

Facility Name & ID Number Shelbyville Manor

0047878 Report Period Beginning: 10/1/10 Ending: 9/30/11

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>115</u>	Skilled (SNF)	<u>115</u>	<u>41,975</u>	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	<u>115</u>	TOTALS	<u>115</u>	<u>41,975</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	4 Other	5 Total	
8	SNF	<u>14,288</u>	<u>5,710</u>	<u>4,894</u>	<u>24,892</u>	8
9	SNF/PED					9
10	ICF		<u>0</u>			10
11	ICF/DD					11
12	SC		<u>0</u>			12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,288</u>	<u>5,710</u>	<u>4,894</u>	<u>24,892</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.30%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

I. On what date did you start providing long term care at this location?
Date started 02/02/06

J. Was the facility purchased or leased after January 1, 1978?
YES Date 02/01/06 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 115 and days of care provided 4,796

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 9/30/11 Fiscal Year: 9/30/11

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	225,276	23,975	4,759	254,010		254,010	(56,791)	197,219		1
2	Food Purchase		288,880		288,880		288,880	(65,679)	223,201		2
3	Housekeeping	105,011	29,928	745	135,684		135,684	(19,990)	115,694		3
4	Laundry	57,499	15,933		73,432		73,432	(10,878)	62,554		4
5	Heat and Other Utilities			142,308	142,308		142,308	(19,901)	122,407		5
6	Maintenance	31,695	25,849	41,432	98,976		98,976	(14,661)	84,315		6
7	Other (specify):*										7
8	TOTAL General Services	419,481	384,565	189,244	993,290		993,290	(187,900)	805,390		8
	B. Health Care and Programs										
9	Medical Director			14,400	14,400		14,400		14,400		9
10	Nursing and Medical Records	1,440,970	220,522	6,518	1,668,010		1,668,010	(164,977)	1,503,033		10
10a	Therapy			474,783	474,783		474,783		474,783		10a
11	Activities	59,048	2,056	167	61,271		61,271	(520)	60,751		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation			626	626	5,287	5,913		5,913		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,500,018	222,578	496,494	2,219,090	5,287	2,224,377	(165,497)	2,058,880		16
	C. General Administration										
17	Administrative	120,377			120,377		120,377		120,377		17
18	Directors Fees							3,240	3,240		18
19	Professional Services			329,590	329,590		329,590	2,847	332,437		19
20	Dues, Fees, Subscriptions & Promotions			52,140	52,140		52,140	(36,656)	15,484		20
21	Clerical & General Office Expenses	62,248	29,412	48,398	140,058		140,058	(2,408)	137,650		21
22	Employee Benefits & Payroll Taxes			429,150	429,150		429,150	(48,986)	380,164		22
23	Inservice Training & Education			6,893	6,893		6,893		6,893		23
24	Travel and Seminar			2,964	2,964		2,964		2,964		24
25	Other Admin. Staff Transportation			10,573	10,573	(5,287)	5,286	(180)	5,106		25
26	Insurance-Prop.Liab.Malpractice			41,266	41,266		41,266	20,006	61,272		26
27	Other (specify):* See Att Sch V	43,589		132,988	176,577		176,577	(176,577)			27
28	TOTAL General Administration	226,214	29,412	1,053,962	1,309,588	(5,287)	1,304,301	(238,714)	1,065,587		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,145,713	636,555	1,739,700	4,521,968		4,521,968	(592,111)	3,929,857		29

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

SEE ACCOUNTANTS' COMPILATION 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

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			38,018	38,018		38,018	152,443	190,461			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							226,642	226,642			32
33	Real Estate Taxes							88,315	88,315			33
34	Rent-Facility & Grounds			565,200	565,200		565,200	(565,200)				34
35	Rent-Equipment & Vehicles			472	472		472		472			35
36	Other (specify):* See Att Sch IV							5,601	5,601			36
37	TOTAL Ownership			603,690	603,690		603,690	(92,199)	511,491			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			29,986	29,986		29,986		29,986			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			62,963	62,963		62,963		62,963			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			92,949	92,949		92,949		92,949			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,145,713	636,555	2,436,339	5,218,607		5,218,607	(684,310)	4,534,297			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(270)	V-2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		V-30		9
10	Interest and Other Investment Income	(439)	V-32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties		V-21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(130,873)	V-27		24
25	Fund Raising, Advertising and Promotional	(36,013)	V-20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Att Sch XV	(540,926)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (708,521)		\$	30

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	2	
		Amount	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)	17,718		34
35	Other- Attach Schedule See Att Sch III	6,493		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 24,211		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (684,310)		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	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary B

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	17,718	0	0	0	0	0	0	0	0	0	17,718	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	17,718	0	17,718	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	0	17,718	0	17,718	45								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
None	N/A	Unlimited Development, Inc. (UDI)		See Attached Schedule I		
		Community Living Options, Inc. (CLO)				
		See Attached Schedule I for specific homes & other CLO subsidiaries				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Facility Rent	\$ 565,200	Shelbyville Route 128, LLC	N/A	\$ 582,918	\$ 17,718	1
2	V							2
3	V			See Att Schedule IV and Independent Accountant's Report				3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 565,200			\$ 582,918	\$ * 17,718	14

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See Attached Schedule II & III								\$ 3,240	18-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 3,240		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' COMPILATION REPORT

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VIII. ALLOCATION OF INDIRECT COSTS

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

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	See Att Sch II & III							6,493	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	6,493

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

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Ending:

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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		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	\$26,328.00	2/1/2006	4,444,650	4,014,071	12/1/2033	5.6000	227,081	2						
3				SNF portion								3						
4												4						
5												5						
Working Capital																		
6	Miscellaneous		X									6						
7	Less Interest Income		X								(439)	7						
8												8						
9	TOTAL Facility Related				\$26,328.00		\$ 4,444,650	\$ 4,014,071			\$ 226,642	9						
B. Non-Facility Related*																		
10	Cambridge Realty Capital											10						
11	LTD. Of Illinois		X	facility purchase	\$4,646.00	2/1/2006	784,350	708,366	12/1/2033	5.6000	40,073	11						
12				ALC portion								12						
13												13						
14	TOTAL Non-Facility Related				\$4,646.00		\$ 784,350	\$ 708,366			\$ 40,073	14						
15	TOTALS (line 9+line14)						\$ 5,229,000	\$ 4,722,437			\$ 266,715	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 23,849 Line # 26

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2010 report.	\$	75,840	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.)	\$	99,341	2
3. Under or (over) accrual (line 2 minus line 1).	\$	23,501	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	77,899	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.)	\$	2,500	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.	\$	103,900	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2006	89,298	8
	2007	92,404	9
	2008	97,129	10
	2009	97,779	11
	2010	99,341	12

This facility was purchased from an unrelated for-profit entity during 2006. A tax exemption has not yet been obtained.

Amount accrued includes estimated taxes for 9 months based on fiscal year end. Estimate 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 an estimated 15%. See Att Sch XV. Real estate taxes paid are for the entire 2010 tax bill.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2010	\$	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' COMPILATION REPORT

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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 (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? (a) Own the Equipment (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 NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility - SNF</u>	<u>5.84 Acres</u>	<u>2006</u>	<u>\$ 195,500</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	#VALUE!		\$ 195,500	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Manor

0047878

Report Period Beginning:

10/1/10

Ending:

9/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	115	2006	1991	\$ 5,078,282	\$ 126,955	40	\$ 126,955	\$	\$ 719,421	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Dry Pipe Valve and Water Softner	2006		11,205	939	10-20 yrs	939		4,711	9
10	Water Heater	2007			310	10	310			10
11	Ceramic Tile Repair, Carpet, Ceramic Tile Repair	2007		11,750	1,019	5-20 yrs	1,019		4,473	11
12	Roof Repair	2008		84,157	8,416	10	8,416		30,858	12
13	Air Handler w/ Heat Strap and Condensor	2009		2,762	276	10	276		759	13
14	Water Heater	2009		9,323	932	10	932		2,408	14
15	Fire Protection System	2009		9,365	936	10	936		2,029	15
16	Water Heater	2010		10,671	1,067	10	1,067		1,334	16
17	Fire Sprinkler	2011		119,000	2,380	25	2,380		2,380	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

*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' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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								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)	\$	\$		\$	\$	\$	70
			5,336,515		143,230		143,230	
							768,373	

SEE ACCOUNTANTS' COMPILATION 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:

10/1/10

Ending:

9/30/11

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	\$ 449,534	\$ 45,499	\$ 45,499	\$	5-15 yrs	\$ 215,611	71
72	Current Year Purchases	39,714	1,732	1,732		7-10 yrs	1,732	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 489,248	\$ 47,231	\$ 47,231	\$		\$ 217,343	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	2003 GMC G3500 Van	2006	\$ 29,848	\$	\$	\$	4 yrs	\$ 29,848	76
77										77
78										78
79										79
80	TOTALS			\$ 29,848	\$	\$	\$		\$ 29,848	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)	\$ 6,051,111	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 190,461	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 190,461	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,015,564	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	Land ALC - 2006	34,500			87
88	Facility ALC - 2006	896,167	22,404	126,957	88
89					89
90					90
91	TOTALS	\$ 945,567	\$ 22,404	\$ 141,857	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Shelbyville Route 128, LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. 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:				\$ <u>See Attached</u>			3
4	Additions				<u>Schedule IV</u>			4
5					<u>Related Party</u>			5
6					<u>Lease</u>			6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A N/A

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

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 472 Description: See Attached Schedule XII

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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.	<u>/2012</u>	\$ <u>N/A</u>
13.	<u>/2013</u>	\$ <u>N/A</u>
14.	<u>/2014</u>	\$ <u>N/A</u>

* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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' COMPILATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Manor# 0047878Report Period Beginning: 10/1/10Ending: 9/30/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/11

(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	\$ 36,107	\$ 99,051	1
2	Cash-Patient Deposits	23,930	23,930	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>67,250</u>)	886,897	886,897	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	77,267	93,452	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Att Sch VII</u>	1,414,272	1,463,059	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,438,473	\$ 2,566,389	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		230,000	13
14	Buildings, at Historical Cost		5,974,449	14
15	Leasehold Improvements, at Historical Cost	258,233	258,233	15
16	Equipment, at Historical Cost	279,163	533,996	16
17	Accumulated Depreciation (book methods)	(166,633)	(1,157,421)	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): <u>See Att Sch VII</u>	624,000	948,171	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 994,763	\$ 6,787,428	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,433,236	\$ 9,353,817	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 72,096	\$ 72,096	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,930	23,930	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	53,212	53,212	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,643	2,643	31
32	Accrued Real Estate Taxes(Sch.IX-B)		77,899	32
33	Accrued Interest Payable	20,125	42,163	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Interdivision Payable</u>		1,403,487	36
37	<u>Current portion of long term payable</u>	624,000	734,021	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 796,006	\$ 2,409,451	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,612,416	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44	<u>Security Deposits</u>	43,500	43,500	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 43,500	\$ 4,655,916	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 839,506	\$ 7,065,367	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,593,730	\$ 2,288,450	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,433,236	\$ 9,353,817	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,927,433	1
2	Restatements (describe):		2
3	See Attached Schedule X	(11,755)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,915,678	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	678,052	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)	\$ 678,052	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)	\$ 2,593,730	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Manor# 0047878Report Period Beginning: 10/1/10Ending: 9/30/11

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.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,730,597	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,730,597	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	139,389	6
7	Oxygen	12,720	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 152,109	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,928	12
13	Barber and Beauty Care	2,000	13
14	Non-Patient Meals	270	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,198	23
D. Non-Operating Revenue			
24	Contributions	735	24
25	Interest and Other Investment Income***	439	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,174	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund Income		28
28a	See Att Schedule XI	8,581	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,581	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,896,659	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	993,290	31
32	Health Care	2,219,090	32
33	General Administration	1,309,588	33
B. Capital Expense			
34	Ownership	603,690	34
C. Ancillary Expense			
35	Special Cost Centers	29,986	35
36	Provider Participation Fee	62,963	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,218,607	40
41	Income before Income Taxes (line 30 minus line 40)**	678,052	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 678,052	43

* 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Shelbyville Manor

0047878

Report Period Beginning:

10/1/10

Ending:

9/30/11

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,892	2,035	\$ 68,160	\$ 33.49	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	6,394	6,875	144,656	21.04	3
4	Licensed Practical Nurses	15,045	16,178	267,419	16.53	4
5	CNAs & Orderlies	78,532	84,444	844,435	10.00	5
6	CNA Trainees					6
7	Licensed Therapist		0			7
8	Rehab/Therapy Aides		0			8
9	Activity Director		0			9
10	Activity Assistants	5,698	6,127	59,048	9.64	10
11	Social Service Workers		0			11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,974	23,628	225,276	9.53	15
16	Dishwashers					16
17	Maintenance Workers	1,714	1,843	31,695	17.20	17
18	Housekeepers	10,193	10,961	105,011	9.58	18
19	Laundry	6,139	6,601	57,499	8.71	19
20	Administrator	1,956	2,080	83,723	40.25	20
21	Assistant Administrator	1,704	1,833	36,654	20.00	21
22	Other Administrative	2,628	2,826	43,589	15.42	22
23	Office Manager					23
24	Clerical	5,075	5,457	62,248	11.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,931	2,076	37,016	17.83	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,496	1,608	16,967	10.55	31
32	Other Health Care(specify)	3,563	3,832	62,317	16.26	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	165,934	178,404	\$ 2,145,713 *	\$ 12.03	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 4,759	1-3	35
36	Medical Director	14,400	9-3	36
37	Medical Records Consultant	1,740	10-3	37
38	Nurse Consultant	0	10-3	38
39	Pharmacist Consultant	4,778	10-3	39
40	Physical Therapy Consultant	219,734	10a-3	40
41	Occupational Therapy Consultant	181,534	10a-3	41
42	Respiratory Therapy Consultant	0	10a-3	42
43	Speech Therapy Consultant	73,515	10a-3	43
44	Activity Consultant		11-3	44
45	Social Service Consultant		12-3	45
46	Other(specify)	0	10-3	46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 500,460		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
FY2007					FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Manor# 0047878Report Period Beginning: 10/1/10Ending: 9/30/11**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. See Page 21 section F
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes - IHCA dues If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 8 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 22,767 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 NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 62,963
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 270
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: McGladrey & Pullen, LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT