

Facility Name & ID Number Shelbyville Manor

0047878 Report Period Beginning: 10/1/2017 Ending: 9/30/2018

III. STATISTICAL DATA

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

	1	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	39,785	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	109	TOTALS	109	39,785	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	15,673	4,855	4,608	25,136	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,673	4,855	4,608	25,136	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.18%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO 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 4,071

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Shelbyville Manor # 0047878 Report Period Beginning: 10/1/2017 Ending: 9/30/2018

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	305,284	36,938	10,509	352,731		352,731	(78,605)	274,126		1
2	Food Purchase		302,690		302,690		302,690	(69,874)	232,816		2
3	Housekeeping	171,063	38,390	400	209,853		209,853	(31,795)	178,058		3
4	Laundry	56,774	13,109	144	70,027		70,027	(10,608)	59,419		4
5	Heat and Other Utilities			171,114	171,114		171,114	(25,732)	145,382		5
6	Maintenance	63,076	23,559	63,353	149,988		149,988	(22,748)	127,240		6
7	Other (specify):*										7
8	TOTAL General Services	596,197	414,686	245,520	1,256,403		1,256,403	(239,362)	1,017,041		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	2,337,975	151,686	10,564	2,500,225		2,500,225	(280,232)	2,219,993		10
10a	Therapy										10a
11	Activities	87,442	3,124		90,566		90,566	(781)	89,785		11
12	Social Services	29,299			29,299		29,299		29,299		12
13	CNA Training										13
14	Program Transportation			7,501	7,501		7,501	(670)	6,831		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,454,716	154,810	36,065	2,645,591		2,645,591	(281,683)	2,363,908		16
	C. General Administration										
17	Administrative	83,586			83,586		83,586		83,586		17
18	Directors Fees							2,361	2,361		18
19	Professional Services			367,588	367,588		367,588	3,002	370,590		19
20	Dues, Fees, Subscriptions & Promotions			32,485	32,485		32,485	(8,025)	24,460		20
21	Clerical & General Office Expenses	131,226	22,436	58,357	212,019		212,019	(2,616)	209,403		21
22	Employee Benefits & Payroll Taxes			494,688	494,688		494,688	(58,981)	435,707		22
23	Inservice Training & Education			8,828	8,828		8,828		8,828		23
24	Travel and Seminar			611	611		611		611		24
25	Other Admin. Staff Transportation			7,503	7,503		7,503		7,503		25
26	Insurance-Prop.Liab.Malpractice			40,512	40,512		40,512	3,749	44,261		26
27	Other (specify):*										27
28	TOTAL General Administration	214,812	22,436	1,010,572	1,247,820		1,247,820	(60,510)	1,187,310		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,265,725	591,932	1,292,157	5,149,814		5,149,814	(581,555)	4,568,259		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:

10/1/2017

Ending:

9/30/2018

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	
	D. Ownership											
30	Depreciation			107,406	107,406		107,406	188,766	296,172			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							134,938	134,938			32
33	Real Estate Taxes							88,427	88,427			33
34	Rent-Facility & Grounds			491,688	491,688		491,688	(491,688)				34
35	Rent-Equipment & Vehicles			10,428	10,428		10,428		10,428			35
36	Other (specify):* Mortg Insurance							21,920	21,920			36
37	TOTAL Ownership			609,522	609,522		609,522	(57,637)	551,885			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		139,500	749,441	888,941		888,941		888,941			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			477	477		477		477			41
42	Provider Participation Fee			185,125	185,125		185,125		185,125			42
43	Other (specify):* See Att Sch 4A	41,851		254,618	296,469		296,469	(272,030)	24,439			43
44	TOTAL Special Cost Centers	41,851	139,500	1,189,661	1,371,012		1,371,012	(272,030)	1,098,982			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,307,576	731,432	3,091,340	7,130,348		7,130,348	(911,222)	6,219,126			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 10/1/2017
 Period End 9/30/2018

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	Ancillary Expense										
	E. Special Cost Centers										
43	Other (specify):*				0		0	0			
	Laboratory/Expenses			18,086	18,086		18,086	18,086			
	Radiology Expenses			6,353	6,353		6,353	6,353			
	Non-Allowable Expenses	41,851		230,179	272,030		272,030	(272,030)	0		
					0		0	0			
					0		0	0			
	TOTAL Other Special Cost Centers	41,851	0	254,618	296,469	0	296,469	(272,030)	24,439		

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	(465)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,852)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(12,893)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,165)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(180,637)	43		24
25	Fund Raising, Advertising and Promotional	(43,690)	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	(736,909)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (983,611)		\$	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)	72,389		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 72,389		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (911,222)		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	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' PREPARATION REPORT

Shelbyville Manor

ID# 0047878

Report Period Beginning: 10/1/2017

Ending: 9/30/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallow Marketing Wages	(41,851)	43	1
2	Disallow R/E Entity HUD Audit	(26,060)	19	2
3	Disallow AL Expenses-Dietary	(78,605)	1	3
4	Disallow AL Expenses-Food	(69,409)	2	4
5	Disallow AL Expenses-Housekeeping	(31,795)	3	5
6	Disallow AL Expenses-Laundry	(10,608)	4	6
7	Disallow AL Expenses-Utilities	(25,732)	5	7
8	Disallow AL Expenses-Maintenance	(22,767)	6	8
9	Disallow AL Expenses-Nursing	(280,232)	10	9
10	Disallow AL Expenses-Activities	(781)	11	10
11	Disallow AL Expenses-Program Transportation	(670)	14	11
12	Disallow AL Expenses-Licenses & Fees	(4,946)	20	12
13	Disallow AL Expenses-Telephone	(2,685)	21	13
14	Disallow AL Expenses-Employee Benefits	(59,005)	22	14
15	Disallow AL Expenses-Insurance	(7,394)	26	15
16	Disallow AL Expenses-Depreciation Expense	(35,346)	30	16
17	Disallow AL Expenses-Interest Expense	(23,400)	32	17
18	Disallow AL Expenses-Real Estate Tax Expense	(15,623)	33	18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(736,909)		49

Facility Name & ID Number Shelbyville Manor

0047878

Report Period Beginning: 10/1/2017 Ending: 9/30/2018

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	6 Maintenance	\$	Unlimited Development, Inc.	100.00%	\$ 19	\$ 19	1	
2	V	18 Director Fees		Unlimited Development, Inc.	100.00%	2,361	2,361	2	
3	V	19 Professional Fees		Unlimited Development, Inc.	100.00%	3,002	3,002	3	
4	V	20 Dues, Licenses and Subs		Unlimited Development, Inc.	100.00%	11	11	4	
5	V	21 General Admin Expense		Unlimited Development, Inc.	100.00%	69	69	5	
6	V	22 Employee Benefits		Unlimited Development, Inc.	100.00%	24	24	6	
7	V	26 Property Insurance		Unlimited Development, Inc.	100.00%	45	45	7	
8	V							8	
9	V							9	
10	V							10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$			\$ 5,531	\$ *	5,531	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	\$ 26,060	\$	26,060	15
16	V	20 Dues, Fees, Subs & Prom		Shelbyville Route 128, LLC	N/A	75		75	16
17	V	26 Property Insurance		Shelbyville Route 128, LLC	N/A	11,098		11,098	17
18	V	30 Depreciation		Shelbyville Route 128, LLC	N/A	224,112		224,112	18
19	V	32 Interest Expense	264	Shelbyville Route 128, LLC	N/A	156,001		155,737	19
20	V	32 Loan Fee Amortization		Shelbyville Route 128, LLC	N/A	15,494		15,494	20
21	V	33 Property Taxes		Shelbyville Route 128, LLC	N/A	104,050		104,050	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	21,920		21,920	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 491,952			\$ 558,810	\$ *	66,858	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Shelbyville Manor

0047878

Report Period Beginning:

10/1/2017

Ending:

9/30/2018

VII. RELATED PARTIES

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

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

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VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Community Living Options, Inc.	100%	Tanner Place	Paris				1
2	Community Living Options, Inc.	100%	Taylor House	Springfield				2
3	Community Living Options, Inc.	100%	Thelma Terrace	Wood River				3
4	Community Living Options, Inc.	100%	Trulson House	Galesburg				4
5	Community Living Options, Inc.	100%	Vahle Terrace	Jerseyville				5
6	Community Living Options, Inc.	100%	Walsh Terrace	Galesburg				6
7	Community Living Options, Inc.	100%	Wetherell Place	Effingham				7
8	Community Living Options, Inc.	100%	Woodriver Group Homes:					8
9	Community Living Options, Inc.	100%	Aberdeen Terrace	Alton				9
10	Community Living Options, Inc.	100%	Linton Terrace	Wood River				10
11	Community Living Options, Inc.	100%	Madison Terrace	Wood River				11
12	Community Living Options, Inc.	100%	Pershing Terrace	Wood River				12
13	Community Living Options, Inc.	100%			Audrey Court	Clinton	CILA	13
14	Unlimited Development, Inc. (UDI)	100%	Parkway Manor	Marion				14
15	Unlimited Development, Inc. (UDI)	100%			Parkway Estates	Marion	Retirement living ce	15
16	Unlimited Development, Inc. (UDI)	100%	Maryville Manor	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

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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	Unlimited Development, Inc. (UDI)	100%			The Kensington	Galesburg	Supportive Living	15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Shelbyville Manor # 0047878 Report Period Beginning: 10/1/2017 Ending: 9/30/2018

VII. RELATED PARTIES (continued)

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

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

	1 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								\$ 2,361	L18, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,361		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:

10/1/2017

Ending: 1/30/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Unlimited Development, Inc.
 Street Address 285 S Farnham
 City / State / Zip Code Galesburg, IL 61401
 Phone Number (309) 343-1550
 Fax Number (309) 343-2857

1	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	6	Maintenance	Weighted Avail Bed Days	505,933	21	\$ 240	\$ 39,785	\$ 19	1
2	18	Director Fees	Weighted Avail Bed Days	505,933	21	\$ 30,020	\$ 39,785	2,361	2
3	19	Professional Fees	Weighted Avail Bed Days	505,933	21	38,188	39,785	3,002	3
4	20	Dues, Licenses and Subs	Weighted Avail Bed Days	505,933	21	144	39,785	11	4
5	21	General Admin Expense	Weighted Avail Bed Days	505,933	21	873	39,785	69	5
6	22	Employee Benefits	Weighted Avail Bed Days	505,933	21	300	39,785	24	6
7	26	Property Insurance	Weighted Avail Bed Days	505,933	21	568	39,785	45	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 70,333	\$	\$ 5,531	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Shelbyville Manor

0047878

Report Period Beginning:

10/1/2017

Ending:

9/30/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Cambridge Realty Capital						\$	\$			\$	1						
2	LTD. of Illinois		X	Facility purchase	\$20,381.00	6/1/2012	4,313,155	3,683,733	4/1/2040	3.5500	132,601	2						
3				SNF portion								3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8										Miscellaneous Interest		8						
9	TOTAL Facility Related				\$20,381.00		\$ 4,313,155	\$ 3,683,733			\$ 132,601	9						
B. Non-Facility Related*																		
10	Cambridge Realty Capital									Amortization Exp	15,494	10						
11	LTD. of Illinois		X	Facility purchase	\$3,597.00	6/1/2012	761,145	650,070	4/1/2040	3.5500	23,400	11						
12				AL portion						Disallow AL Int Exp	(23,400)	12						
13										Int Income Offset	(13,157)	13						
14	TOTAL Non-Facility Related				\$3,597.00		\$ 761,145	\$ 650,070			\$ 2,337	14						
15	TOTALS (line 9+line14)						\$ 5,074,300	\$ 4,333,803			\$ 134,938	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 21,920 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 2017 report.		\$	80,058	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2017	\$	104,159	2
3. Under or (over) accrual (line 2 minus line 1).		\$	24,101	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	79,949	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			(15,623)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	88,427	7

Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2013	106,531	8	
	2014	103,372	9	
	2015	104,883	10	
	2016	105,370	11	
	2017	104,159	12	

FOR BHF USE ONLY				
13	FROM R. E. TAX STATEMENT FOR 2017	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

This facility was purchased from an unrelated for-profit entity during 2006. A tax exemption has not yet been obtained. Amount accrued includes the taxes for 9 months based on fiscal year end. Estimate is based on prior year tax bill. Real estate taxes reported on Sch V line 33 have been reduced by an allocation of expenses relating to ALC services based on as estimated 15%. See Att Sch 22A. Taxes paid during year represents the entire 2017 bill.

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

(A)	(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>104,159.48</u>	\$ <u>88,535.56</u>
2. _____	<u>SW COR SW SW 550' X 520' & 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. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>104,159.48</u></u>	\$ <u><u>88,535.56</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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Shelbyville Manor

0047878

Report Period Beginning:

10/1/2017 Ending:

9/30/2018

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

Facility Name & ID Number Shelbyville Manor

0047878

Report Period Beginning:

10/1/2017

Ending:

9/30/2018

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

	1	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	\$ 126,962	\$ 126,962	\$ 1,608,101	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Dry Pipe Valve and Water Softner	2006		11,205	181	10-20 yrs	181		9,769	9
10		Ceramic Tile Repair, Carpet, Ceramic Tile	2007		11,750	444	5-20 yrs	444		7,915	10
11		Roof Repair	2008		84,157	2,804	10	2,804		84,157	11
12		Air Handler, Water Heater, Fire Protection System	2009		21,450	2,145	10	2,145		20,213	12
13		Water Heater	2010		10,671	1,067	10	1,067		8,803	13
14		Fire Sprinkler, Oil/Chip Parking Lot	2011		123,200	5,285	8-25 yrs	5,285		39,375	14
15		Physical Therapy Addition (Contracted Total)	2011		762,407		12	63,534	63,534	444,743	15
16		Hallway Rmdl-Vinyl tile/Base/Drywall/Handrails/Wall & Crnr Grds/AC	2011		56,356	4,697	12	4,697		32,873	16
17		Shower Rmdl-Exhaust fan/Fire access dr/Flr-tile/wiring/fxts/drains	2012		130,718	10,893	12	10,893		73,528	17
18		Laundry/Hallway Rmdl-Handrails/Guardrails/Vinyl Tile/Drywall/Paint	2012		138,186	11,514	12	11,514		74,852	18
19		Faux Wood Blinds - 14	2012		5,256	1	5	1		5,256	19
20		Fire Alarm System and Components	2012		8,555	855	10	855		5,063	20
21		Faux Wood Blinds	2012		5,108	84	5	84		5,108	21
22		Crown Light Boxes	2012		7,764	258	5	258		7,764	22
23		Faux Wood Blinds - 28	2013		4,883	654	5	654		4,883	23
24		Water Heater	2013		8,780	878	10	878		4,390	24
25		Doors	2014		16,820	1,682	10	1,682		7,569	25
26		Storage Building/Garage	2014		2,700	180	15	180		780	26
27		Sprinkler Pipe	2014		9,620	641	15	641		2,778	27
28		Condensor/Air Handler	2014		3,380	225	15	225		919	28
29		Doors	2014		9,500	950	10	950		3,721	29
30		Quarry Tile - Kitchen	2015		14,986	749	20	749		2,809	30
31		Maple Solid Core Doors	2015		9,540	636	15	636		2,332	31
32		Wood Blinds	2015		6,587	1,317	5	1,317		4,390	32
33		Garage Siding and Garage Door	2015		2,706	270	10	270		902	33
34		Water Heater	2015		3,842	384	10	384		1,216	34
35		Water Softener	2015		3,472	347	10	347		983	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

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	2016	82,774	6,898	12	6,898	\$	\$ 18,395	37
38	2016	5,682	1,136	5	1,136		2,604	38
39	2017	3,100	310	10	310		465	39
40	2017	8,467	847	10	847		1,200	40
41	2017	4,408	441	10	441		514	41
42	2018	19,832	992	10	992		992	42
43	2018	4,532	302	5	302		302	43
44	2018	4,250	24	15	24		24	44
45	2017	3,390	622	5	622		622	45
46	2018	5,702	521	5	521		521	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		\$ 6,694,018	\$ 61,234		\$ 251,730	\$ 190,496	\$ 2,490,831	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	\$ 781,202	\$ 44,395	\$ 44,395	\$	3-15 yrs	\$ 624,962	71
72	Current Year Purchases	3,975	47	47		7 yrs	47	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 785,177	\$ 44,442	\$ 44,442	\$		\$ 625,009	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	\$	\$	\$	4	\$ 43,627	76
77										77
78										78
79										79
80	TOTALS			\$ 43,627	\$	\$	\$		\$ 43,627	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,718,322	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 105,676	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 296,172	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 190,496	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,159,467	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	2006 Toyota Corolla - 2006	\$ 14,900	\$	\$ 14,900	86
87	2003 GMC G3500 Van - 2006	29,848		29,848	87
88	Carpet/Vinyl Tile ALC - 2016	11,883	1,730	4,938	88
89					89
90					90
91	TOTALS	\$ 56,631	\$ 1,730	\$ 49,686	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.

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

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: \$ 10,428 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	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: Shelbyville Manor
IDPH License ID Number: 0047878
Fiscal Year End: 9/30/2018

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment Rental	9,418
Office Equipment	
Other Equipment Rental	1,010
Total - Line 16	<u>10,428</u>

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' PREPARATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	39(3)	hrs	\$	6,101	\$ 280,869	\$	6,101	\$	280,869						1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,127	93,735		2,127		93,735						2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39(3)	hrs		7,692	351,020		7,692		351,020						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							139,500					139,500	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): <u>Respiratory Therapy</u>	39(3)			2,491	23,817		2,491		23,817			2,491		23,817	12
13	Other (specify):															13
14	TOTAL			\$	18,411	\$ 749,441	\$	18,411	\$	888,941			18,411	\$	888,941	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*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 51,075	\$ 77,758	1
2	Cash-Patient Deposits	9,158	9,158	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>63,000</u>)	887,009	893,135	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	80,217	96,273	6
7	Other Prepaid Expenses	3,258	11,154	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interdivision Receivable</u>	2,903,165	1,030,320	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,933,882	\$ 2,117,798	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		195,500	13
14	Buildings, at Historical Cost	850,438	6,694,018	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	633,493	828,804	16
17	Accumulated Depreciation (book methods)	(901,472)	(3,159,467)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe See Sch 17A)		709,864	22
23	Other(specify): <u>See Sch 17A</u>		609,705	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 582,459	\$ 5,878,424	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,516,341	\$ 7,996,222	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 90,964	\$ 102,964	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,158	9,158	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	77,581	77,581	30
31	Accrued Taxes Payable (excluding real estate taxes)	53,174	53,174	31
32	Accrued Real Estate Taxes(Sch.IX-B)	234	79,949	32
33	Accrued Interest Payable		12,821	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 231,111	\$ 335,647	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,333,803	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Security Deposits</u>	37,500	37,500	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 37,500	\$ 4,371,303	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 268,611	\$ 4,706,950	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,247,730	\$ 3,289,272	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,516,341	\$ 7,996,222	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Shelbyville Manor

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

Schedule 17A

XV. Balance Sheet

Line 22 Other Long Term Assets

	Operating	After Consolidation
Land-Assisted Living		34,500
Building-Assisted Living		896,167
Reserve for Depr-Building-Assisted Living		(283,804)
Physical Therapy Addition-Assisted Living		134,542
Reserve for Depr-Physical Therapy Addition-Assisted Living		(78,486)
Leasehold Improvements-Assisted Living		11,883
Reserve for Depr-Leasehold Improvements-Assisted Living		(4,938)
2006 Toyota Corolla - 2006		14,900
Reserve for Depr-2006 Toyota Corolla - 2006		(14,900)
2003 GMC G3500 Van - 2006		29,848
Reserve for Depr-2003 GMC G3500 Van - 2006		(29,848)
TOTAL		709,864

Line 23 Other

	Operating	After Consolidation
Replacement Reserve		351,125
Loan Fees, Net		223,085
Real Estate Tax Escrow		19,151
Insurance Escrow		7,779
MIP Escrow		8,565
TOTAL		609,705

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,598,872	1
2	Restatements (describe):		2
3	Prior Year Post Closing Adjustment	(6,900)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,591,972	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(344,242)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (344,242)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,247,730	24 *

* 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

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,496,223	1
2	Discounts and Allowances for all Levels	(34,822)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,461,401	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	267,806	6
7	Oxygen	7,875	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 275,681	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,535	13
14	Non-Patient Meals	465	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,742	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	28,138	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 32,880	23
D. Non-Operating Revenue			
24	Contributions	1,160	24
25	Interest and Other Investment Income***	12,820	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13,980	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	2,164	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,164	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,786,106	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,256,403	31
32	Health Care	2,645,591	32
33	General Administration	1,247,820	33
B. Capital Expense			
34	Ownership	609,522	34
C. Ancillary Expense			
35	Special Cost Centers	1,185,887	35
36	Provider Participation Fee	185,125	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,130,348	40
41	Income before Income Taxes (line 30 minus line 40)**	(344,242)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (344,242)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,311,303	44
45	Private Pay - Net Inpatient Revenue	1,857,688	45
46	Medicare - Net Inpatient Revenue	2,121,682	46
47	Other-(specify) <u>Medicare Replacement/Managed Care</u>	139,736	47
48	Other-(specify) <u>Hospice</u>	30,992	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,461,401	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: Shelbyville Manor
IDPH License ID Number: 0047878
Fiscal Year End: 9/30/2018

Schedule 19A

XVII. Income Statement
Line 28a Other Income

Rental Description	Amount
Late Fees	73
Processing Fee	901
AJ's Fitness Center	1,190
Total - Line 16	2,164

Facility Name & ID Number Shelbyville Manor

0047878

Report Period Beginning: 10/1/2017

Ending: 9/30/2018

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,086	2,086	87,462	\$ 41.93	1
2	Assistant Director of Nursing	1,622	1,794	49,015	27.32	2
3	Registered Nurses	18,131	19,605	515,897	26.31	3
4	Licensed Practical Nurses	13,372	14,239	323,061	22.69	4
5	CNAs & Orderlies	96,480	102,055	1,305,517	12.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,544	8,030	87,442	10.89	10
11	Social Service Workers	1,957	2,085	29,299	14.06	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,577	30,564	305,284	9.99	15
16	Dishwashers					16
17	Maintenance Workers	3,806	4,079	63,076	15.46	17
18	Housekeepers	16,368	17,249	171,063	9.92	18
19	Laundry	5,699	6,136	56,774	9.25	19
20	Administrator	1,650	1,942	83,586	43.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,004	9,502	131,226	13.81	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,440	1,681	35,374	21.05	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,934	2,098	21,649	10.32	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	1,960	2,111	41,851	19.83	33
34	TOTAL (lines 1 - 33)	212,630	225,254	\$ 3,307,576 *	\$ 14.68	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	\$ 10,509	L1, C3	35
36	Medical Director	Monthly	18,000	L9, C3	36
37	Medical Records Consultant	Monthly	2,000	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,666	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 37,175		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' PREPARATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Karen Dailey</u>	<u>Administrator</u>	<u>None</u>	\$ <u>83,586</u>	<u>Workers' Compensation Insurance</u>	\$ <u>23,343</u>	<u>IDPH License Fee</u>	\$ <u>2,058</u>	
				<u>Unemployment Compensation Insurance</u>	<u>7,493</u>	<u>Advertising: Employee Recruitment</u>	<u>12,179</u>	
				<u>FICA Taxes</u>	<u>245,800</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>190,214</u>	<u>(Indicate # of checks performed <u>107</u>)</u>	<u>2,694</u>	
				<u>Employee Meals</u>		<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Subscriptions</u>	<u>3,216</u>	
				<u>401k</u>	<u>17,713</u>	<u>IHCA Dues</u>	<u>7,531</u>	
				<u>Other Employee Benefits</u>	<u>10,125</u>	<u>Other Licenses & Fees</u>	<u>4,882</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>83,586</u>	<u>Less: AL Allocated Expenses</u>	<u>(59,005)</u>	<u>Less: Disallow AL License Fees</u>	<u>(4,946)</u>	
(List each licensed administrator separately.)				<u>Indirect costs</u>	<u>24</u>	<u>Indirect costs</u>	<u>11</u>	
						<u>Less: Public Relations Expense</u>	<u>(3,165)</u>	
						<u>Non-allowable advertising</u>	<u>()</u>	
						<u>Yellow page advertising</u>	<u>()</u>	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ <u>435,707</u>	TOTAL (agree to Sch. V, line 20, col. 8)	\$ <u>24,460</u>	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>N/A</u>			\$	<u>N/A</u>		\$	<u>Out-of-State Travel</u>	\$
							<u>In-State Travel</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$				<u>Seminar Expense</u>	<u>611</u>
(Attach a copy of any management service agreement)								
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type		Amount			\$	<u>()</u>	
<u>LTC Support Services, LLC</u>	<u>Support Services</u>		\$ <u>172,440</u>				TOTAL (agree to Sch. V, line 24, col. 8)	\$ <u>611</u>
<u>RFMS, Inc.</u>	<u>Administrative Services</u>		<u>171,600</u>					
<u>Templin Healthcare Accounting</u>	<u>Accounting Services</u>		<u>3,226</u>					
<u>RSM US LLP</u>	<u>Accounting Services</u>		<u>19,903</u>					
<u>Bolen Robinson & Ellis</u>	<u>Legal Services</u>		<u>419</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>367,588</u>					
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name & ID Number Shelbyville Manor# 0047878Report Period Beginning: 10/1/2017Ending: 9/30/2018**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 7,531 IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 56,195 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 185,125
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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 465
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% line 14
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: RSM US LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' PREPARATION REPORT

FACILITY NAME: Shelbyville Manor
 ID#: 0047878

BEGINNING: 10/1/2017
 ENDING: 9/30/2018

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

Attached Schedule 22A

SUMMARY SCHEDULE of Allocation of Assisted Living Facility Costs						
Sch. V Line #		Basis of Allocation	Salaries	Supplies	Other	Total
1	Dietary	Census	70,121	8,484		78,605
2	Food Purchase	Census		69,409		69,409
3	Housekeeping	Rooms	25,968	5,827		31,795
4	Laundry	Rooms	8,618	1,990		10,608
5	Heat and Other Utilities				25,732	25,732
6	Maintenance	Rooms	9,575	3,576	9,616	22,767
7	Other (specify):*					-
9	Medical Director					-
10	Nursing and Medical Records	100% of RSD/Personal Care	280,232			280,232
10a	Therapy					-
11	Activities	25%		781		781
12	Social Services					-
13	CNA Training					-
14	Program Transportation	Rooms			670	670
15	Other (specify):*					-
17	Administrative					-
18	Directors Fees					-
19	Professional Services					-
20	Dues, Fees, Subscriptions & Promotions	Rooms			1,042	1,042
21	Clerical & General Office Expenses	Rooms			2,685	2,685
22	Employee Benefits & Payroll Taxes	% of AL Wages			59,005	59,005
23	Inservice Training & Education					-
24	Travel and Seminar					-
25	Other Admin. Staff Transportation					-
26	Insurance-Prop.Liab.Malpractice	Rooms			7,394	7,394
27	Other (specify):*					-
30	Depreciation	Direct				-
31	Amortization of Pre-Op. & Org.					-
32	Interest	15%				-
33	Real Estate Taxes	15%				-
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			394,514	90,067	106,144	590,725