,431)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,584)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1)	30		9
10	Interest and Other Investment Income	(52)	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	(250)	20		17
18	Fines and Penalties				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	(57,895)	43		24
25	Fund Raising, Advertising and Promotional	(64,043)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(623)	43		28
29	Other-Attach Schedule See Page 5A	(63,159)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (193,038)		$	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)	4,777		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 4,777		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (188,261)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' PREPARATION REPORT

Pekin Manor

ID# 0047969

Report Period Beginning: 10/1/15

Ending: 9/30/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Vending Expenses Against Income	$ (1,408)	41	1
2	Disallow Marketing Wages	(48,361)	43	2
3	Disallow R/E Entity HUD Audit	(13,390)	19	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**	(63,159)		49

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/15 Ending: 9/30/16

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 Page 6 Supplemental		
		Community Living Options, Inc. (CLO)				
		See Page 6 Supplemental for specific homes				

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	18	Director Fees	$	Unlimited Development, Inc.	100.00%	$ 4,323	$ 4,323	1
2	V	19	Professional Fees		Unlimited Development, Inc.	100.00%	4,746	4,746	2
3	V	20	Dues, Licenses and Subs		Unlimited Development, Inc.	100.00%	2	2	3
4	V	21	General Admin Expense		Unlimited Development, Inc.	100.00%	6	6	4
5	V	26	Property/ Liability Insurance		Unlimited Development, Inc.	100.00%	992	992	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			$			$ 10,069	$ * 10,069	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/15 Ending: 9/30/16

VII. RELATED PARTIES (continued)

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)	
15	V	19	Professional Fees	$	Pekin El Camino, LLC	N/A	$ 13,390	$ 13,390	15
16	V	20	Dues, Fees, Subs & Prom		Pekin El Camino, LLC	N/A	250	250	16
17	V	26	Property Insurance		Pekin El Camino, LLC	N/A	7,698	7,698	17
18	V	30	Depreciation		Pekin El Camino, LLC	N/A	218,946	218,946	18
19	V	32	Interest Expense	432	Pekin El Camino, LLC	N/A	204,738	204,306	19
20	V	33	Property Taxes		Pekin El Camino, LLC	N/A	84,990	84,990	20
21	V	34	Facility Rent	563,652	Pekin El Camino, LLC	N/A		(563,652)	21
22	V	36	Mortgage Insurance		Pekin El Camino, LLC	N/A	28,780	28,780	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 564,084			$ 558,792	$ * (5,292)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/15 Ending: 9/30/16

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	Community Living Options, Inc.	100%			Allen Court	Clinton	CILA	1
2	Community Living Options, Inc.	100%	Beardstown Terrace	Beardstown				2
3	Community Living Options, Inc.	100%	Bellefontaine Place	Waterloo				3
4	Community Living Options, Inc.	100%	Braun's Terrace	Greenville				4
5	Community Living Options, Inc.	100%	Carthage Terrace	Carthage				5
6	Community Living Options, Inc.	100%	Curtiss Court	Springfield				6
7	Community Living Options, Inc.	100%	Davies Square	Pekin				7
8	Community Living Options, Inc.	100%	Douglas Terrace	Jacksonville				8
9	Community Living Options, Inc.	100%	Edwardsville Terrace	Edwardsville				9
10	Community Living Options, Inc.	100%	Effingham Terrace	Effingham				10
11	Community Living Options, Inc.	100%			Eisenhower Terrace	Jacksonville	CILA	11
12	Community Living Options, Inc.	100%	Freeburg Terrace	Freeburg				12
13	Community Living Options, Inc.	100%	Froehlich House	Galesburg				13
14	Community Living Options, Inc.	100%	Gaines Mill Place	Springfield				14
15	Community Living Options, Inc.	100%	Glenwood Terrace	Springfield				15
16	Community Living Options, Inc.	100%			Hawthorne Terrace	Galesburg	CILA	16
17	Community Living Options, Inc.	100%	Highview Terrace	Paris				17
18	Community Living Options, Inc.	100%	Jacksonville Group Homes:					18
19	Community Living Options, Inc.	100%	Anna Terrace	Jacksonville				19
20	Community Living Options, Inc.	100%	Campbell Court	Jacksonville				20
21	Community Living Options, Inc.	100%	LaFayette Terrace	Jacksonville				21
22	Community Living Options, Inc.	100%	Kepley House	Pittsfield				22
23	Community Living Options, Inc.	100%	Lawrence Place	Lincoln				23
24	Community Living Options, Inc.	100%	Lincoln Terrace	Lincoln				24
25	Community Living Options, Inc.	100%	Maple Terrace	Quincy				25
26	Community Living Options, Inc.	100%	Plonka Terrace	Galesburg				26
27	Community Living Options, Inc.	100%	Quincy Terrace	Quincy				27
28	Community Living Options, Inc.	100%	Schultz House	Danville				28
29	Community Living Options, Inc.	100%	Stevens House	Galesburg				29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/15 Ending: 9/30/16

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	Community Living Options, Inc.	100%	Tanner Place	Paris				1
2	Community Living Options, Inc.	100%	Taylor House	Springfield				2
3	Community Living Options, Inc.	100%	Thelma Terrace	Wood River				3
4	Community Living Options, Inc.	100%	Trulson House	Galesburg				4
5	Community Living Options, Inc.	100%	Vahle Terrace	Jerseyville				5
6	Community Living Options, Inc.	100%	Walsh Terrace	Galesburg				6
7	Community Living Options, Inc.	100%	Wetherell Place	Effingham				7
8	Community Living Options, Inc.	100%	Woodriver Group Homes:					8
9	Community Living Options, Inc.	100%	Aberdeen Terrace	Alton				9
10	Community Living Options, Inc.	100%	Linton Terrace	Wood River				10
11	Community Living Options, Inc.	100%	Madison Terrace	Wood River				11
12	Community Living Options, Inc.	100%	Pershing Terrace	Wood River				12
13	Community Living Options, Inc.	100%			Audrey Court-CILA	Clinton	CILA	13
14	Unlimited Development, Inc. (UDI)	100%	Parkway Manor	Marion				14
15	Unlimited Development, Inc. (UDI)	100%			Parkway Estates	Marion	Retirement living ce	15
16	Unlimited Development, Inc. (UDI)	100%	Maryville Manor	Maryvillle				16
17	Unlimited Development, Inc. (UDI)	100%	Shelbyville Manor	Shelbyville				17
18	Unlimited Development, Inc. (UDI)	100%	Leroy Manor	Leroy				18
19	Unlimited Development, Inc. (UDI)	100%			Liberty Estates of Carl	Carbondale	Retirement living ce	19
20	Unlimited Development, Inc. (UDI)	100%	Care Center of Abingdon	Abingdon				20
21	Unlimited Development, Inc. (UDI)	100%	Seminary Manor	Galesburg				21
22	Unlimited Development, Inc. (UDI)	100%			Seminary Estates	Galesburg	Retirement living ce	22
23	Unlimited Development, Inc. (UDI)	100%			Hawthorne Inn of Gal	Galesburg	Assisted Living Faci	23
24	Unlimited Development, Inc. (UDI)	100%	Centralia Manor	Centralia				24
25	Unlimited Development, Inc. (UDI)	100%			Centralia Estates	Centralia Estates	Retirement living ce	25
26	Unlimited Development, Inc. (UDI)	100%	Pittsfield Manor	Pittsfield				26
27	Unlimited Development, Inc. (UDI)	100%	Pekin Manor	Pekin				27
28	Unlimited Development, Inc. (UDI)	100%			Pekin Estates	Pekin	Retirement living ce	28
29	Unlimited Development, Inc. (UDI)	100%	Jerseyville Manor	Jerseyville				29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/15 Ending: 9/30/16

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	Unlimited Development, Inc. (UDI)	100%	River Hills Manor	Keokuk, IA				1
2	Unlimited Development, Inc. (UDI)	100%			River Hills Estates	Keokuk, IA	Retirement living ce	2
3	Unlimited Development, Inc. (UDI)	100%			River Hills Inn	Keokuk, IA	Assisted living facili	3
4	Unlimited Development, Inc. (UDI)	100%			Centralia East McCor	Galesburg	Lessor	4
5	Unlimited Development, Inc. (UDI)	100%			Galesburg North Semi	Galesburg	Lessor	5
6	Unlimited Development, Inc. (UDI)	100%			Jerseyville North State	Galesburg	Lessor	6
7	Unlimited Development, Inc. (UDI)	100%			Shelbyville Route 128,	Galesburg	Lessor	7
8	Unlimited Development, Inc. (UDI)	100%			Marion Willimason Co	Galesburg	Lessor	8
9	Unlimited Development, Inc. (UDI)	100%			Leroy South Buck, LL	Galesburg	Lessor	9
10	Unlimited Development, Inc. (UDI)	100%			2245 Seminary Street,	Galesburg	Lessor	10
11	Unlimited Development, Inc. (UDI)	100%			Pittsfield Lowry, LLC	Galesburg	Lessor	11
12	Unlimited Development, Inc. (UDI)	100%			Pekin El Camino, LLC	Galesburg	Lessor	12
13	Unlimited Development, Inc. (UDI)	100%			Abingdon West Martin	Galesburg	Lessor	13
14	Unlimited Development, Inc. (UDI)	100%			Keokuk Village Circle,	Galesburg	Lessor	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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/15 Ending: 9/30/16

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 7A								$ 4,323	L18, C7	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	$ 4,323		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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/15 Ending: 9/30/16

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	18	Director Fees	Weighted Avail Bed Days	543,144	20	$ 49,346	$	47,580	$ 4,323	1
2	19	Professional Fees	Weighted Avail Bed Days	543,144	20	54,173	$	47,580	4,746	2
3	20	Dues, Licenses and Subs	Weighted Avail Bed Days	543,144	20	25		47,580	2	3
4	21	General Admin Expense	Weighted Avail Bed Days	543,144	20	70		47,580	6	4
5	26	Property/ Liability Insurance	Weighted Avail Bed Days	543,144	20	11,324		47,580	992	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					$ 114,938	$		$ 10,069	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/15 Ending: 9/30/16

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	5,703,330	10/1/2041	3.5500	204,738	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$28,646.12		$ 6,249,800	$ 5,703,330			$ 204,738	9
	B. Non-Facility Related*											
10												10
11									Int Income Offset		(484)	11
12									Misc. Interest Expense		14	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (470)	14
15	TOTALS (line 9+line14)						$ 6,249,800	$ 5,703,330			$ 204,268	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 28,780 Line # 36

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

SEE ACCOUNTANTS' PREPARATION REPORT

**** 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: 10/1/15 Ending: 9/30/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 108,267	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.)	2015	$ 109,505	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,238	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 83,752	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.		$ 84,990	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	98,550	8
	2012	106,626	9
	2013	106,580	10
	2014	108,662	11
	2015	109,505	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 2015 bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

2015 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 2015 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 2015.

	(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	$ 108,542.40	$ 108,542.40
2.		PT OF E 1/2 SE 1/2 4.77 AC	$	$
3.			$	$
4.	10-10-14-205-010	SEC 14 T24N R5W	$ 962.24	$ 962.24
5.		PT OF E 1/2 NE 1/4 1.47 AC	$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 109,504.64	$ 109,504.64

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 10/1/15 Ending: 9/30/16

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: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/15 Ending: 9/30/16

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	$	40	$ 179,358	$ 179,358	$ 1,883,252	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Light Sign - Double Faced, Fire Alarm Panel			2006	43,700	1,709	10	1,709		43,636	9
10	Replace Defective Pipe for Dry System, Roof			2007	139,058	13,027	10-25 yrs	13,027		116,159	10
11	Roof Repair, Furnace Duct Repair, Sprinkler System			2008	179,648	5,614	10-25 yrs	10,561	4,947	87,470	11
12	A/C, Shower Room, Firewall, Wall/Ceiling, Kitchen Repairs			2009	78,867	5,777	5-15 yrs	5,777		49,572	12
13	Shower, Shower, Tile, AC, Carpet, Sprinkler, Sidewalks			2009	50,035	2,573	5-25 yrs	2,573		25,711	13
14	Water Heater, Landscaping/Lights			2009	12,030	1,203	10	1,203		8,221	14
15	Single Face Lighted Sign, Water Heater			2010	5,773	577	10	577		3,579	15
16	Physical Therapy Completion, Water Heater			2010	397,172	33,169	10-12 yrs	33,169		218,043	16
17	Apollo Tub Room - Sink/Mirror/Shower/Tile/Drywall/Drains/Faucets			2011	56,049	4,671	12	4,671		26,468	17
18	Water Heater, Condensor, Bathroom remodel			2011	47,199	3,974	10-15 yrs	3,974		20,945	18
19	PT Remodel, Dining Room, Sprinkler			2011	458,041	17,363	12-25 yrs	32,643	15,280	176,136	19
20	Sprinkler-New Tamper Switch/Relocate FDC Check Valve			2012	5,867	235	25	235		1,115	20
21	Kitchenette Rmdl-Sink/Vnyl Tile/Cabinet/Counter/Crnr Grds			2012	53,384	4,449	12	4,449		18,908	21
22	Nurse Station/Lounge Remodel-Paint/Vinyl/Counter/Cabinet			2012	150,956	12,580	12	12,580		53,464	22
23	Remodel-Paint/drywall/corner Plates			2012	4,570	914	5	914		3,732	23
24	Smoke Detectors-48/Pull Stations-6.5/Heat Detectors-10			2012	9,831	983	10	983		4,014	24
25	Water Heater			2012	3,717	372	10	372		1,518	25
26	Excavation of Lake			2012	13,885	1,389	10	1,389		6,134	26
27	Overbed Lights - 25			2012	6,266	627	10	627		2,507	27
28	Air Conditioners			2012	9,440	1,888	5	1,888		7,237	28
29	New Well for Lake			2012	7,760	931	15	931		2,396	29
30	Sidewalk/Landscaping			2012	3,050	203	15	203		813	30
31	Nurse Call System			2013	17,031	1,703	10	1,703		6,245	31
32	Double Egress Doors			2013	4,730	473	10	473		1,537	32
33	Water Heater			2013	5,147	515	10	515		1,630	33
34	Phone System			2013	2,637	264	10	264		748	34
35	Water Heater			2013	4,014	401	10	401		1,137	35
36	Storage Shed			2014	18,870	943	20	943		2,594	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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/15 Ending: 9/30/16

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	$	$ 838	37
38	Water Heater	2014	5,104	510	10	510		1,105	38
39	Pekin Manor Shower Remodel-Tile/Fixtures/Electrical/Drains	2014	66,251	5,521	12	5,521		11,502	39
40	Roof	2014	2,900	580	10	580		846	40
41	Landscaping	2014	22,225	2,223	10	2,223		4,446	41
42	Water Heater	2015	3,550	355	10	355		562	42
43	Water Heater	2015	6,420	642	10	642		963	43
44	Ceramic Tile-Service Cooridor	2015	3,242	162	20	162		243	44
45	Concrete-Parking Lot	2015	3,300	220	15	220		238	45
46	Relocate Water Lines from Floor to Overhead	2015	62,335	2,493	25	2,493		2,701	46
47	Soffits - West Corridor	2015	43,300	4,330	10	4,330		4,691	47
48	Parking Lot Lights	2015	11,850	1,185	10	1,185		1,285	48
49	100 Hall Remodekl-Tile/Fire Alarm/Carpet/Fixtures/Cabinets	2015	54,280	4,523	12	4,523		4,900	49
50	Carpet/VCT Tile 100 Hall	2016	11,368	853	10	853		853	50
51	Soffits over water lines	2016	4,400	183	10	183		183	51
52	Pond Excavation-Filled in with Dirt	2016	71,996	400	15	400		400	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)		$ 9,341,361	$ 143,094		$ 342,679	$ 199,585	$ 2,810,677	70

SEE ACCOUNTANTS' PREPARATION REPORT

**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: 10/1/15 Ending: 9/30/16

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	$ 842,787	$ 31,721	$ 51,081	$ 19,360	3-15 yrs	$ 684,144	71
72	Current Year Purchases	61,399	7,274	7,274		5-10 Yrs	7,274	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 904,186	$ 38,995	$ 58,355	$ 19,360		$ 691,418	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	$ 41,723	76
77										77
78										78
79										79
80	TOTALS			$ 42,610	$ 10,653	$ 10,653	$		$ 41,723	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)	$ 10,738,157	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 192,742	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 411,687	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 218,945	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,543,818	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	N/A	$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/15 Ending: 9/30/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								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 .

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 9,695 Description: See Attached Schedule 14A
(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	N/A				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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Pekin Manor**
IDPH License ID Number: **0047969**
Fiscal Year End: **9/30/16**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment Rental	8,609
Office Equipment	798
Other Equipment Rental	288
Total - Line 16	**9,695**

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/15 Ending: 9/30/16

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

It is the policy of this facility to only hire certified nurses aides.

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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	10A(3)	hrs	$	664	$ 235,830	$	664	$ 235,830	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		95	73,554		95	73,554	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		805	334,404		805	334,404	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				234,998		234,998	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapy	10A(3)			360	38,059		360	38,059	12
13	Other (specify):									13
14	TOTAL			$	1,924	$ 681,847	$ 234,998	1,924	$ 916,845	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.

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Pekin Manor **#** 0047969 **Report Period Beginning:** 10/1/15 **Ending:** 9/30/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 9/30/16 **(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	$ 268,123	$ 332,088	1
2	Cash-Patient Deposits	7,015	7,015	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 116,000)	1,020,135	1,020,135	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	118,176	144,234	6
7	Other Prepaid Expenses	2,318	2,318	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,415,767	$ 1,505,790	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		450,000	13
14	Buildings, at Historical Cost	1,826,108	9,341,361	14
15	Leasehold Improvements, at Historical Cost	108,106		15
16	Equipment, at Historical Cost	608,599	946,796	16
17	Accumulated Depreciation (book methods)	(1,197,676)	(3,543,818)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Att Sch 17A		590,154	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,345,137	$ 7,784,493	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,760,904	$ 9,290,283	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 254,963	$ 262,269	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,015	7,015	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	55,134	55,134	30
31	Accrued Taxes Payable (excluding real estate taxes)	87,044	87,044	31
32	Accrued Real Estate Taxes(Sch.IX-B)		83,752	32
33	Accrued Interest Payable		16,872	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Interdivision Payable	3,805,002	5,734,098	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,209,158	$ 6,246,184	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,703,330	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Security Deposits	35,815	35,815	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 35,815	$ 5,739,145	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,244,973	$ 11,985,329	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,484,069)	$ (2,695,046)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,760,904	$ 9,290,283	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Pekin Manor

Period 10/1/15
Period 9/30/16

Schedule 17A

XV. Balance Sheet
Line 23 Other

	Operating	After Consolidation
Replacement Reserve		**561,713**
Real Estate Tax Escrow		**9,495**
Insurance Escrow		**10,725**
MIP Escrow		**8,221**
TOTAL		**590,154**

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/15 Ending: 9/30/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,643,313)	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,643,312)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	159,243	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)**	$ 159,243	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)**	$ (1,484,069)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/15 Ending: 9/30/16

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	$ 8,093,772	1
2	Discounts and Allowances for all Levels	(55,976)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,037,796	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	55,936	6
7	Oxygen	7,781	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 63,717	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	1,408	12
13	Barber and Beauty Care	6,267	13
14	Non-Patient Meals	1,431	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	5,224	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 14,330	23
	D. Non-Operating Revenue		
24	Contributions	263	24
25	Interest and Other Investment Income***	52	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 315	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Late Fees	2,241	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,241	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,118,399	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,476,345	31
32	Health Care	3,640,330	32
33	General Administration	1,342,849	33
	B. Capital Expense		
34	Ownership	766,103	34
	C. Ancillary Expense		
35	Special Cost Centers	480,514	35
36	Provider Participation Fee	253,015	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,959,156	40
41	**Income before Income Taxes (line 30 minus line 40)****	159,243	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 159,243	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,457,042	44
45	Private Pay - Net Inpatient Revenue	2,615,358	45
46	Medicare - Net Inpatient Revenue	2,785,809	46
47	Other-(specify) Medicare Replacement/Managed Care	926,784	47
48	Other-(specify) Hospce	252,803	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,037,796	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/15 Ending: 9/30/16

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	1,456	1,662	$ 57,587	$ 34.65	1
2	Assistant Director of Nursing	1,920	2,000	58,295	29.15	2
3	Registered Nurses	13,701	14,424	348,127	24.14	3
4	Licensed Practical Nurses	32,372	34,103	795,275	23.32	4
5	CNAs & Orderlies	102,154	107,271	1,217,593	11.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,069	8,517	93,914	11.03	10
11	Social Service Workers	3,530	3,826	72,339	18.91	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	35,707	37,982	331,524	8.73	15
16	Dishwashers					16
17	Maintenance Workers	11,633	12,125	174,062	14.36	17
18	Housekeepers	16,599	17,645	169,716	9.62	18
19	Laundry	5,245	5,551	50,151	9.03	19
20	Administrator	1,984	2,080	92,548	44.49	20
21	Assistant Administrator					21
22	Other Administrative	1,852	1,900	48,361	25.45	22
23	Office Manager					23
24	Clerical	7,989	8,313	131,689	15.84	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	1,884	2,012	28,096	13.97	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	246,095	259,411	$ 3,669,277 *	$ 14.14	34

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	Monthly	$ 12,367	L1, C3	35
36	Medical Director	Monthly	19,500	L9, C3	36
37	Medical Records Consultant	Monthly	1,970	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,878	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 41,715		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/15 Ending: 9/30/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Brandy Cooper	Administrator	None	$ 92,548
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 92,548

B. Administrative - Other

Description	Amount
N/A	$
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	177,360
LTC Support Services, LLC	Support Services	24,683
Davis & Campbell LLC	Legal Services	3,654
Polsinelli Shughart PC	Legal Services	4,097
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 381,394

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 92,490
Unemployment Compensation Insurance	40,740
FICA Taxes	276,948
Employee Health Insurance	154,285
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401k	14,584
Other Employee Benefits	6,664
TOTAL (agree to Schedule V, line 22, col.8)	$ 585,711

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,992
Advertising: Employee Recruitment	1,949
Health Care Worker Background Check	
(Indicate # of checks performed 51)	1,283
Patient Background Checks 152	3,798
Subscriptions	778
IHCA Dues	7,966
Other Licenses & Fees	1,819
Allocation from Home Office	2
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,587

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	71
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 71

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pekin Manor # 0047969 **Report Period Beginning:** 10/1/15 **Ending:** 9/30/16

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. **7,966 IHCA**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(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? **7.5 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **70,037** 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **253,015**
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.

SEE ACCOUNTANTS' PREPARATION REPORT

(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. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,431**

(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? **100% line 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **RSM US LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? **Yes**
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees