FOR BHF USE

LL1

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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0047878

Facility Name: Shelbyville Manor

Address: Route 128 North (Number) Shelbyville (City) 62565 (Zip Code)

County: Shelby

Telephone Number: (217) 774-2111 **Fax #** (217) 774-2209

HFS ID Number:

Date of Initial License for Current Owners: 2/2/06

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 10/1/16 to 9/30/17 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 Shelbyville Manor # 0047878 Report Period Beginning: 10/1/16 Ending: 9/30/17

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	109	Skilled (SNF)	109	39,785	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	109	TOTALS	109	39,785	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	14,104	6,384	5,501	25,989	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,104	6,384	5,501	25,989	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.32%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 2/2/06

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/06 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 109 and days of care provided 5,133

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: 9/30/2017 Fiscal Year: 9/30/2017

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Shelbyville Manor # 0047878 Report Period Beginning: 10/1/16 Ending: 9/30/17

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	285,058	29,171	11,958	326,187		326,187	(66,354)	259,833			1
2	Food Purchase		298,349		298,349		298,349	(63,950)	234,399			2
3	Housekeeping	170,027	31,924	789	202,740		202,740	(30,658)	172,082			3
4	Laundry	58,490	10,650	1,440	70,580		70,580	(10,496)	60,084			4
5	Heat and Other Utilities			158,439	158,439		158,439	(23,531)	134,908			5
6	Maintenance	67,460	26,828	62,114	156,402		156,402	(23,742)	132,660			6
7	Other (specify):*											7
8	TOTAL General Services	581,035	396,922	234,740	1,212,697		1,212,697	(218,731)	993,966			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,105,923	135,859	9,508	2,251,290		2,251,290	(263,176)	1,988,114			10
10a	Therapy											10a
11	Activities	85,162	2,323		87,485		87,485	(581)	86,904			11
12	Social Services	29,098			29,098		29,098		29,098			12
13	CNA Training											13
14	Program Transportation			9,649	9,649		9,649	(1,352)	8,297			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,220,183	138,182	37,157	2,395,522		2,395,522	(265,109)	2,130,413			16
	C. General Administration											
17	Administrative	90,775			90,775		90,775		90,775			17
18	Directors Fees							2,373	2,373			18
19	Professional Services			367,778	367,778		367,778	3,018	370,796			19
20	Dues, Fees, Subscriptions & Promotions			24,093	24,093		24,093	(3,893)	20,200			20
21	Clerical & General Office Expenses	131,813	23,166	57,802	212,781		212,781	(2,408)	210,373			21
22	Employee Benefits & Payroll Taxes			497,848	497,848		497,848	(62,541)	435,307			22
23	Inservice Training & Education			6,061	6,061		6,061		6,061			23
24	Travel and Seminar			702	702		702		702			24
25	Other Admin. Staff Transportation			9,653	9,653		9,653		9,653			25
26	Insurance-Prop.Liab.Malpractice			46,956	46,956		46,956	2,799	49,755			26
27	Other (specify):*											27
28	TOTAL General Administration	222,588	23,166	1,010,893	1,256,647		1,256,647	(60,652)	1,195,995			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,023,806	558,270	1,282,790	4,864,866		4,864,866	(544,492)	4,320,374			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 Shelbyville Manor #0047878 Report Period Beginning: 10/1/16 Ending: 9/30/17

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			117,975	117,975		117,975	188,754	306,729			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(10)	(10)		(10)	151,699	151,689			32
33	Real Estate Taxes							90,044	90,044			33
34	Rent-Facility & Grounds			491,688	491,688		491,688	(491,688)				34
35	Rent-Equipment & Vehicles			5,262	5,262		5,262		5,262			35
36	Other (specify):* Mort Ins							22,558	22,558			36
37	**TOTAL Ownership**			614,915	614,915		614,915	(38,633)	576,282			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,806	2,806		2,806		2,806			38
39	Ancillary Service Centers		134,824	914,798	1,049,622		1,049,622		1,049,622			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			184,716	184,716		184,716		184,716			42
43	Other (specify):* See Att Sch 4A	45,577		(45,011)	566		566	35,449	36,015			43
44	**TOTAL Special Cost Centers**	45,577	134,824	1,057,309	1,237,710		1,237,710	35,449	1,273,159			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,069,383	693,094	2,955,014	6,717,491		6,717,491	(547,676)	6,169,815			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

Shelbyville Manor

Period Beginning 10/1/16
Period End 9/30/17

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
		1	2	3	4	5	6	7	8	9	10	
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory/Expenses			23,741	23,741		23,741		23,741			
	Radiology Expenses			12,274	12,274		12,274		12,274			
	Non-Allowable Expenses	45,577		(81,026)	(35,449)		(35,449)	35,449	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special C	45,577	0	(45,011)	566	0	566	35,449	36,015			

Facility Name & ID Number Shelbyville Manor # 0047878 Report Period Beginning: 10/1/16 Ending: 9/30/17

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	(425)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,431)	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	(12)	30		9
10	Interest and Other Investment Income	(79)	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	(3,740)	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	(79)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	144,288	43		24
25	Fund Raising, Advertising and Promotional	(57,831)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(690,867)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (614,176)		$	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)	66,500		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ 66,500		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (547,676)		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

Shelbyville Manor

ID# 0047878

Report Period Beginning: 10/1/16

Ending: 9/30/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Vending Income Against Expense	$ (606)	2	1
2	Disallow Marketing Wages	(45,577)	43	2
3	Disallow R/E Entity HUD Audit	(14,060)	19	3
4	Disallow AL Expenses-Dietary	(66,354)	1	4
5	Disallow AL Expenses-Food	(62,919)	2	5
6	Disallow AL Expenses-Housekeeping	(30,658)	3	6
7	Disallow AL Expenses-Laundry	(10,496)	4	7
8	Disallow AL Expenses-Utilities	(23,531)	5	8
9	Disallow AL Expenses-Maintenance	(23,742)	6	9
10	Disallow AL Expenses-Nursing	(263,176)	10	10
11	Disallow AL Expenses-Activities	(581)	11	11
12	Disallow AL Expenses-Program Transportation	(1,352)	14	12
13	Disallow AL Expenses-Licenses & Fees	(405)	20	13
14	Disallow AL Expenses-Telephone	(2,461)	21	14
15	Disallow AL Expenses-Employee Benefits	(62,541)	22	15
16	Disallow AL Expenses-Insurance	(7,168)	26	16
17	Disallow AL Expenses-Depreciation Expense	(35,346)	30	17
18	Disallow AL Expenses-Interest Expense	(24,088)	32	18
19	Disallow AL Expenses-Real Estate Tax Expense	(15,806)	33	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**	(690,867)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Shelbyville Manor # 0047878 **Report Period Beginning:** 10/1/16 **Ending:** 9/30/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(66,354)	0	0	0	0	0	0	0	0	0	0	(66,354)	1
2	Food Purchase	(63,950)	0	0	0	0	0	0	0	0	0	0	(63,950)	2
3	Housekeeping	(30,658)	0	0	0	0	0	0	0	0	0	0	(30,658)	3
4	Laundry	(10,496)	0	0	0	0	0	0	0	0	0	0	(10,496)	4
5	Heat and Other Utilities	(23,531)	0	0	0	0	0	0	0	0	0	0	(23,531)	5
6	Maintenance	(23,742)	0	0	0	0	0	0	0	0	0	0	(23,742)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(218,731)	0	0	0	0	0	0	0	0	0	0	(218,731)	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	(263,176)	0	0	0	0	0	0	0	0	0	0	(263,176)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(581)	0	0	0	0	0	0	0	0	0	0	(581)	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	(1,352)	0	0	0	0	0	0	0	0	0	0	(1,352)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(265,109)	0	0	0	0	0	0	0	0	0	0	(265,109)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	2,373	0	0	0	0	0	0	0	0	0	2,373	18
19	Professional Services	(14,139)	3,097	14,060	0	0	0	0	0	0	0	0	3,018	19
20	Fees, Subscriptions & Promotions	(4,145)	2	250	0	0	0	0	0	0	0	0	(3,893)	20
21	Clerical & General Office Expenses	(2,461)	53	0	0	0	0	0	0	0	0	0	(2,408)	21
22	Employee Benefits & Payroll Taxes	(62,541)	0	0	0	0	0	0	0	0	0	0	(62,541)	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	(7,168)	0	9,967	0	0	0	0	0	0	0	0	2,799	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(90,454)	5,525	24,277	0	0	0	0	0	0	0	0	(60,652)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(574,294)	5,525	24,277	0	0	0	0	0	0	0	0	(544,492)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Shelbyville Manor # 0047878 **Report Period Beginning:** 10/1/16 **Ending:** 9/30/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(35,358)	0	224,112	0	0	0	0	0	0	0	0	188,754	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(24,167)	0	175,866	0	0	0	0	0	0	0	0	151,699	32
33	Real Estate Taxes	(15,806)	0	105,850	0	0	0	0	0	0	0	0	90,044	33
34	Rent-Facility & Grounds	0	0	(491,688)	0	0	0	0	0	0	0	0	(491,688)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	22,558	0	0	0	0	0	0	0	0	22,558	36
37	TOTAL Ownership	(75,331)	0	36,698	0	0	0	0	0	0	0	0	(38,633)	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):*	35,449	0	0	0	0	0	0	0	0	0	0	35,449	43
44	TOTAL Special Cost Centers	35,449	0	0	0	0	0	0	0	0	0	0	35,449	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(614,176)	5,525	60,975	0	0	0	0	0	0	0	0	(547,676)	45

Facility Name & ID Number Shelbyville Manor # 0047878 Report Period Beginning: 10/1/16 Ending: 9/30/17

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%	$ 2,373	$ 2,373	1
2	V	19	Professional Fees		Unlimited Development, Inc.	100.00%	3,097	3,097	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%	53	53	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			$			$ 5,525	$ * 5,525	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Shelbyville Manor # 0047878 Report Period Beginning: 10/1/16 Ending: 9/30/17

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	$	Shelbyville Route 128, LLC	N/A	$ 14,060	$ 14,060	15
16	V	20	Dues, Fees, Subs & Prom		Shelbyville Route 128, LLC	N/A	250	250	16
17	V	26	Property Insurance		Shelbyville Route 128, LLC	N/A	9,967	9,967	17
18	V	30	Depreciation		Shelbyville Route 128, LLC	N/A	224,112	224,112	18
19	V	32	Interest Expense	230	Shelbyville Route 128, LLC	N/A	160,588	160,358	19
20	V	32	Loan Fee Amortization		Shelbyville Route 128, LLC	N/A	15,508	15,508	20
21	V	33	Property Taxes		Shelbyville Route 128, LLC	N/A	105,850	105,850	21
22	V	34	Facility Rent	491,688	Shelbyville Route 128, LLC	N/A		(491,688)	22
23	V	36	Mortgage Insurance		Shelbyville Route 128, LLC	N/A	22,558	22,558	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			$ 491,918			$ 552,893	$ * 60,975	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Shelbyville Manor # 0047878 Report Period Beginning: 10/1/16 Ending: 9/30/17

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 Shelbyville Manor # 0047878 Report Period Beginning: 10/1/16 Ending: 9/30/17

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	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 Shelbyville Manor # 0047878 Report Period Beginning: 10/1/16 Ending: 9/30/17

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	Unlimited Development, Inc. (UDI)	100%			The Kensington	Galesburg	Supportive Living	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 Shelbyville Manor # 0047878 Report Period Beginning: 10/1/16 Ending: 9/30/17

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								$ 2,373	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	$ 2,373		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 Shelbyville Manor # 0047878 Report Period Beginning: 10/1/16 Ending: 9/30/17

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	528,155	21	$ 31,500	$	39,785	$ 2,373	1
2	19	Professional Fees	Weighted Avail Bed Days	528,155	21	41,123		39,785	3,097	2
3	20	Dues, Licenses and Subs	Weighted Avail Bed Days	528,155	21	25		39,785	2	3
4	21	General Admin Expense	Weighted Avail Bed Days	528,155	21	703		39,785	53	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					$ 73,351	$		$ 5,525	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Shelbyville Manor # 0047878 Report Period Beginning: 10/1/16 Ending: 9/30/17

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	$20,381.00	6/1/2012	4,313,155	3,795,373	4/1/2040	3.5500	136,500	2
3				SNF portion								3
4												4
5												5
	Working Capital											
6												6
7												7
8									Miscellaneous Interest		(10)	8
9	TOTAL Facility Related				$20,381.00		$ 4,313,155	$ 3,795,373			$ 136,490	9
	B. Non-Facility Related*											
10	Cambridge Realty Capital								Amortization Exp		15,508	10
11	LTD. of Illinois		X	Facility purchase	$3,597.00	6/1/2012	761,145	669,772	4/1/2040	3.5500	24,088	11
12				AL portion					Disallow AL Int Exp		(24,088)	12
13									Int Income Offset		(309)	13
14	TOTAL Non-Facility Related				$3,597.00		$ 761,145	$ 669,772			$ 15,199	14
15	TOTALS (line 9+line14)						$ 5,074,300	$ 4,465,145			$ 151,689	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 22,558 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 Shelbyville Manor # 0047878 Report Period Beginning: 10/1/16 Ending: 9/30/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 79,578	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.)	2016	$ 105,370	2
3. Under or (over) accrual (line 2 minus line 1).		$ 25,792	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 80,058	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.	**Less AL Allocation of Expenses**	(15,806)	
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.		$ 90,044	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	106,616	8
	2013	106,531	9
	2014	103,372	10
	2015	104,883	11
	2016	105,370	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.
Real estate taxes reported on Sch V line 33 have been reduced by an allocation of expenses relating to ALC services based on as estimated 15%. See Att Sch 22A. Taxes paid during year represents the entire 2016 bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Shelbyville Manor COUNTY Shelby

FACILITY IDPH LICENSE NUMBER 0047878

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

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

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	2013-06-17-305-001	W N 12TH	$ 105,369.74	$ 89,564.28
2.		SW COR SW SW 550' X 520' & 30'	$	$
3.		VAC STREET LESS .11 AC TO	$	$
4.		ST HWY 6.76 AC	$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 105,369.74	$ 89,564.28

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Shelbyville Manor # 0047878 Report Period Beginning: 10/1/16 Ending: 9/30/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,041 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [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).

Assisted Living-20 Units

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-SNF	5.84 Acres	2006	$ 195,500	1
2					2
3	TOTALS	#VALUE!		$ 195,500	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Shelbyville Manor # 0047878 Report Period Beginning: 10/1/16 Ending: 9/30/17

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	109		2006	1991	$ 5,078,282	$	40	$ 126,948	$ 126,948	$ 1,481,139	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Dry Pipe Valve and Water Softner			2006	11,205	181	10-20 yrs	181		9,588	9
10	Ceramic Tile Repair, Carpet, Ceramic Tile			2007	11,750	444	5-20 yrs	444		7,471	10
11	Roof Repair			2008	84,157	8,416	10	8,416		81,353	11
12	Air Handler, Water Heater, Fire Protection System			2009	21,450	2,145	10	2,145		18,067	12
13	Water Heater			2010	10,671	1,067	10	1,067		7,736	13
14	Fire Sprinkler, Oil/Chip Parking Lot			2011	123,200	5,285	8-25 yrs	5,285		34,090	14
15	Physical Therapy Addition (Contracted Total)			2011	762,407		12	63,536	63,536	381,209	15
16	Hallway Rmdl-Vinyl tile/Base/Drywall/Handrails/Wall & Crnr Grds/AC			2011	56,356	4,696	12	4,696		28,176	16
17	Shower Rmdl-Exhaust fan/Fire access dr/Flr-tile/wiring/fxtrs/drains			2012	130,718	10,893	12	10,893		62,635	17
18	Laundry/Hallway Rmdl-Handrails/Guardrails/Vinyl Tile/Drywall/Paint			2012	138,186	11,516	12	11,516		63,338	18
19	Faux Wood Blinds - 14			2012	5,256	613	5	613		5,255	19
20	Fire Alarm System and Components			2012	8,555	856	10	856		4,208	20
21	Faux Wood Blinds			2012	5,108	1,022	5	1,022		5,024	21
22	Crown Light Boxes			2012	7,764	1,553	5	1,553		7,506	22
23	Faux Wood Blinds - 28			2013	4,883	976	5	976		4,229	23
24	Water Heater			2013	8,780	878	10	878		3,512	24
25	Doors			2014	16,820	1,682	10	1,682		5,887	25
26	Storage Building/Garage			2014	2,700	180	15	180		600	26
27	Sprinkler Pipe			2014	9,620	641	15	641		2,137	27
28	Condensor/Air Handler			2014	3,380	225	15	225		694	28
29	Doors			2014	9,500	950	10	950		2,771	29
30	Quarry Tile - Kitchen			2015	14,986	749	20	749		2,060	30
31	Maple Solid Core Doors			2015	9,540	636	15	636		1,696	31
32	Wood Blinds			2015	6,587	1,317	5	1,317		3,073	32
33	Garage Siding and Garage Door			2015	2,706	271	10	271		632	33
34	Water Heater			2015	3,842	384	10	384		832	34
35	Water Softener			2015	3,472	347	10	347		636	35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Shelbyville Manor # 0047878 Report Period Beginning: 10/1/16 Ending: 9/30/17

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	Remodel-Corridor 200 Office Area Flooring Tile/Electrical	2016	82,774	6,898	12	6,898	$	$ 11,497	37
38	PTAC Units	2016	5,682	1,136	5	1,136		1,468	38
39	100 Amp Sub Panel/Breakers	2017	3,100	155	10	155		155	39
40	Install 2 New Refrigeration Systems for Existing Boxes	2017	8,467	353	10	353		353	40
41	Water Softener	2017	4,408	73	10	73		73	41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,656,312	$ 66,538		$ 257,022	$ 190,484	$ 2,239,100	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Shelbyville Manor # 0047878 Report Period Beginning: 10/1/16 Ending: 9/30/17

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	$ 767,514	$ 47,279	$ 47,279	$	3-15 Years	$ 579,955	71
72	Current Year Purchases	13,688	612	612		7-15 Years	612	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 781,202	$ 47,891	$ 47,891	$		$ 580,567	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2012 Ford E350 Bus	2012	$ 43,627	$ 1,816	$ 1,816	$	4	$ 43,627	76
77										77
78										78
79										79
80	TOTALS			$ 43,627	$ 1,816	$ 1,816	$		$ 43,627	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,676,641	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 116,245	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 306,729	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 190,484	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,863,294	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 GMC G3500 Van - 2006	29,848		29,848	87
88	Carpet/Vinyl Tile ALC - 2016	11,883	1,730	3,208	88
89					89
90					90
91	TOTALS	$ 56,631	$ 1,730	$ 47,956	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 Shelbyville Manor # 0047878 Report Period Beginning: 10/1/16 Ending: 9/30/17

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 5,262 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: **Shelbyville Manor**
IDPH License ID Number: **0047878**
Fiscal Year End: **9/30/17**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment Rental	4,050
Office Equipment	
Other Equipment Rental	1,212
Total - Line 16	**5,262**

Facility Name & ID Number Shelbyville Manor # 0047878 Report Period Beginning: 10/1/16 Ending: 9/30/17

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.

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 Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$	792	$ 340,511	$	792	$ 340,511	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		302	126,480		302	126,480	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		1,117	421,027		1,117	421,027	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				134,824		134,824	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapy	39(3)			478	26,780		478	26,780	12
13	Other (specify):									13
14	TOTAL			$	2,689	$ 914,798	$ 134,824	2,689	$ 1,049,622	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 Shelbyville Manor **#** 0047878 **Report Period Beginning:** 10/1/16 **Ending:** 9/30/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 9/30/17 **(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	$ 13,064	$ 30,464	1
2	Cash-Patient Deposits	7,159	7,159	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 52,000)	1,088,215	1,094,341	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	80,959	97,519	6
7	Other Prepaid Expenses	4,830	11,982	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interdivision Receivable	3,044,295	1,171,452	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,238,522	$ 2,412,917	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		195,500	13
14	Buildings, at Historical Cost	821,825	6,656,312	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	620,428	824,829	16
17	Accumulated Depreciation (book methods)	(794,066)	(2,863,294)	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 (spe See Sch 17A		745,230	22
23	Other(specify): See Sch 17A		581,812	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 648,187	$ 6,140,389	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,886,709	$ 8,553,306	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 93,852	$ 93,852	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,159	7,159	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	82,908	82,908	30
31	Accrued Taxes Payable (excluding real estate taxes)	64,861	64,861	31
32	Accrued Real Estate Taxes(Sch.IX-B)	234	80,058	32
33	Accrued Interest Payable		13,209	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 249,014	$ 342,047	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,465,145	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Security Deposits	38,823	38,823	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 38,823	$ 4,503,968	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 287,837	$ 4,846,015	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,598,872	$ 3,707,291	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,886,709	$ 8,553,306	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Shelbyville Manor

Period Beginning	**10/1/16**
Period End	**9/30/17**

Schedule 17A

XV. Balance Sheet

Line 22 Other Long Term Assets

	Operating	After Consolidation
Land-Assisted Living		**34,500**
Building-Assisted Living		**896,167**
Reserve for Depr-Building-Assisted Living		**(261,382)**
Physical Therapy Addition-Assisted Living		**134,542**
Reserve for Depr-Physical Therapy Addition-Assisted Living		**(67,272)**
Leasehold Improvements-Assisted Living		**11,883**
Reserve for Depr-Leasehold Improvements-Assisted Living		**(3,208)**
2006 Toyota Corolla - 2006		**14,900**
Reserve for Depr-2006 Toyota Corolla - 2006		**(14,900)**
2003 GMC G3500 Van - 2006		**29,848**
Reserve for Depr-2003 GMC G3500 Van - 2006		**(29,848)**
TOTAL		**745,230**

Line 23 Other

	Operating	After Consolidation
Replacement Reserve		**309,161**
Loan Fees, Net		**238,579**
Real Estate Tax Escrow		**19,880**
Insurance Escrow		**6,421**
MIP Escrow		**7,771**
TOTAL		**581,812**

Facility Name & ID Number Shelbyville Manor # 0047878 Report Period Beginning: 10/1/16 Ending: 9/30/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,323,236	1
2	Restatements (describe):		2
3	**Prior Year Post Closing Adjustment**	(5,172)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,318,064	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	280,808	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)**	$ 280,808	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,598,872	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Shelbyville Manor # 0047878 Report Period Beginning: 10/1/16 Ending: 9/30/17

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	$ 6,701,343	1
2	Discounts and Allowances for all Levels	(47,405)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,653,938	3
	B. Ancillary Revenue		
4	Day Care	220	4
5	Other Care for Outpatients		5
6	Therapy	313,051	6
7	Oxygen	4,068	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 317,339	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	606	12
13	Barber and Beauty Care	2,218	13
14	Non-Patient Meals	425	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	3	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	80	20
21	Other Medical Services	23,905	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 27,237	23
	D. Non-Operating Revenue		
24	Contributions	510	24
25	Interest and Other Investment Income***	79	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 589	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Late Fees//Processing Fees	(804)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (804)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,998,299	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,212,697	31
32	Health Care	2,395,522	32
33	General Administration	1,256,647	33
	B. Capital Expense		
34	Ownership	614,915	34
	C. Ancillary Expense		
35	Special Cost Centers	1,052,994	35
36	Provider Participation Fee	184,716	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,717,491	40
41	**Income before Income Taxes (line 30 minus line 40)****	280,808	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 280,808	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,015,700	44
45	Private Pay - Net Inpatient Revenue	1,790,836	45
46	Medicare - Net Inpatient Revenue	2,590,850	46
47	Other-(specify) Medicare Replacement/Managed Care	190,701	47
48	Other-(specify) Hospice	65,851	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,653,938	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 Shelbyville Manor # 0047878 Report Period Beginning: 10/1/16 Ending: 9/30/17

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	2,192	2,272	$ 78,078	$ 34.37	1
2	Assistant Director of Nursing	1,077	1,165	30,383	26.07	2
3	Registered Nurses	12,414	13,146	339,897	25.86	3
4	Licensed Practical Nurses	17,619	18,554	379,967	20.48	4
5	CNAs & Orderlies	97,642	103,503	1,215,376	11.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,732	8,153	85,162	10.44	10
11	Social Service Workers	2,045	2,125	29,098	13.69	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	28,926	30,222	285,058	9.43	15
16	Dishwashers					16
17	Maintenance Workers	4,058	4,238	67,460	15.92	17
18	Housekeepers	16,273	17,262	170,027	9.85	18
19	Laundry	5,916	6,248	58,490	9.36	19
20	Administrator	1,876	2,080	90,775	43.64	20
21	Assistant Administrator					21
22	Other Administrative	1,900	2,080	45,577	21.91	22
23	Office Manager					23
24	Clerical	9,309	9,561	131,813	13.79	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,914	2,080	45,356	21.81	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,275	1,538	16,866	10.97	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	212,168	224,227	$ 3,069,383 *	$ 13.69	34

SEE ACCOUNTANTS' PREPARATION REPORT

* 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	Monthly	$ 11,958	L1, C3	35
36	Medical Director	Monthly	18,000	L9, C3	36
37	Medical Records Consultant	Monthly	2,000	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,502	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)		$ 38,460		49

C. CONTRACT NURSES

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

Facility Name & ID Number Shelbyville Manor # 0047878 Report Period Beginning: 10/1/16 Ending: 9/30/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karen Dailey	Administrator	None	$ 90,775
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 90,775

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
LTC Support Services, LLC	Support Services	$ 172,440
RFMS, Inc.	Administrative Services	171,600
Templin Healthcare Accounting	Accounting Services	3,231
RSM US LLP	Accounting Services	20,428
Bolen Robinson & Ellis	Legal Services	79
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 367,778

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,448
Unemployment Compensation Insurance	28,710
FICA Taxes	226,793
Employee Health Insurance	168,993
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401k	14,294
Other Employee Benefits	11,610
Less: AL Allocated Expenses	(62,541)
TOTAL (agree to Schedule V, line 22, col.8)	$ 435,307

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	$ 2,158
Advertising: Employee Recruitment	6,135
Health Care Worker Background Check	
(Indicate # of checks performed 128)	
Patient Background Checks	3,211
Subscriptions	2,323
IHCA Dues	7,104
Other Licenses & Fees	3,162
Less: Disallow AL License Fees	(3,055)
Allocation of Home Office	2
Less: Public Relations Expense	(840)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,200

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	702
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 702

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Shelbyville Manor # 0047878 **Report Period Beginning:** 10/1/16 **Ending:** 9/30/17

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. **7,104 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? **9 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **41,477** 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. $ **184,716**
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. $ **1,031**

(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

FACILITY NAME: Shelbyville Manor **BEGINNING:** 10/1/16
ID#: 0047878 **ENDING:** 9/30/17

Shelbyville Manor houses both the skilled nursing facility and the assisted living facility in the same bldg and reported as a single division of Unlimited Development, Inc. Therefore, the divisional income statement and balance sheet report both operations. The AL related costs have been adjusted out of this cost report

Attached Schedule 22A

SUMMARY SCHEDULE
of Allocation of Assisted Living Facility Costs

Sch. V Line #		Basis of Allocation	Salaries	Supplies	Other	Total
1	Dietary	Census	60,194	6,160		66,354
2	Food Purchase	Census		62,919		62,919
3	Housekeeping	Rooms	25,811	4,847		30,658
4	Laundry	Rooms	8,879	1,617		10,496
5	Heat and Other Utilities				23,531	23,531
6	Maintenance	Rooms	10,241	4,072	9,429	23,742
7	Other (specify):*					-
9	Medical Director					-
10	Nursing and Medical Records	100% of RSD/Personal Care	263,176			263,176
10a	Therapy					-
11	Activities	25%		581		581
12	Social Services					-
13	CNA Training					-
14	Program Transportation	Rooms			1,352	1,352
15	Other (specify):*					-
17	Administrative					-
18	Directors Fees					-
19	Professional Services					-
20	Dues, Fees, Subscriptions & Promot	Rooms			405	405
21	Clerical & General Office Expenses	Rooms			2,461	2,461
22	Employee Benefits & Payroll Taxes	% of AL Wages			62,541	62,541
23	Inservice Training & Education					-
24	Travel and Seminar					-
25	Other Admin. Staff Transportation					-
26	Insurance-Prop.Liab.Malpractice	Rooms			7,168	7,168
27	Other (specify):*					-
30	Depreciation	Direct			35,346	35,346
31	Amortization of Pre-Op. & Org.					-
32	Interest	15%			24,088	24,088
33	Real Estate Taxes	15%			15,806	15,806
34	Rent-Facility & Grounds					-
35	Rent-Equipment & Vehicles					-
36	Other (specify):*					-
38	Medically Necessary Transportation					-
39	Ancillary Service Centers					-
40	Barber and Beauty Shops					-
41	Coffee and Gift Shops					-
42	Provider Participation Fee					-
43	Other (specify):*					-
	TOTALS		368,301	80,196	182,127	630,624

Net adjustment required 630,624