

		FOR BHF USE					

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**2014**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2014)**

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.

<p><b>I. IDPH License ID Number:</b> <u>0047944</u></p> <p><b>Facility Name:</b> <u>Pittsfield Manor</u></p> <p><b>Address:</b> <u>610 Lowry Street</u> <u>Pittsfield</u> <u>62363</u>        Number City Zip Code</p> <p><b>County:</b> <u>Pike</u></p> <p><b>Telephone Number:</b> <u>(800) 373-5202</u> <b>Fax #</b> <u>(217) 285-5212</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>04/26/06</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> <u>501 (c) (3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Ron Wilson</u> <b>Telephone Number:</b> <u>(309) 343-1550</u>  <b>Email Address:</b> _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> <u>501 (c) (3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust	_____		<input type="checkbox"/> Other	_____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/13</u> to <u>9/30/14</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Matt Hails</u></td> </tr> <tr> <td></td> <td>(Title) <u>LTC CEO</u></td> </tr> <tr> <td rowspan="4"><b>Paid Preparer</b></td> <td>(Signed) <u>See Preparation Report</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>McGladrey LLP</u> <u>117 E. Main St., Suite 210</u></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>P.O. Box 1070</u> <u>Galesburg, IL 61401</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(309) 342-1175</u> <b>Fax #</b> <u>(309) 342-7816</u></td> </tr> </table> <p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b></p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____		(Type or Print Name) <u>Matt Hails</u>		(Title) <u>LTC CEO</u>	<b>Paid Preparer</b>	(Signed) <u>See Preparation Report</u>	(Date) _____	(Print Name and Title) <u>McGladrey LLP</u> <u>117 E. Main St., Suite 210</u>	(Firm Name & Address) <u>P.O. Box 1070</u> <u>Galesburg, IL 61401</u>		(Telephone) <u>(309) 342-1175</u> <b>Fax #</b> <u>(309) 342-7816</u>
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Facility Name & ID Number Pittsfield Manor

# 0047944 Report Period Beginning: 10/1/13 Ending: 9/30/14

**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	89	Skilled (SNF)	89	32,485	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	89	TOTALS	89	32,485	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	8,785	7,528	3,609	19,922	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,785	7,528	3,609	19,922	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.33%

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 04/26/06

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 04/01/06 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 89 and days of care provided 2,971

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 9/30/14 Fiscal Year: 9/30/14

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

Facility Name &amp; ID Number

Pittsfield Manor

# 0047944

Report Period Beginning:

10/1/13

Ending:

9/30/14

**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
	<b>A. General Services</b>										
1	Dietary	248,149	29,653	5,238	283,040		283,040	(46,297)	236,743		1
2	Food Purchase		278,134		278,134		278,134	(47,535)	230,599		2
3	Housekeeping	88,438	53,008		141,446		141,446	(28,034)	113,412		3
4	Laundry	63,925	31,370		95,295		95,295	(18,888)	76,407		4
5	Heat and Other Utilities			112,979	112,979		112,979	(21,597)	91,382		5
6	Maintenance	79,359	52,182	56,776	188,317		188,317	(37,324)	150,993		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	479,871	444,347	174,993	1,099,211		1,099,211	(199,675)	899,536		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			8,900	8,900		8,900		8,900		9
10	Nursing and Medical Records	1,551,551	224,610	6,185	1,782,346		1,782,346	(185,005)	1,597,341		10
10a	Therapy			553,659	553,659		553,659		553,659		10a
11	Activities	50,692	4,074		54,766		54,766	(13,692)	41,074		11
12	Social Services	24,109			24,109		24,109		24,109		12
13	CNA Training										13
14	Program Transportation			64	64	7,160	7,224		7,224		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,626,352	228,684	568,808	2,423,844	7,160	2,431,004	(198,697)	2,232,307		16
	<b>C. General Administration</b>										
17	Administrative	102,695			102,695		102,695		102,695		17
18	Directors Fees							2,099	2,099		18
19	Professional Services			299,688	299,688		299,688	5,139	304,827		19
20	Dues, Fees, Subscriptions & Promotions			68,897	68,897		68,897	(49,083)	19,814		20
21	Clerical & General Office Expenses	56,049	35,573	58,054	149,676		149,676	(19,595)	130,081		21
22	Employee Benefits & Payroll Taxes			380,697	380,697		380,697	(47,258)	333,439		22
23	Inservice Training & Education			7,178	7,178		7,178		7,178		23
24	Travel and Seminar			2,541	2,541		2,541		2,541		24
25	Other Admin. Staff Transportation			14,319	14,319	(7,160)	7,159	(683)	6,476		25
26	Insurance-Prop.Liab.Malpractice			44,933	44,933		44,933	22,170	67,103		26
27	Other (specify):* See Att Sch V	30,569		277,678	308,247		308,247	(308,247)			27
28	<b>TOTAL General Administration</b>	189,313	35,573	1,153,985	1,378,871	(7,160)	1,371,711	(395,458)	976,253		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,295,536	708,604	1,897,786	4,901,926		4,901,926	(793,830)	4,108,096		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

Pittsfield Manor

#0047944

Report Period Beginning:

10/1/13

Ending:

9/30/14

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	<b>D. Ownership</b>											
30	Depreciation			86,017	86,017	86,017	197,026	283,043				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						142,575	142,575				32
33	Real Estate Taxes			3,084	3,084	3,084	61,440	64,524				33
34	Rent-Facility & Grounds			487,200	487,200	487,200	(487,200)					34
35	Rent-Equipment & Vehicles			16,331	16,331	16,331		16,331				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			592,632	592,632	592,632	(86,159)	506,473				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			14,799	14,799	14,799		14,799				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			151,621	151,621	151,621		151,621				42
43	Other (specify):* <b>Outpatient Care</b>			20,906	20,906	20,906		20,906				43
44	<b>TOTAL Special Cost Centers</b>			187,326	187,326	187,326		187,326				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,295,536	708,604	2,677,744	5,681,884	5,681,884	(879,989)	4,801,895				45

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

Facility Name & ID Number Pittsfield Manor

# 0047944

Report Period Beginning: 10/1/13

Ending: 9/30/14

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,185)	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	(14,439)	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	(17,095)	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	(275,969)	V-27		24
25	Fund Raising, Advertising and Promotional	(47,433)	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 VI	(588,907)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (945,028)</b>		<b>\$</b>	<b>30</b>

<b>BHF USE ONLY</b>						
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	2	
		<b>Amount</b>	<b>Reference</b>	
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)	55,823		34
35	Other- Attach Schedule See Att Sch III	9,216		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 65,039</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (879,989)</b>		<b>37</b>

\*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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

Pittsfield Manor

ID# 0047944

Report Period Beginning: 10/1/13

Ending: 9/30/14

Sch. V Line

Reference

NON-ALLOWABLE EXPENSES

Amount

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
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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	<b>Total</b>		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pittsfield Manor

# 0047944

Report Period Beginning:

10/1/13

Ending:

9/30/14

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	0	0	0	0	0	0	0	0	0	0	0	0	28
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Facility Name & ID Number Pittsfield Manor

# 0047944

Report Period Beginning:

10/1/13

Ending:

Summary B

9/30/14

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)	
	<b>D. Ownership</b>													
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	55,823	0	0	0	0	0	0	0	0	0	55,823	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	<b>TOTAL Ownership</b>	<b>0</b>	<b>55,823</b>	<b>0</b>	<b>55,823</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>0</b>	<b>55,823</b>	<b>0</b>	<b>55,823</b>	<b>45</b>								

**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	\$ 487,200	Pittsfield Lowry, LLC	N/A	\$ 543,023	\$ 55,823	1
2	V							2
3	V			See Att Schedule IV and Preparation Report				3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 487,200			\$ 543,023	\$ * 55,823	14

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

Facility Name & ID Number

Pittsfield Manor

# 0047944

Report Period Beginning:

10/1/13

Ending:

9/30/14

VII. RELATED PARTIES

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

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

Facility Name & ID Number Pittsfield Manor # 0047944 Report Period Beginning: 10/1/13 Ending: 9/30/14

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See Attached Schedule II & III								\$ 2,099	18-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,099		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Pittsfield Manor

# 0047944

Report Period Beginning:

10/1/13

Ending: 9/30/14

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  NO

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

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							9,216	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				\$	\$		\$	9,216

Facility Name &amp; ID Number

Pittsfield Manor

# 0047944

Report Period Beginning:

10/1/13

Ending:

9/30/14

## 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	Name of Lender	2		3	4	5	6		8	9	10	Reporting Period Interest Expense					
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	<b>A. Directly Facility Related</b>																
	<b>Long-Term</b>																
1	Cambridge Realty Capital						\$	\$			\$	1					
2	LTD. Of Illinois		X	Facility purchase	\$19,553.00	5/1/2012	4,557,600	4,387,250	6/1/2045	3.5500	157,014	2					
3				SNF portion								3					
4												4					
5												5					
	<b>Working Capital</b>																
6	Miscellaneous		X									6					
7	Less Interest Income		X								(14,439)	7					
8												8					
9	<b>TOTAL Facility Related</b>				\$19,553.00		\$ 4,557,600	\$ 4,387,250			\$ 142,575	9					
	<b>B. Non-Facility Related*</b>																
10	Cambridge Realty Capital											10					
11	LTD. Of Illinois		X	Facility purchase	\$4,888.00	5/1/2012	1,139,400	1,096,813	6/1/2045	3.5500	39,254	11					
12				ALC portion								12					
13												13					
14	<b>TOTAL Non-Facility Related</b>				\$4,888.00		\$ 1,139,400	\$ 1,096,813			\$ 39,254	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 5,697,000	\$ 5,484,063			\$ 181,829	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 27,601 Line # 26

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

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

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2013 report.		\$	<b>63,069</b>	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.)		\$	<b>78,712</b>	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>15,643</b>	3	
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>64,241</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>79,884</b>	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	<u>77,806</u>	8		
	2010	<u>76,734</u>	9		
	2011	<u>76,716</u>	10		
	2012	<u>75,850</u>	11		
	2013	<u>78,712</u>	12		
<b><u>This facility was purchased from an unrelated for-profit entity during 2006. A tax exemption has not yet been obtained</u></b>					
<b><u>Amount accrued includes the taxes for 9 months based on fiscal year end. Estimate is based on prior year tax bill</u></b>					
<b><u>Real estate taxes reported on Sch V line 33 have ben reduced by an allocation of expenses relating to ALC</u></b>					
<b><u>services based on an estimated 20%. See Att Sch VI. Taxes paid during year represents the entire 2013 bill</u></b>					
				<b>FOR BHF USE ONLY</b>	
	13	FROM R. E. TAX STATEMENT FOR 2013	\$		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.**

## 2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Pittsfield Manor COUNTY Pike

FACILITY IDPH LICENSE NUMBER 0047944

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 2013 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 2013.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>54-130-01</u>	<u>RNG/BLK:2 TWP:54 SEC/LOT:3</u>	\$ <u>75,009.78</u>	\$ <u>60,007.82</u>
2. _____	<u>PT LOT 1,2,3 EX. SW COR 2</u>	\$ _____	\$ _____
3. _____	<u>NORRIS SD E SIDE SEC 25</u>	\$ _____	\$ _____
4. <u>54-130-01A</u>	<u>RNG/BLK:2 TWP:54 SECT/LOT:3</u>	\$ <u>617.86</u>	\$ <u>494.29</u>
5. _____	<u>OUTLOT 1(PITTSVILLE</u>	\$ _____	\$ _____
6. _____	<u>VILLAGE) NORRIS SD E SIDE</u>	\$ _____	\$ _____
7. <u>54-130-01B</u>	<u>RNG/BLK:2 TWP:54 SECT/LOT:3</u>	\$ <u>114.96</u>	\$ <u>91.97</u>
8. _____	<u>PT ROW PARK ST</u>	\$ _____	\$ _____
9. <u>54-129-13</u>	<u>RNG/BLK:2 TWP:54 SECT/LOT:4</u>	\$ <u>2,969.02</u>	\$ <u>2,375.22</u>
10. _____	<u>PT LOT 1, 2, 3 AND PT LOT 4 N</u>	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>78,711.62</u></u>	\$ <u><u>62,969.30</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

C.    **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

**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 Pittsfield Manor

# 0047944 Report Period Beginning:

10/1/13 Ending:

9/30/14

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 41,400 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

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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>2.6 Acres</u>	<u>2006</u>	<u>\$ 144,000</u>	<u>1</u>
2	<u>Facility - SNF</u>	<u>.06 Acres</u>	<u>2013</u>	<u>1,662</u>	<u>2</u>
3	<b>TOTALS</b>	<b>#VALUE!</b>		<b>\$ 145,662</b>	<b>3</b>

Facility Name & ID Number **Pittsfield Manor**

# **0047944**

Report Period Beginning:

10/1/13

Ending:

9/30/14

**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	89	2006	1990	\$ 5,262,410	\$ 131,558	40	\$ 131,558	\$	\$ 1,118,262
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	Landscaping	2006		4,720	472	10	472		4,012
10	Water Heaters, Replaced Sheetrock Ceilings (gypsum)	2008		12,251	1,226	10	1,226		7,460
11	Shtrock wlls/repl ceiling/repl tiles, Wall light/bdside tbls/chairs/nightstand	2008		98,212	7,142	10-15 yrs	7,142		42,548
12	Wtr Heatr/Roof/Frnce & A/C/Gttrs/Fire sprinklers	2009		372,840	27,021	10-25 yrs	27,021		151,241
13	Sprinkler System/Carpet/Carpet/Carpeting	2009		22,969	3,804	5-25 yrs	3,804		18,928
14	Parker Tub Rm-Sink,Mirror,toilet,shwr walls,flr,drywall,drains,plumbing	2011		44,775	3,732	12	3,732		12,438
15	Parking Lot Overlay and Sealcoat	2011		52,770	6,597	8	6,597		19,789
16	Hallway-Handrails/whlchair guards/covebs/paint/light/insulation/wall gua	2012		57,129	4,761	12	4,761		12,299
17	Water Heater	2012		3,691	369	10	369		738
18	Water Softener	2012		2,522	252	10	252		504
19	Water Heater	2012		3,760	375	10	375		720
20	Cable TV System	2013		5,014	501	10	501		752
21	Water Softener	2013		2,633	263	10	263		285
22	Physical Therapy Addition (contracted total)	2013		269,325	18,703	12	18,703		18,703
23	Dining Room Addition (contracted total)	2013		238,316	16,550	12	16,550		16,550
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

Facility Name & ID Number **Pittsfield Manor**

# **0047944**

Report Period Beginning:

**10/1/13**

Ending:

**9/30/14**

**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	<b>TOTAL (lines 4 thru 69)</b>		\$ <b>6,453,337</b>	\$ <b>223,326</b>		\$ <b>223,326</b>	\$	\$ <b>1,425,229</b>	70

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

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	\$ 475,012	\$ 44,965	\$ 44,965	\$	5-15 yrs	\$ 341,233	71
72	Current Year Purchases	153,776	14,752	14,752		5-20 yrs	14,752	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 628,788	\$ 59,717	\$ 59,717	\$		\$ 355,985	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 G350 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)	\$ 7,257,635	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 283,043	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 283,043	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)	\$ 1,811,062	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	36,000			87
88	Facility ALC - 2006	1,315,602	32,891	279,566	88
89	Dining Room Addition ALC - 2013	59,579	4,137	4,137	89
90					90
91	TOTALS	\$ 1,426,081	\$ 37,028	\$ 298,603	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number

Pittsfield Manor

# 0047944

Report Period Beginning:

10/1/13

Ending:

9/30/14

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Pittsfield Lowry, 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

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. \_\_\_\_\_ /2015                      \$ N/A

13. \_\_\_\_\_ /2016                      \$ N/A

14. \_\_\_\_\_ /2017                      \$ N/A

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

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: \$ 16,331 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

\* 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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
1. From this facility		
2. From other facilities (f)		
<b>TOTAL TRAINED</b>		

- (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.

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

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

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

Facility Name & ID Number Pittsfield Manor# 0047944Report Period Beginning: 10/1/13

Ending:

9/30/14

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/14

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 27,351	\$ 56,318	1
2	Cash-Patient Deposits	9,930	9,930	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>318,000</u> )	836,619	836,619	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	79,339	109,505	6
7	Other Prepaid Expenses	3,566	3,566	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Att Sch VII</u>	5,230	60,408	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 962,035	\$ 1,076,346	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		181,662	13
14	Buildings, at Historical Cost		7,145,232	14
15	Leasehold Improvements, at Historical Cost	683,286	683,286	15
16	Equipment, at Historical Cost	371,403	673,536	16
17	Accumulated Depreciation (book methods)	(415,633)	(2,109,665)	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>Replacement Reserve</u>		410,481	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 639,056	\$ 6,984,532	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,601,091	\$ 8,060,878	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 111,808	\$ 112,183	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,930	9,930	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	65,759	65,759	30
31	Accrued Taxes Payable (excluding real estate taxes)	48,095	48,095	31
32	Accrued Real Estate Taxes(Sch.IX-B)		64,241	32
33	Accrued Interest Payable		16,224	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Interdivision Payable</u>	2,676,008	4,760,288	36
37	<u>Current portion of long term payable</u>		100,229	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,911,600	\$ 5,176,949	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,383,834	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44	<u>Security Deposits</u>	49,500	49,500	44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 49,500	\$ 5,433,334	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,961,100	\$ 10,610,283	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,360,009)	\$ (2,549,405)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,601,091	\$ 8,060,878	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (292,295)	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	To adjust rent expense	(1,500)	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ (293,795)	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(1,066,214)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (1,066,214)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (1,360,009)	<b>24</b> *

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

**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		
I. Revenue		Amount		
<b>A. Inpatient Care</b>				
1	Gross Revenue -- All Levels of Care	\$ 4,356,336	1	
2	Discounts and Allowances for all Levels	( )	2	
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,356,336	3	
<b>B. Ancillary Revenue</b>				
4	Day Care	3,820	4	
5	Other Care for Outpatients		5	
6	Therapy	221,790	6	
7	Oxygen	2,185	7	
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 227,795	8	
<b>C. Other Operating Revenue</b>				
9	Payments for Education		9	
10	Other Government Grants		10	
11	CNA Training Reimbursements		11	
12	Gift and Coffee Shop	2,124	12	
13	Barber and Beauty Care	3,732	13	
14	Non-Patient Meals	1,185	14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	142	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 7,183	23	
<b>D. Non-Operating Revenue</b>				
24	Contributions	2,739	24	
25	Interest and Other Investment Income***	14,439	25	
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 17,178	26	
<b>E. Other Revenue (specify):****</b>				
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27	
28	<b>Durable Medical Equipment</b>	3,549	28	
28a	<b>Miscellaneous Income</b>	3,629	28a	
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 7,178	29	
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,615,670	30	

		2		
II. Expenses		Amount		
<b>A. Operating Expenses</b>				
31	General Services	1,099,211	31	
32	Health Care	2,423,844	32	
33	General Administration	1,378,871	33	
<b>B. Capital Expense</b>				
34	Ownership	592,632	34	
<b>C. Ancillary Expense</b>				
35	Special Cost Centers	35,705	35	
36	Provider Participation Fee	151,621	36	
<b>D. Other Expenses (specify):</b>				
37			37	
38			38	
39			39	
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,681,884	40	
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,066,214)	41	
42	<b>Income Taxes</b>		42	
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,066,214)	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,103,657	44
45	Private Pay - Net Inpatient Revenue	1,252,123	45
46	Medicare - Net Inpatient Revenue	1,360,088	46
47	Other-(specify) <u>Assisted Living</u>	423,245	47
48	Other-(specify) <u>See Att Schedule XI</u>	217,223	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 4,356,336	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

Facility Name & ID Number Pittsfield Manor

# 0047944

Report Period Beginning:

10/1/13

Ending:

9/30/14

**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	1,764	1,802	\$ 47,530	\$ 26.38	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	7,047	7,567	159,523	21.08	3
4	Licensed Practical Nurses	15,728	16,728	300,706	17.98	4
5	CNAs & Orderlies	85,535	90,645	920,850	10.16	5
6	CNA Trainees					6
7	Licensed Therapist		0			7
8	Rehab/Therapy Aides		0			8
9	Activity Director		0			9
10	Activity Assistants	4,748	5,302	50,692	9.56	10
11	Social Service Workers	1,944	2,080	24,109	11.59	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,016	25,815	248,149	9.61	15
16	Dishwashers					16
17	Maintenance Workers	4,374	4,625	79,359	17.16	17
18	Housekeepers	8,635	9,502	88,438	9.31	18
19	Laundry	6,784	7,096	63,925	9.01	19
20	Administrator	1,984	2,080	69,107	33.22	20
21	Assistant Administrator	1,820	1,976	33,588	17.00	21
22	Other Administrative	1,996	2,080	30,569	14.70	22
23	Office Manager					23
24	Clerical	5,193	5,435	56,049	10.31	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,976	2,080	34,878	16.77	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,979	2,075	21,342	10.29	31
32	Other Health Care(specify)	3,886	4,130	66,722	16.16	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	180,409	191,018	\$ 2,295,536 *	\$ 12.02	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	***	\$ 5,238	1-3	35
36	Medical Director	***	8,900	9-3	36
37	Medical Records Consultant	***	2,184	10-3	37
38	Nurse Consultant	***	0	10-3	38
39	Pharmacist Consultant	***	4,001	10-3	39
40	Physical Therapy Consultant	***	214,331	10a-3	40
41	Occupational Therapy Consultant	***	234,789	10a-3	41
42	Respiratory Therapy Consultant	***	12,983	10a-3	42
43	Speech Therapy Consultant	***	91,556	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	*** Monthly Fee				48
49	TOTAL (lines 35 - 48)		\$ 573,982		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



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	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	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Pittsfield Manor# 0047944

Report Period Beginning:

10/1/13Ending: 9/30/14**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? 9 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,262 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 151,621  
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. \$ 1,185
- (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 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? See page 39 of the instructions for detail Yes-See Att Sch XIII  
Attach invoices and a summary of services for all architect and appraisal fees.