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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0047597

Facility Name: Jerseyville Manor

Address: 1251 North State (Number) Jerseyville (City) 62502 (Zip Code)

County: Jersey

Telephone Number: (618) 498-6441 **Fax #** (618) 498-9025

HFS ID Number:

Date of Initial License for Current Owners: 09/28/05

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/2017 to 9/30/2018 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) Sherri Miller
(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 Jerseyville Manor # 0047597 Report Period Beginning: 10/1/2017 Ending: 9/30/2018

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	160	Skilled (SNF)	160	58,400	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	160	TOTALS	160	58,400	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	29,570	9,387	10,407	49,364	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,570	9,387	10,407	49,364	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.53%

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 10/01/05

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/28/05 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 160 and days of care provided 7,597

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: 9/30/18 Fiscal Year: 9/30/18

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/2017 Ending: 9/30/2018

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	369,803	34,325	13,923	418,051		418,051		418,051			1
2	Food Purchase		410,837		410,837		410,837	(8,729)	402,108			2
3	Housekeeping	212,248	57,871		270,119		270,119		270,119			3
4	Laundry	79,206	30,927		110,133		110,133		110,133			4
5	Heat and Other Utilities			181,067	181,067		181,067		181,067			5
6	Maintenance	94,128	29,919	57,766	181,813		181,813	28	181,841			6
7	Other (specify):*											7
8	TOTAL General Services	755,385	563,879	252,756	1,572,020		1,572,020	(8,701)	1,563,319			8
	B. Health Care and Programs											
9	Medical Director			35,100	35,100		35,100		35,100			9
10	Nursing and Medical Records	3,184,669	280,860	15,462	3,480,991		3,480,991		3,480,991			10
10a	Therapy											10a
11	Activities	117,787	2,141		119,928		119,928		119,928			11
12	Social Services	75,361			75,361		75,361		75,361			12
13	CNA Training											13
14	Program Transportation			7,682	7,682		7,682		7,682			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,377,817	283,001	58,244	3,719,062		3,719,062		3,719,062			16
	C. General Administration											
17	Administrative	106,899			106,899		106,899		106,899			17
18	Directors Fees							3,465	3,465			18
19	Professional Services			401,794	401,794		401,794	4,408	406,202			19
20	Dues, Fees, Subscriptions & Promotions			22,137	22,137		22,137	(3,405)	18,732			20
21	Clerical & General Office Expenses	144,607	29,993	55,650	230,250		230,250	98	230,348			21
22	Employee Benefits & Payroll Taxes			703,232	703,232		703,232	35	703,267			22
23	Inservice Training & Education			7,187	7,187		7,187		7,187			23
24	Travel and Seminar			686	686		686		686			24
25	Other Admin. Staff Transportation			7,684	7,684		7,684		7,684			25
26	Insurance-Prop.Liab.Malpractice			118,240	118,240		118,240	19,841	138,081			26
27	Other (specify):*											27
28	TOTAL General Administration	251,506	29,993	1,316,610	1,598,109		1,598,109	24,442	1,622,551			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,384,708	876,873	1,627,610	6,889,191		6,889,191	15,741	6,904,932			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 Jerseyville Manor #0047597 Report Period Beginning: 10/1/2017 Ending: 9/30/2018

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			223,346	223,346		223,346	379,644	602,990			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							110,817	110,817			32
33	Real Estate Taxes			269	269		269	149,280	149,549			33
34	Rent-Facility & Grounds			861,744	861,744		861,744	(861,744)				34
35	Rent-Equipment & Vehicles			11,441	11,441		11,441		11,441			35
36	Other (specify):* Mortg Insurance							18,771	18,771			36
37	**TOTAL Ownership**			1,096,800	1,096,800		1,096,800	(203,232)	893,568			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			676	676		676		676			38
39	Ancillary Service Centers		294,142	1,295,356	1,589,498		1,589,498		1,589,498			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			333,131	333,131		333,131		333,131			42
43	Other (specify):* See Att Sch 4A	57,207		191,160	248,367		248,367	(181,143)	67,224			43
44	**TOTAL Special Cost Centers**	57,207	294,142	1,820,323	2,171,672		2,171,672	(181,143)	1,990,529			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,441,915	1,171,015	4,544,733	10,157,663		10,157,663	(368,634)	9,789,029			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

Jerseyville Manor

Period Beginning 10/1/2017
Period End 9/30/2018

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			57,921	57,921		57,921		57,921			
	Radiology Expenses			9,303	9,303		9,303		9,303			
	Non-Allowable Expenses	57,207		123,936	181,143		181,143	(181,143)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special C	57,207	0	191,160	248,367	0	248,367	(181,143)	67,224			

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/2017 Ending: 9/30/2018

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	(8,729)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,051)	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				9
10	Interest and Other Investment Income	(22,574)	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	(3,497)	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	(70,434)	43		24
25	Fund Raising, Advertising and Promotional	(46,451)	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	(427,583)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (586,319)		$	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)	217,685		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 217,685		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (368,634)		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

Jerseyville Manor

ID# 0047597

Report Period Beginning: 10/1/2017

Ending: 9/30/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Disallow Marketing Wages	(57,207)	43	1
2	Disallow R/E Entity HUD Audit	(26,060)	19	2
3	Disallow Related Party Interest Expense	(344,316)	32	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**	(427,583)		49

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/2017 Ending: 9/30/2018

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	6	Maintenance	$	Unlimited Development, Inc.	100.00%	$ 28	$ 28	1
2	V	18	Director Fees		Unlimited Development, Inc.	100.00%	3,465	3,465	2
3	V	19	Professional Fees		Unlimited Development, Inc.	100.00%	4,408	4,408	3
4	V	20	Dues, Licenses and Subs		Unlimited Development, Inc.	100.00%	17	17	4
5	V	21	General Admin Expense		Unlimited Development, Inc.	100.00%	98	98	5
6	V	22	Employee Benefits		Unlimited Development, Inc.	100.00%	35	35	6
7	V	26	Property Insurance		Unlimited Development, Inc.	100.00%	66	66	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 8,117	$ * 8,117	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/2017 Ending: 9/30/2018

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	$	Jerseyville North State, LLC	N/A	$ 26,060	$ 26,060	15
16	V	20	Dues, Fees, Subs & Prom		Jerseyville North State, LLC	N/A	75	75	16
17	V	26	Property Insurance		Jerseyville North State, LLC	N/A	19,775	19,775	17
18	V	30	Depreciation		Jerseyville North State, LLC	N/A	379,644	379,644	18
19	V	32	Interest Expense	122	Jerseyville North State, LLC	N/A	477,829	477,707	19
20	V	33	Property Taxes		Jerseyville North State, LLC	N/A	149,280	149,280	20
21	V	34	Facility Rent	861,744	Jerseyville North State, LLC	N/A		(861,744)	21
22	V	36	Mortgage Insurance		Jerseyville North State, LLC	N/A	18,771	18,771	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			$ 861,866			$ 1,071,434	$ * 209,568	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/2017 Ending: 9/30/2018

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 Jerseyville Manor # 0047597 Report Period Beginning: 10/1/2017 Ending: 9/30/2018

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 Car	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 Jerseyville Manor # 0047597 Report Period Beginning: 10/1/2017 Ending: 9/30/2018

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 Jerseyville Manor # 0047597 Report Period Beginning: 10/1/2017 Ending: 9/30/2018

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								$ 3,465	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	$ 3,465		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 Jerseyville Manor # 0047597 Report Period Beginning: 10/1/2017 Ending: 9/30/2018

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	6	Maintenance	Weighted Avail Bed Days	505,933	21	$ 240	$	58,400	$ 28	1
2	18	Director Fees	Weighted Avail Bed Days	505,933	21	$ 30,020		58,400	3,465	2
3	19	Professional Fees	Weighted Avail Bed Days	505,933	21	38,188		58,400	4,408	3
4	20	Dues, Licenses and Subs	Weighted Avail Bed Days	505,933	21	144		58,400	17	4
5	21	General Admin Expense	Weighted Avail Bed Days	505,933	21	873		58,400	98	5
6	22	Employee Benefits	Weighted Avail Bed Days	505,933	21	300		58,400	35	6
7	26	Property Insurance	Weighted Avail Bed Days	505,933	21	568		58,400	66	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					$ 70,333	$		$ 8,117	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/2017 Ending: 9/30/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Cambridge Realty Capital						$	$			$	1
2	LTD. of Illinois		X	Facility purchase	$17,694.29	5/1/12	4,173,100	3,724,688	3/1/2046	3.5500	133,513	2
3												3
4	Community Living											4
5	Options, Inc.	X		Wing addition		8/1/2009	5,738,601	5,738,601	7/1/2039	6.0000	344,316	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$17,694.29		$ 9,911,701	$ 9,463,289			$ 477,829	9
	B. Non-Facility Related*											
10												10
11								Int Income Offset			(22,696)	11
12								Disallow Related Party Int Exp			(344,316)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (367,012)	14
15	TOTALS (line 9+line14)						$ 9,911,701	$ 9,463,289			$ 110,817	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 18,771 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 Jerseyville Manor # 0047597 Report Period Beginning: 10/1/2017 Ending: 9/30/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 111,067	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.)	2017	$ 147,113	2
3. Under or (over) accrual (line 2 minus line 1).		$ 36,046	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 113,503	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.		$ 149,549	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	126,179	8
	2014	133,834	9
	2015	139,259	10
	2016	147,738	11
	2017	147,113	12

This facility was purchased from an unrelated for-profit entity during 2005. A tax exemption has not yet been obtained.

Amount accrued includes the taxes for 9 months based on fiscal year end. Estimate is based on prior year tax bill.

Taxes paid during year represents the entire 2017 bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Jerseyville Manor COUNTY Jersey

FACILITY IDPH LICENSE NUMBER 0047597

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 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-127-014-00	S17 T8 R11 UNPLATTED	$ 146,843.96	$ 146,843.96
2.		PARCELS PT SE 1/4 (TRACT	$	$
3.		1 - SURVEY IN PLAT CAB 1/54B)	$	$
4.	04-017-009-00	S17 T8 R11 TRACT IN SE1/4	$	$
5.		SE 1/4 9-04 85K, 10-00 75K	$ 268.92	$ 268.92
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 147,112.88	$ 147,112.88

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Jerseyville Manor # 0047597 Report Period Beginning: 10/1/2017 Ending: 9/30/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,306 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	3.5 Acres	2005	$ 160,000	1
2	Facility Addition	.88 Acres	2008	14,025	2
3	TOTALS	#VALUE!		$ 174,025	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/2017 Ending: 9/30/2018

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	92		2005		$ 4,578,867	$	40	$ 114,472	$ 114,472	$ 1,497,673	4
5	68		2008		4,926,175		25	197,047	197,047	1,970,470	5
6											6
7											7
8											8
	Improvement Type**										
9	Attic Insulation			2005	5,952	397	15	397		5,159	9
10	Parking Lot Lighting			2006	5,355	357	15	357		4,463	10
11	Furnace, Wall Paper/Paint Dining/Kitchen/Beauty Shop			2008	13,072	168	5-15 yrs	168		12,292	11
12	Floor Scrubber, Elec Sign, Prking Lot, Renten Pnd, Sidwlks			2008	398,166	2,983	5-20 yrs	9,101	6,118	358,315	12
13	Landscaping, Fence			2008	47,677		10-15 yrs	4,487	4,487	44,865	13
14	Electric Install, Recliner Wheelchairs, Baskets			2008	37,076	2,852	13	2,852		28,282	14
15	Dish Truck, Steamable, Convect. Steamer, Wiring Convec Over			2008	15,149	1,515	10	1,515		14,897	15
16	Roof			2008	116,316	11,631	10	11,631		115,347	16
17	Paint & Wallpaper, Paint & Wallpaper, Fence			2008	16,441		5-8 yrs			16,441	17
18	Wndw Decs, Duct work, Veranda, outsde lights, Jrsyvile Parking Lot			2009	265,075	4,720	5-15 yrs	4,720		247,132	18
19	Water heater			2010	4,760	476	10	476		3,808	19
20	Generator, Water heater, lobby remodel (Contracted Total)			2011	39,722	3,065	5-12 yrs.	3,065		27,939	20
21	Bathroom #1- Fixtures/Plumbing/Toilet/Drywall/Cabinets/Tile Floor/Pain			2012	68,090	5,674	12	5,674		33,571	21
22	Bathroom #2- Drywall/Plumbing/Fixtures/Cabinets/Tile Floor/Toilet/ Gra			2012	59,732	4,978	12	4,978		29,452	22
23	Bathroom #3- Fixtures/Plumbing/Toilet/Cabinets/Paint/ Drywall			2012	29,696	2,475	12	2,475		14,643	23
24	Bathroom #4- Fixtures/Drywall/Paint/Cabinets/Toilet/Tile Floor/ Grab Ba			2012	30,269	2,522	12	2,522		14,922	24
25	Water heater			2014	10,185	1,018	10	1,018		4,838	25
26	Water heater			2014	5,204	520	10	520		2,471	26
27	Exterior Double Doors			2014	5,641	564	10	564		2,491	27
28	Courtyard Doors			2014	2,615	174	15	174		769	28
29	Hollow Metal Doors			2014	4,937	246	20	246		1,090	29
30	Water Softener			2014	3,539	354	10	354		1,504	30
31	Concrete-Parking Lot			2014	52,000	3,467	15	3,467		14,157	31
32	Concrete Driveway			2015	25,040	1,669	15	1,669		5,563	32
33	Furnace/AC			2015	6,800	680	10	680		2,210	33
34	Carpet Therapy Room			2015	2,791	558	5	558		1,721	34
35	Therapy Room Addition			2015	582,659			14,566	14,566	41,271	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 Jerseyville Manor # 0047597 Report Period Beginning: 10/1/2017 Ending: 9/30/2018

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	Quarry Tile-Kitchen/VCT-Hall/Breakroom/Office/3 Bathrooms	2015	9,804	490	20	490	$	$ 1,429	37
38	Seal Parking Lot	2016	5,058	632	8	632		1,580	38
39	Kitchen Remodel-Tile/Cabinets/Counter Tops/Fixtures/Plumbing	2016	152,555	12,713	12	12,713		30,723	39
40	A/C Unit; Coil	2016	10,100	2,020	5	2,020		4,208	40
41	A/C Unit; Coil, Furnace, Condenser-Roof Top Unit	2016	10,250	683	15	683		1,423	41
42	Repair Boiler Fill Valve	2016	2,836	284	10	284		544	42
43	Furnace/AC Units/Coil	2017	10,950	730	15	730		1,034	43
44	100 Wing-Demo Electrical, Install TV Receptacles, Jacks/Light Fix	2017	16,985	1,699	10	1,699		2,124	44
45	300 Wing-Demo Electrical, Install TV Receptacles, Jacks/Light Fix	2017	14,536	1,454	10	1,454		1,817	45
46	200 Wing-Demo Electrical, Install TV Receptacles, Jacks/Light Fix	2017	20,217	2,022	10	2,022		2,527	46
47	100-300 Wing Remodel-VCT Tile/Lighting/Cove Base/Nurse Call/	2017	949,403	79,117	12	79,117		85,710	47
48	Life Safety/Ceiling Mural								48
49	Furnace/AC Units/Coil	2018	8,601	96	15	96		96	49
50	Compressor	2018	3,301	18	15	18		18	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)		$ 12,573,597	$ 155,021		$ 491,711	$ 336,690	$ 4,650,989	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/2017 Ending: 9/30/2018

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	$ 1,333,951	$ 58,382	$ 101,336	$ 42,954	3-15 yrs	$ 952,165	71
72	Current Year Purchases	4,674	234	234		15	234	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,338,625	$ 58,616	$ 101,570	$ 42,954		$ 952,399	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2014 Braun Entervan	2014	$ 41,928	$ 6,114	$ 6,114	$	4	$ 41,927	76
77	Patient Care	2018 Turtle Top Bus	2018	57,517	3,595	3,595		4	3,595	77
78										78
79										79
80	TOTALS			$ 99,445	$ 9,709	$ 9,709	$		$ 45,522	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)	$ 14,185,692	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 223,346	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 602,990	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 379,644	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,648,910	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	$ 15,288	$	$ 15,288	86
87	2003 GMC G3500 Van - 2006	29,848		29,848	87
88					88
89					89
90					90
91	TOTALS	$ 45,136	$	$ 45,136	91

G. Construction-in-Progress

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/2017 Ending: 9/30/2018

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 11,441 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	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Jerseyville Manor**
IDPH License ID Number: **0047597**
Fiscal Year End: **9/30/2018**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment Rental	11,223
Office Equipment	
Other Equipment Rental	218
Total - Line 16	**11,441**

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/2017 Ending: 9/30/2018

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	$	13,507	$ 595,998	$	13,507	$ 595,998	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,669	112,252		2,669	112,252	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		12,355	547,982		12,355	547,982	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				294,142		294,142	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapy	39(3)			3,797	39,124		3,797	39,124	12
13	Other (specify):									13
14	TOTAL			$	32,328	$ 1,295,356	$ 294,142	32,328	$ 1,589,498	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

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/2017 Ending: 9/30/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/2018 (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	$ 79,686	$ 807,251	1
2	Cash-Patient Deposits	29,128	29,128	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 84,000)	1,741,283	1,744,771	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	124,124	136,462	6
7	Other Prepaid Expenses	2,980	16,708	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interdivision Receivable	8,468,691	7,704,061	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 10,445,892	$ 10,438,381	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		174,025	13
14	Buildings, at Historical Cost	2,092,862	12,573,597	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	817,531	1,438,070	16
17	Accumulated Depreciation (book methods)	(1,175,851)	(5,648,910)	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 Sch 17A		140,103	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,734,542	$ 8,676,885	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,180,434	$ 19,115,266	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 159,898	$ 171,898	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	29,128	29,128	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	101,166	101,166	30
31	Accrued Taxes Payable (excluding real estate taxes)	100,950	100,950	31
32	Accrued Real Estate Taxes(Sch.IX-B)		113,503	32
33	Accrued Interest Payable		183,177	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)**	$ 391,142	$ 699,822	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,463,289	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Security Deposits	42,000	42,000	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 42,000	$ 9,505,289	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 433,142	$ 10,205,111	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 11,747,292	$ 8,910,155	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,180,434	$ 19,115,266	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Jerseyville Manor

Period Beginning **10/1/2017**
Period End **9/30/2018**

Schedule 17A

XV. Balance Sheet

Line 23 Other

		Operating	After Consolidation
Replacement Reserve			**124,461**
Real Estate Tax Escrow			**8,407**
Insurance Escrow			**2,000**
MIP Escrow			**5,235**
	TOTAL		**140,103**

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/2017 Ending: 9/30/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 10,550,125	1
2	Restatements (describe):		2
3	**Prior Year Post Closing Adjustment**	(8,279)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 10,541,846	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,205,446	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)**	$ 1,205,446	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)**	$ 11,747,292	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/2017 Ending: 9/30/2018

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	$ 10,859,375	1
2	Discounts and Allowances for all Levels	(111,262)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,748,113	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	553,722	6
7	Oxygen	6,291	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 560,013	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,019	12
13	Barber and Beauty Care	4,628	13
14	Non-Patient Meals	8,729	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	32	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,436	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 17,844	23
	D. Non-Operating Revenue		
24	Contributions	2,952	24
25	Interest and Other Investment Income***	22,574	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 25,526	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	11,613	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,613	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,363,109	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,572,020	31
32	Health Care	3,719,062	32
33	General Administration	1,598,109	33
	B. Capital Expense		
34	Ownership	1,096,800	34
	C. Ancillary Expense		
35	Special Cost Centers	1,838,541	35
36	Provider Participation Fee	333,131	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,157,663	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,205,446	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,205,446	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,327,065	44
45	Private Pay - Net Inpatient Revenue	1,689,389	45
46	Medicare - Net Inpatient Revenue	3,944,698	46
47	Other-(specify) Medicare Replacement/Managed Care	583,417	47
48	Other-(specify) Hospice	203,544	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,748,113	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: **Jerseyville Manor**
IDPH License ID Number: **0047597**
Fiscal Year End: **9/30/2018**

Schedule 19A

XVII. Income Statement
Line 28a Other Income

Rental Description	Amount
Late Fees Reversal	(1,367)
Processing Fee Reversal	(25)
Maintenance Fee Income	13,005
Total - Line 16	**11,613**

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/2017 Ending: 9/30/2018

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	1,920	2,040	88,179	$ 43.23	1
2	Assistant Director of Nursing	2,000	2,080	63,445	30.50	2
3	Registered Nurses	23,840	25,498	608,511	23.87	3
4	Licensed Practical Nurses	32,087	33,828	726,782	21.48	4
5	CNAs & Orderlies	128,275	135,760	1,670,983	12.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,436	11,106	117,787	10.61	10
11	Social Service Workers	3,752	4,104	75,361	18.36	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	34,084	35,544	369,803	10.40	15
16	Dishwashers					16
17	Maintenance Workers	5,978	6,526	94,128	14.42	17
18	Housekeepers	20,389	21,307	212,248	9.96	18
19	Laundry	7,288	7,685	79,206	10.31	19
20	Administrator	1,880	2,080	106,899	51.39	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,658	9,349	144,607	15.47	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	1,813	1,914	26,769	13.99	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	1,888	2,080	57,207	27.50	33
34	TOTAL (lines 1 - 33)	284,288	300,898	$ 4,441,915 *	$ 14.76	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	$ 13,923	L1, C3	35
36	Medical Director	Monthly	35,100	L9, C3	36
37	Medical Records Consultant	Monthly	2,000	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	11,606	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)		$ 62,629		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

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/2017 Ending: 9/30/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dana Bainter	Administrator	None	$ 106,899
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 106,899

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	$ 206,940
RFMS, Inc.	Administrative Services	171,600
Templin Healthcare Accounting	Accounting Services	3,226
RSM US LLP	Accounting Services	19,903
Norbert J Goetten	Legal Services	125
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 401,794

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 30,948
Unemployment Compensation Insurance	13,930
FICA Taxes	327,652
Employee Health Insurance	305,181
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401k	19,537
Other Employee Benefits	5,984
Indirect costs	35
TOTAL (agree to Schedule V, line 22, col.8)	$ 703,267

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	$ 1,990
Advertising: Employee Recruitment	4,045
Health Care Worker Background Check	
(Indicate # of checks performed 37)	930
Patient Background Checks 105	2,626
Subscriptions	844
IHCA Dues	10,032
Other Licenses & Fees	1,745
Indirect costs	17
Less: Public Relations Expense	(3,497)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,732

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	686
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 686

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/2017 Ending: 9/30/2018

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. **10,032 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? **15 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **119,578** 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. $ **333,131**
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. $ **8,729**

(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