

		FOR BHF USE					

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

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH License ID Number:</b> <u>0047878</u></p> <p><b>Facility Name:</b> <u>Shelbyville Manor</u></p> <p><b>Address:</b> <u>1111 W North 12th St</u> <u>Shelbyville</u> <u>62565</u>        Number City Zip Code</p> <p><b>County:</b> <u>Shelby</u></p> <p><b>Telephone Number:</b> <u>(217) 774-2111</u> Fax # <u>(217) 774-2209</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>2/2/06</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td style="width:33%"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><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>10/1/15</u> to <u>9/30/16</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" style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>Matt Hails</u> (Title) <u>LTC CEO</u></td> </tr> <tr> <td style="width:20%; vertical-align: top;">Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name &amp; Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # ( )</td> </tr> </table> <p align="center"><b>MAIL TO: BUREAU OF HEALTH FINANCE        ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES        201 S. Grand Avenue East        Springfield, IL 62763-0001 Phone # (217) 782-1630</b></p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Matt Hails</u> (Title) <u>LTC CEO</u>	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # ( )
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Shelbyville Manor

# 0047878 Report Period Beginning: 10/1/15 Ending: 9/30/16

**III. STATISTICAL DATA**

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

	1	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	109	Skilled (SNF)	109	39,894	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	109	TOTALS	109	39,894	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	16,777	4,827	5,338	26,942	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,777	4,827	5,338	26,942	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 67.53%

**D. How many bed-hold days during this year were paid by the Department?**

None (Do not include bed-hold days in Section B.)

**E. List all services provided by your facility for non-patients.**

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

Yes

**G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?**

YES  NO  Non-allowable costs have been eliminated in Schedule V, Column 7

**H. Does the BALANCE SHEET (page 17) reflect any non-care assets?**

YES  NO

**I. On what date did you start providing long term care at this location?**

Date started 2/2/06

**J. Was the facility purchased or leased after January 1, 1978?**

YES  Date 2/1/06 NO

**K. Was the facility certified for Medicare during the reporting year?**

YES  NO  If YES, enter number of beds certified 109 and days of care provided 4,817

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Shelbyville Manor # 0047878 Report Period Beginning: 10/1/15 Ending: 9/30/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 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	251,267	23,534	8,667	283,468		283,468	(54,545)	228,923		1
2	Food Purchase		298,331		298,331		298,331	(59,652)	238,679		2
3	Housekeeping	162,939	29,991	553	193,483		193,483	(29,288)	164,195		3
4	Laundry	67,692	14,044	1,652	83,388		83,388	(12,407)	70,981		4
5	Heat and Other Utilities			162,435	162,435		162,435	(24,282)	138,153		5
6	Maintenance	62,423	31,209	40,617	134,249		134,249	(20,380)	113,869		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	544,321	397,109	213,924	1,155,354		1,155,354	(200,554)	954,800		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	2,105,294	125,613	7,863	2,238,770		2,238,770	(246,454)	1,992,316		10
10a	Therapy	152		857,024	857,176		857,176		857,176		10a
11	Activities	70,343	1,979		72,322		72,322	(495)	71,827		11
12	Social Services	28,037			28,037		28,037		28,037		12
13	CNA Training										13
14	Program Transportation			7,006	7,006		7,006	(332)	6,674		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,203,826	127,592	889,893	3,221,311		3,221,311	(247,281)	2,974,030		16
	<b>C. General Administration</b>										
17	Administrative	99,877			99,877		99,877		99,877		17
18	Directors Fees							3,624	3,624		18
19	Professional Services			368,722	368,722		368,722	3,979	372,701		19
20	Dues, Fees, Subscriptions & Promotions			18,305	18,305		18,305	(3,243)	15,062		20
21	Clerical & General Office Expenses	103,874	21,517	55,272	180,663		180,663	(2,528)	178,135		21
22	Employee Benefits & Payroll Taxes			487,008	487,008		487,008	(57,582)	429,426		22
23	Inservice Training & Education			7,694	7,694		7,694		7,694		23
24	Travel and Seminar			43	43		43		43		24
25	Other Admin. Staff Transportation			6,671	6,671		6,671		6,671		25
26	Insurance-Prop.Liab.Malpractice			40,842	40,842		40,842	3,632	44,474		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	203,751	21,517	984,557	1,209,825		1,209,825	(52,118)	1,157,707		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,951,898	546,218	2,088,374	5,586,490		5,586,490	(499,953)	5,086,537		29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Shelbyville Manor

#0047878

Report Period Beginning:

10/1/15

Ending:

9/30/16

## 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			123,903	123,903		123,903	197,500	321,403			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							155,628	155,628			32
33	Real Estate Taxes							88,817	88,817			33
34	Rent-Facility & Grounds			491,688	491,688		491,688	(491,688)				34
35	Rent-Equipment & Vehicles			3,022	3,022		3,022		3,022			35
36	Other (specify):* <u>Mort Ins</u>							23,191	23,191			36
37	<b>TOTAL Ownership</b>			618,613	618,613		618,613	(26,552)	592,061			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		134,395	137	134,532		134,532		134,532			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			167	167		167	(167)				41
42	Provider Participation Fee			191,353	191,353		191,353		191,353			42
43	Other (specify):* <u>See Att Sch 4A</u>	46,783		280,258	327,041		327,041	(299,189)	27,852			43
44	<b>TOTAL Special Cost Centers</b>	46,783	134,395	471,915	653,093		653,093	(299,356)	353,737			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,998,681	680,613	3,178,902	6,858,196		6,858,196	(825,861)	6,032,335			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Shelbyville Manor

Period Beginning 10/1/15

Period End 9/30/16

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					5	6
		1	2	3	4						
	Ancillary Expense										
	<b>E. Special Cost Centers</b>										
43	Other (specify):*				0		0		0		
	Laboratory/Expenses			17,864	17,864		17,864		17,864		
	Radiology Expenses			9,988	9,988		9,988		9,988		
	Non-Allowable Expenses	46,783		252,406	299,189		299,189	(299,189)	0		
					0		0		0		
					0		0		0		
	<b>TOTAL Other Special C</b>	<b>46,783</b>	<b>0</b>	<b>280,258</b>	<b>327,041</b>	<b>0</b>	<b>327,041</b>	<b>(299,189)</b>	<b>27,852</b>		

Facility Name & ID Number Shelbyville Manor

# 0047878

Report Period Beginning:

10/1/15

Ending:

9/30/16

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		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	(573)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,013)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,478)	30		9
10	Interest and Other Investment Income	(11)	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	(2,780)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	91	43		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(184,800)	43		24
25	Fund Raising, Advertising and Promotional	(62,684)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(649,834)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (907,082)		\$	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)	81,221		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 81,221		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (825,861)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' PREPARATION REPORT

Shelbyville Manor

ID# 0047878

Report Period Beginning: 10/1/15

Ending: 9/30/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Vending Expenses Against Income	\$ (167)	41	1
2	Disallow Marketing Wages	(46,783)	43	2
3	Disallow R/E Entity HUD Audit	(13,390)	19	3
4	Disallow AL Expenses-Dietary	(54,545)	1	4
5	Disallow AL Expenses-Food	(59,079)	2	5
6	Disallow AL Expenses-Housekeeping	(29,288)	3	6
7	Disallow AL Expenses-Laundry	(12,407)	4	7
8	Disallow AL Expenses-Utilities	(24,282)	5	8
9	Disallow AL Expenses-Maintenance	(20,380)	6	9
10	Disallow AL Expenses-Nursing	(246,454)	10	10
11	Disallow AL Expenses-Activities	(495)	11	11
12	Disallow AL Expenses-Program Transportation	(332)	14	12
13	Disallow AL Expenses-Licenses & Fees	(715)	20	13
14	Disallow AL Expenses-Telephone	(2,533)	21	14
15	Disallow AL Expenses-Employee Benefits	(57,582)	22	15
16	Disallow AL Expenses-Insurance	(7,291)	26	16
17	Disallow AL Expenses-Depreciation Expense	(33,626)	30	17
18	Disallow AL Expenses-Interest Expense	(24,752)	32	18
19	Disallow AL Expenses-Real Estate Tax Expense	(15,733)	33	19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(649,834)		49

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
None	N/A	Unlimited Development, Inc (UDI)		See Page 6 Supplemental		
		Community Living Options, Inc. (CLO)				
		See Page 6 Supplemental for specific homes				

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  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	18 Director Fees	\$	Unlimited Development, Inc.	100.00%	\$ 3,624	\$ 3,624	1	
2	V	19 Professional Fees		Unlimited Development, Inc.	100.00%	3,979	3,979	2	
3	V	20 Dues, Licenses and Subs		Unlimited Development, Inc.	100.00%	2	2	3	
4	V	21 General Admin Expense		Unlimited Development, Inc.	100.00%	5	5	4	
5	V	26 Property/ Liability Insurance		Unlimited Development, Inc.	100.00%	832	832	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		\$			\$ 8,442	\$ *	8,442	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

**VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  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:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	19 Professional Fees	\$	Shelbyville Route 128, LLC	N/A	\$ 13,390	\$	13,390	15
16	V	20 Dues, Fees, Subs & Prom		Shelbyville Route 128, LLC	N/A	250		250	16
17	V	26 Property Insurance		Shelbyville Route 128, LLC	N/A	10,091		10,091	17
18	V	30 Depreciation		Shelbyville Route 128, LLC	N/A	232,604		232,604	18
19	V	32 Interest Expense	197	Shelbyville Route 128, LLC	N/A	165,016		164,819	19
20	V	32 Loan Fee Amortization		Shelbyville Route 128, LLC	N/A	15,572		15,572	20
21	V	33 Property Taxes		Shelbyville Route 128, LLC	N/A	104,550		104,550	21
22	V	34 Facility Rent	491,688	Shelbyville Route 128, LLC	N/A			(491,688)	22
23	V	36 Mortgage Insurance		Shelbyville Route 128, LLC	N/A	23,191		23,191	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	<b>Total</b>		\$ 491,885			\$ 564,664	\$ *	72,779	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number

Shelbyville Manor

# 0047878

Report Period Beginning:

10/1/15

Ending:

9/30/16

## VII. RELATED PARTIES

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number

Shelbyville Manor

# 0047878

Report Period Beginning:

10/1/15

Ending:

9/30/16

## VII. RELATED PARTIES

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Shelbyville Manor

# 0047878

Report Period Beginning:

10/1/15

Ending:

9/30/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Unlimited Development, Inc. (UDI)	100%	River Hills Manor	Keokuk, IA				1
2	Unlimited Development, Inc. (UDI)	100%			River Hills Estates	Keokuk, IA	Retirement living ce	2
3	Unlimited Development, Inc. (UDI)	100%			River Hills Inn	Keokuk, IA	Assisted living facili	3
4	Unlimited Development, Inc. (UDI)	100%			Centralia East McCorn	Galesburg	Lessor	4
5	Unlimited Development, Inc. (UDI)	100%			Galesburg North Semi	Galesburg	Lessor	5
6	Unlimited Development, Inc. (UDI)	100%			Jerseyville North State	Galesburg	Lessor	6
7	Unlimited Development, Inc. (UDI)	100%			Shelbyville Route 128,	Galesburg	Lessor	7
8	Unlimited Development, Inc. (UDI)	100%			Marion Willimason Co	Galesburg	Lessor	8
9	Unlimited Development, Inc. (UDI)	100%			Leroy South Buck, LL	Galesburg	Lessor	9
10	Unlimited Development, Inc. (UDI)	100%			2245 Seminary Street,	Galesburg	Lessor	10
11	Unlimited Development, Inc. (UDI)	100%			Pittsfield Lowry, LLC	Galesburg	Lessor	11
12	Unlimited Development, Inc. (UDI)	100%			Pekin El Camino, LLC	Galesburg	Lessor	12
13	Unlimited Development, Inc. (UDI)	100%			Abingdon West Marti	Galesburg	Lessor	13
14	Unlimited Development, Inc. (UDI)	100%			Keokuk Village Circle	Galesburg	Lessor	14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Shelbyville Manor # 0047878 Report Period Beginning: 10/1/15 Ending: 9/30/16

VII. RELATED PARTIES (continued)

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

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

	1 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 7A								\$ 3,624	L18, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 3,624		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Shelbyville Manor

# 0047878

Report Period Beginning:

10/1/15

Ending: 9/30/16

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	18	Director Fees	Weighted Avail Bed Days 543,144	20	\$ 49,346	\$	39,894	\$ 3,624	1
2	19	Professional Fees	Weighted Avail Bed Days 543,144	20	54,173	\$	39,894	3,979	2
3	20	Dues, Licenses and Subs	Weighted Avail Bed Days 543,144	20	25		39,894	2	3
4	21	General Admin Expense	Weighted Avail Bed Days 543,144	20	70		39,894	5	4
5	26	Property/ Liability Insurance	Weighted Avail Bed Days 543,144	20	11,324		39,894	832	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 114,938	\$		\$ 8,442	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Shelbyville Manor

# 0047878

Report Period Beginning:

10/1/15

Ending:

9/30/16

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Cambridge Realty Capital																			
2	LTD. of Illinois		X	Facility purchase	\$20,381.00	6/1/2012	4,313,155	3,903,125	4/1/2040	3.5500	140,264									
3				SNF portion																
4																				
5																				
<b>Working Capital</b>																				
6																				
7																				
8																				
9	<b>TOTAL Facility Related</b>				\$20,381.00		\$ 4,313,155	\$ 3,903,125			\$ 140,264									
<b>B. Non-Facility Related*</b>																				
10	Cambridge Realty Capital								Amortization Exp		15,572									
11	LTD. of Illinois		X	Facility purchase	\$3,597.00	6/1/2012	761,145	688,787	4/1/2040	3.5500	24,752									
12				AL portion					Disallow AL Int Exp		(24,752)									
13									Int Income Offset		(208)									
14	<b>TOTAL Non-Facility Related</b>				\$3,597.00		\$ 761,145	\$ 688,787			\$ 15,364									
15	<b>TOTALS (line 9+line14)</b>						\$ 5,074,300	\$ 4,591,912			\$ 155,628									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ 23,191      Line # 36

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

(See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

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

(See instructions.)

**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 2015 report.		\$	<b>83,877</b>	<b>1</b>
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2015	\$	<b>104,883</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>21,006</b>	<b>3</b>
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>79,578</b>	<b>4</b>
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>		\$	<b>3,966</b>	<b>5</b>
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>			<b>(15,733)</b>	<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>88,817</b>	<b>7</b>
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2011	<b>95,914</b>	<b>8</b>	
	2012	<b>106,616</b>	<b>9</b>	
	2013	<b>106,531</b>	<b>10</b>	
	2014	<b>103,372</b>	<b>11</b>	
	2015	<b>104,883</b>	<b>12</b>	
<b>This facility was purchased from an unrelated for-profit entity during 2006. A tax exemption has not yet been obtained.</b>				
<b>Amount accrued includes the taxes for 9 months based on fiscal year end. Estimate is based on prior year tax bill.</b>				
<b>Real estate taxes reported on Sch V line 33 have been reduced by an allocation of expenses relating to ALC services based on as estimated 15%. See Att Sch 22A. Taxes paid during year represents the entire 2015 bill.</b>				
				<b>FOR BHF USE ONLY</b>
	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2015	\$	<b>13</b>
	<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
	<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' PREPARATION REPORT

**2015 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Shelbyville Manor COUNTY Shelby

FACILITY IDPH LICENSE NUMBER 0047878

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

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

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>2013-06-17-305-001</u>	<u>W N 12TH</u>	\$ <u>104,882.90</u>	\$ <u>89,150.47</u>
2. _____	<u>SW COR SW SW 550' X 520' &amp; 30'</u>	\$ _____	\$ _____
3. _____	<u>VAC STREET LESS .11 AC TO</u>	\$ _____	\$ _____
4. _____	<u>ST HWY 6.76 AC</u>	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>104,882.90</u></u>	\$ <u><u>89,150.47</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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Shelbyville Manor

# 0047878 Report Period Beginning:

10/1/15 Ending:

9/30/16

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).

Assisted Living-20 Units

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Facility-SNF, 5.84 Acres, 2006, \$ 195,500, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, #VALUE!, (blank), \$ 195,500, 3.

SEE ACCOUNTANTS' PREPARATION REPORT

**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	109	2006	1991	\$ 5,078,282	\$	40	\$ 126,948	\$ 126,948	\$ 1,354,191	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Dry Pipe Valve and Water Softner	2006		11,205	939	10-20 yrs	939		9,407	9
10	Ceramic Tile Repair, Carpet, Ceramic Tile	2007		11,750	444	5-20 yrs	444		7,027	10
11	Roof Repair	2008		84,157	8,416	10	8,416		72,937	11
12	Air Handler, Water Heater, Fire Protection System	2009		21,450	2,145	10	2,145		15,922	12
13	Water Heater	2010		10,671	1,067	10	1,067		6,669	13
14	Fire Sprinkler, Oil/Chip Parking Lot	2011		123,200	5,285	8-25 yrs	5,285		28,805	14
15	Physical Therapy Addition (Contracted Total)	2011		762,407		12	63,536	63,536	317,673	15
16	Hallway Rmdl-Vinyl tile/Base/Drywall/Handrails/Wall & Crnr Grds/AC	2011		56,356	4,696	12	4,696		23,480	16
17	Shower Rmdl-Exhaust fan/Fire access dr/Flr-tile/wiring/fxts/drains	2012		130,718	10,893	12	10,893		51,742	17
18	Laundry/Hallway Rmdl-Handrails/Guardrails/Vinyl Tile/Drywall/Paint	2012		138,186	11,516	12	11,516		51,822	18
19	Faux Wood Blinds - 14	2012		5,256	1,051	5	1,051		4,642	19
20	Fire Alarm System and Components	2012		8,555	856	10	856		3,352	20
21	Faux Wood Blinds	2012		5,108	1,022	5	1,022		4,002	21
22	Crown Light Boxes	2012		7,764	1,553	5	1,553		5,953	22
23	Faux Wood Blinds - 28	2013		4,883	976	5	976		3,253	23
24	Water Heater	2013		8,780	878	10	878		2,634	24
25	Doors	2014		16,820	1,682	10	1,682		4,205	25
26	Storage Building/Garage	2014		2,700	180	15	180		420	26
27	Sprinkler Pipe	2014		9,620	641	15	641		1,496	27
28	Condensor/Air Handler	2014		3,380	225	15	225		469	28
29	Doors	2014		9,500	950	10	950		1,821	29
30	Quarry Tile - Kitchen	2015		14,986	749	20	749		1,311	30
31	Maple Solid Core Doors	2015		9,540	636	15	636		1,060	31
32	Wood Blinds	2015		6,587	1,317	5	1,317		1,756	32
33	Garage Siding and Garage Door	2015		2,706	271	10	271		361	33
34	Water Heater	2015		3,842	384	10	384		448	34
35	Water Softener	2015		3,472	289	10	289		289	35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Shelbyville Manor

# 0047878

Report Period Beginning:

10/1/15

Ending:

9/30/16

XI. OWNERSHIP COSTS (continued)

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

1	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	2016	82,774	4,599	12	4,599		4,599	38	
39	2016	5,682	332	5	332		332	39	
40								40	
41								41	
42								42	
43								43	
44								44	
45								45	
46								46	
47								47	
48								48	
49								49	
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51								51	
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53								53	
54								54	
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56								56	
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58								58	
59								59	
60								60	
61								61	
62								62	
63								63	
64								64	
65								65	
66								66	
67								67	
68								68	
69								69	
70	TOTAL (lines 4 thru 69)		\$ 6,640,337	\$ 63,992		\$ 254,476	\$ 190,484	\$ 1,982,078	70

SEE ACCOUNTANTS' PREPARATION REPORT

\*\*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	\$ 730,626	\$ 42,731	\$ 51,225	\$ 8,494	3-15 yrs	\$ 527,881	71
72	Current Year Purchases	36,888	4,795	4,795		5-10 Yrs	4,795	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 767,514	\$ 47,526	\$ 56,020	\$ 8,494		\$ 532,676	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2012 Ford E350 Bus	2012	\$ 43,627	\$ 10,907	\$ 10,907	\$	4	\$ 41,811	76
77										77
78										78
79										79
80	TOTALS			\$ 43,627	\$ 10,907	\$ 10,907	\$		\$ 41,811	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)	\$ 7,646,978	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 122,425	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 321,403	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 198,978	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,556,565	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	2006 Toyota Corolla - 2006	\$ 14,900	\$	\$ 14,900	86
87	2003 GMC G3500 Van - 2006	29,848		29,848	87
88	Carpet/Vinyl Tile ALC - 2016	11,883	1,478	1,478	88
89					89
90					90
91	TOTALS	\$ 56,631	\$ 1,478	\$ 46,226	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			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.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

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: \$ 3,022 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	<u>N/A</u>				18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

**Facility Name:** Shelbyville Manor  
**IDPH License ID Number:** 0047878  
**Fiscal Year End:** 9/30/16

**Schedule 14A**

**XIV. Rental Costs**

**Line 16 Rental Amount for Moveable Equipment**

<b>Rental Description</b>	<b>Amount</b>
Medical Equipment Rental	1,865
Office Equipment	832
Other Equipment Rental	325
<b>Total - Line 16</b>	<b>3,022</b>

**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> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</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			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<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.
- SEE ACCOUNTANTS' PREPARATION 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	10A(3)	hrs	\$	793	\$ 340,597	\$	793	\$ 340,597	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		320	134,149		320	134,149	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		952	358,536		952	358,536	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				134,395		134,395	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	10A(3)			419	23,629		419	23,629	12
13	Other (specify): _____									13
14	<b>TOTAL</b>			\$	2,484	\$ 856,911	\$ 134,395	2,484	\$ 991,306	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	\$ 39,513	\$ 104,393	1
2	Cash-Patient Deposits	9,781	9,781	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>282,000</u> )	1,259,684	1,265,810	3
4	Supply Inventory (priced at _____ )			4
5	Short-Term Investments			5
6	Prepaid Insurance	96,535	119,964	6
7	Other Prepaid Expenses	5,248	5,248	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interdivision Receivable</u>	2,461,153	541,310	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,871,914	\$ 2,046,506	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		195,500	13
14	Buildings, at Historical Cost	805,849	6,640,337	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	606,739	811,141	16
17	Accumulated Depreciation (book methods)	(676,091)	(2,556,565)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>See Att Sch 17A</u> )		780,576	22
23	Other(specify): <u>See Att Sch 17A</u>		554,728	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 736,497	\$ 6,425,717	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,608,411	\$ 8,472,223	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 101,097	\$ 110,684	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,781	9,781	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	73,903	73,903	30
31	Accrued Taxes Payable (excluding real estate taxes)	61,160	61,160	31
32	Accrued Real Estate Taxes(Sch.IX-B)	234	79,578	32
33	Accrued Interest Payable		13,584	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 246,175	\$ 348,690	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,591,912	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Security Deposits</u>	39,000	39,000	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 39,000	\$ 4,630,912	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 285,175	\$ 4,979,602	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 4,323,236	\$ 3,492,621	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,608,411	\$ 8,472,223	48

SEE ACCOUNTANTS' PREPARATION REPORT

\*(See instructions.)

Shelbyville Manor

Period 10/1/15

Period 9/30/16

Schedule 17A

XV. Balance Sheet

Line 22 Other Long Term Assets

	After <u>Operating Consolidation</u>
Land-Assisted Living	34,500
Building-Assisted Living	896,167
Reserve for Depr-Building-Assisted Living	(238,978)
Physical Therapy Addition-Assisted Living	134,542
Reserve for Depr-Physical Therapy Addition-Assisted Living	(56,060)
Leasehold Improvements-Assisted Living	11,883
Reserve for Depr-Leasehold Improvements-Assisted Living	(1,478)
2006 Toyota Corolla - 2006	14,900
Reserve for Depr-2006 Toyota Corolla - 2006	(14,900)
2003 GMC G3500 Van - 2006	29,848
Reserve for Depr-2003 GMC G3500 Van - 2006	(29,848)
<b>TOTAL</b>	<b><u><u>780,576</u></u></b>

XV. Balance Sheet

Line 23 Other

	After <u>Operating Consolidation</u>
Replacement Reserve	267,231
Loan Fees, Net	254,087
Real Estate Tax Escrow	25,050
Insurance Escrow	3,948
MIP Escrow	4,412
<b>TOTAL</b>	<b><u><u>554,728</u></u></b>

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b>	
		<b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>4,455,525</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<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>	\$ <b>4,455,525</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(132,289)	<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>	\$ (132,289)	<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>	\$ <b>4,323,236</b>	<b>24</b> *

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

SEE ACCOUNTANTS' PREPARATION REPORT

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,457,472	1
2	Discounts and Allowances for all Levels	(46,646)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,410,826	3
<b>B. Ancillary Revenue</b>			
4	Day Care	2,285	4
5	Other Care for Outpatients		5
6	Therapy	289,390	6
7	Oxygen	1,815	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 293,490	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	866	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	573	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	(1,730)	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	17,870	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 17,579	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	660	24
25	Interest and Other Investment Income***	11	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 671	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Transportation Income</u>	65	28
28a	<u>Late Fees/Processing Fees</u>	3,276	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 3,341	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,725,907	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,155,354	31
32	Health Care	3,221,311	32
33	General Administration	1,209,825	33
<b>B. Capital Expense</b>			
34	Ownership	618,613	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	461,740	35
36	Provider Participation Fee	191,353	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,858,196	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(132,289)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (132,289)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 2,301,005	44
45	Private Pay - Net Inpatient Revenue	1,475,792	45
46	Medicare - Net Inpatient Revenue	2,323,196	46
47	Other-(specify) <u>Medicare Replacement/Managed Care</u>	225,483	47
48	Other-(specify) <u>Hospice</u>	85,350	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 6,410,826	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Shelbyville Manor

# 0047878

Report Period Beginning:

10/1/15

Ending:

9/30/16

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,004	2,218	\$ 73,637	\$ 33.20	1
2	Assistant Director of Nursing	408	408	14,371	35.22	2
3	Registered Nurses	12,831	13,519	318,962	23.59	3
4	Licensed Practical Nurses	19,797	20,877	410,745	19.67	4
5	CNAs & Orderlies	101,748	107,441	1,225,023	11.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13	13	152	11.69	8
9	Activity Director					9
10	Activity Assistants	6,653	7,124	70,343	9.87	10
11	Social Service Workers	2,095	2,219	28,037	12.64	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,312	26,344	251,267	9.54	15
16	Dishwashers					16
17	Maintenance Workers	3,826	4,101	62,423	15.22	17
18	Housekeepers	15,075	16,210	162,939	10.05	18
19	Laundry	7,237	7,733	67,692	8.75	19
20	Administrator	1,948	2,080	99,877	48.02	20
21	Assistant Administrator					21
22	Other Administrative	1,984	2,080	46,783	22.49	22
23	Office Manager					23
24	Clerical	6,796	7,095	103,874	14.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,824	2,080	42,080	20.23	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,728	1,812	20,476	11.30	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	211,279	223,352	\$ 2,998,681 *	\$ 13.43	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	Monthly	\$ 8,667	L1, C3	35
36	Medical Director	Monthly	18,000	L9, C3	36
37	Medical Records Consultant	Monthly	2,000	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,820	L10, C3	39
40	Physical Therapy Consultant	Monthly	113	L10A, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 34,600		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' PREPARATION REPORT





FACILITY NAME: Shelbyville Manor  
 ID#: 0047878

BEGINNING: 10/1/15  
 ENDING: 9/30/16

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

Attached Schedule 22A

**SUMMARY SCHEDULE**

**Sch. V of Allocation of Assisted Living Facility Costs**

Line #		Basis of Allocation	Salaries	Supplies	Other	Total
1	Dietary	Census	49,874	4,671		54,545
2	Food Purchase	Census		59,079		59,079
3	Housekeeping	Rooms	24,735	4,553		29,288
4	Laundry	Rooms	10,276	2,131		12,407
5	Heat and Other Utilities				24,282	24,282
6	Maintenance	Rooms	9,476	4,738	6,166	20,380
7	Other (specify):*					-
9	Medical Director					-
10	Nursing and Medical Records	100% of RSD/Personal Care	246,454			246,454
10a	Therapy					-
11	Activities	25%		495		495
12	Social Services					-
13	CNA Training					-
14	Program Transportation	Rooms			332	332
15	Other (specify):*					-
17	Administrative					-
18	Directors Fees					-
19	Professional Services					-
20	Dues, Fees, Subscriptions & Promotions	Rooms			715	715
21	Clerical & General Office Expenses	Rooms			2,533	2,533
22	Employee Benefits & Payroll Taxes	% of AL Wages			57,582	57,582
23	Inservice Training & Education					-
24	Travel and Seminar					-
25	Other Admin. Staff Transportation					-
26	Insurance-Prop.Liab.Malpractice	Rooms			7,291	7,291
27	Other (specify):*					-
30	Depreciation	Direct			33,626	33,626
31	Amortization of Pre-Op. & Org.					-
32	Interest	15%			24,752	24,752
33	Real Estate Taxes	15%			15,733	15,733
34	Rent-Facility & Grounds					-
35	Rent-Equipment & Vehicles					-
36	Other (specify):*					-
38	Medically Necessary Transportation					-
39	Ancillary Service Centers					-
40	Barber and Beauty Shops					-
41	Coffee and Gift Shops					-
42	Provider Participation Fee					-
43	Other (specify):*					-

**TOTALS** 340,815 75,667 173,012 589,494

Net adjustment required 589,494

SEE ACCOUNTANTS' COMPILATION REPORT