

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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.

I. IDPH License ID Number: <u>0047969</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Pekin Manor</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/2019</u> to <u>9/30/2020</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>1520 El Camino Drive</u> <u>Pekin</u> <u>61554</u>																									
Number City Zip Code																									
County: <u>Tazewell</u>																									
Telephone Number: <u>(309) 353-1099</u> Fax # <u>(309) 353-1363</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Sherri Miller</u></td></tr><tr><td>(Title) <u>LTC CEO</u></td></tr><tr><td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Larry Templin Partner</u></td></tr><tr><td>(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 326, Plainfield, IL 60544-0326</u></td></tr><tr><td>(Telephone) <u>(630) 361-2868</u> Fax # ()</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Sherri Miller</u>	(Title) <u>LTC CEO</u>	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	Paid Preparer	(Date) _____	(Print Name and Title) <u>Larry Templin Partner</u>	(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 326, Plainfield, IL 60544-0326</u>	(Telephone) <u>(630) 361-2868</u> Fax # ()												
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	(Telephone) <u>(630) 361-2868</u> Fax # ()																								
Date of Initial License for Current Owners: <u>4/26/06</u>																									
Type of Ownership:																									
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>501 (c) (3)</u></td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code <u>501 (c) (3)</u>	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust			☐ Other _____	
☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL																							
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☐ Trust	☐ Partnership	☐ County																							
IRS Exemption Code <u>501 (c) (3)</u>	☐ Corporation	☐ Other _____																							
	☐ "Sub-S" Corp.	_____																							
	☐ Limited Liability Co.	_____																							
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>Ron Wilson</u> Telephone Number: <u>(309) 343-1550</u>																									
Email Address: _____																									
SEE ACCOUNTANTS' PREPARATION REPORT																									

Facility Name & ID Number Pekin Manor

0047969 Report Period Beginning: 10/1/2019 Ending: 9/30/2020

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	<u>130</u>	Skilled (SNF)	<u>130</u>	<u>47,580</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>130</u>	TOTALS	<u>130</u>	<u>47,580</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>14,916</u>	<u>5,587</u>	<u>10,514</u>	<u>31,017</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,916</u>	<u>5,587</u>	<u>10,514</u>	<u>31,017</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 65.19%

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 4/26/06

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 4/1/06 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 130 and days of care provided 2,980

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: 9/30/2020 Fiscal Year: 9/30/2020
* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/2019 Ending: 9/30/2020

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	322,608	45,900	22,298	390,806		390,806		390,806			1
2	Food Purchase		343,257		343,257		343,257	(965)	342,292			2
3	Housekeeping	181,763	49,346		231,109		231,109		231,109			3
4	Laundry	61,968	13,389		75,357		75,357		75,357			4
5	Heat and Other Utilities			119,685	119,685		119,685		119,685			5
6	Maintenance	111,051	43,194	131,012	285,257		285,257	(2,703)	282,554			6
7	Other (specify):*											7
8	TOTAL General Services	677,390	495,086	272,995	1,445,471		1,445,471	(3,668)	1,441,803			8
	B. Health Care and Programs											
9	Medical Director			19,202	19,202		19,202		19,202			9
10	Nursing and Medical Records	2,422,594	176,072	78,454	2,677,120		2,677,120		2,677,120			10
10a	Therapy			575	575		575		575			10a
11	Activities	89,093	1,326		90,419		90,419		90,419			11
12	Social Services	87,892			87,892		87,892		87,892			12
13	CNA Training			4,125	4,125		4,125		4,125			13
14	Program Transportation			4,797	4,797		4,797		4,797			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,599,579	177,398	107,153	2,884,130		2,884,130		2,884,130			16
	C. General Administration											
17	Administrative	110,068			110,068		110,068		110,068			17
18	Directors Fees							1,392	1,392			18
19	Professional Services			410,608	410,608		410,608	2,757	413,365			19
20	Dues, Fees, Subscriptions & Promotions			48,851	48,851		48,851	(2,649)	46,202			20
21	Clerical & General Office Expenses	144,106	31,095	84,064	259,265		259,265	36	259,301			21
22	Employee Benefits & Payroll Taxes			494,248	494,248		494,248	15	494,263			22
23	Inservice Training & Education			1,189	1,189		1,189		1,189			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			4,800	4,800		4,800		4,800			25
26	Insurance-Prop.Liab.Malpractice			156,004	156,004		156,004	12,996	169,000			26
27	Other (specify):*											27
28	TOTAL General Administration	254,174	31,095	1,199,764	1,485,033		1,485,033	14,547	1,499,580			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,531,143	703,579	1,579,912	5,814,634		5,814,634	10,879	5,825,513			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			236,414	236,414		236,414	194,773	431,187			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							182,092	182,092			32
33	Real Estate Taxes							122,700	122,700			33
34	Rent-Facility & Grounds			563,652	563,652		563,652	(563,652)				34
35	Rent-Equipment & Vehicles			13,116	13,116		13,116	30	13,146			35
36	Other (specify):* MIP Insurance							25,779	25,779			36
37	TOTAL Ownership			813,182	813,182		813,182	(38,278)	774,904			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			12,664	12,664		12,664		12,664			38
39	Ancillary Service Centers		187,463	448,395	635,858		635,858		635,858			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			301	301		301	(301)				41
42	Provider Participation Fee			234,082	234,082		234,082		234,082			42
43	Other (specify):* Disallowed Costs	20,596		247,466	268,062		268,062	(226,750)	41,312			43
44	TOTAL Special Cost Centers	20,596	187,463	942,908	1,150,967		1,150,967	(227,051)	923,916			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,551,739	891,042	3,336,002	7,778,783		7,778,783	(254,450)	7,524,333			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

Pekin Manor

Period Beginning 10/1/2019
Period End 9/30/2020

Schedule 4A

V. Cost Center Expenses

		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	
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory/Expenses			30,045	30,045		30,045		30,045			
	Radiology Expenses			11,267	11,267		11,267		11,267			
	Non-Allowable Expenses	20,596		206,154	226,750		226,750	(226,750)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special Cost Centers	20,596	0	247,466	268,062	0	268,062	(226,750)	41,312			

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(965)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,318)	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	135	30		9
10	Interest and Other Investment Income	(688)	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	(2,750)	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	(149,463)	43		24
25	Fund Raising, Advertising and Promotional	(49,373)	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	(50,510)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (260,932)		\$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	6,482		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 6,482		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (254,450)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES			Sch. V Line
	Amount	Reference	
1	Offset Vending Expenses Against Income	\$ (301)	41
2	Disallow Marketing Wages	(20,596)	43
3	Disallow R/E Entity HUD Audit	(26,910)	19
4	Capitalize Repairs over \$2,500	(2,703)	6
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
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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	(50,510)	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:	
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)	
1	V	18	Director Fees	\$	Unlimited Development, Inc.	100.00%	\$ 1,392	\$ 1,392	1
2	V	19	Professional Fees		Unlimited Development, Inc.	100.00%	2,757	2,757	2
3	V	20	Dues, Licenses and Subs		Unlimited Development, Inc.	100.00%	26	26	3
4	V	21	General Admin Expense		Unlimited Development, Inc.	100.00%	36	36	4
5	V	22	Employee Benefits		Unlimited Development, Inc.	100.00%	15	15	5
6	V	26	Property Insurance		Unlimited Development, Inc.	100.00%	1,963	1,963	6
7	V	35	Equipment Rental		Unlimited Development, Inc.	100.00%	30	30	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 6,219	\$ * 6,219	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	\$	Pekin El Camino, LLC	N/A	\$ 26,910	\$ 26,910	15
16	V	20	Dues, Fees, Subs & Prom		Pekin El Camino, LLC	N/A	75	75	16
17	V	26	Property Insurance		Pekin El Camino, LLC	N/A	11,033	11,033	17
18	V	30	Depreciation		Pekin El Camino, LLC	N/A	194,638	194,638	18
19	V	32	Interest Expense	325	Pekin El Camino, LLC	N/A	183,105	182,780	19
20	V	33	Property Taxes		Pekin El Camino, LLC	N/A	122,700	122,700	20
21	V	34	Facility Rent	563,652	Pekin El Camino, LLC	N/A		(563,652)	21
22	V	36	Mortgage Insurance		Pekin El Camino, LLC	N/A	25,779	25,779	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 563,977			\$ 564,240	\$ * 263	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Pekin Manor

0047969

Report Period Beginning:

10/1/2019

Ending:

9/30/2020

VII. RELATED PARTIES

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Pekin Manor

0047969

Report Period Beginning:

10/1/2019

Ending:

9/30/2020

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%			Liberty Estates of Car	Carbondale	Retirement living ce	18
19	Unlimited Development, Inc. (UDI)	100%	Seminary Manor	Galesburg				19
20	Unlimited Development, Inc. (UDI)	100%			Seminary Estates	Galesburg	Retirement living ce	20
21	Unlimited Development, Inc. (UDI)	100%			Hawthorne Inn of Gal	Galesburg	Assisted Living Faci	21
22	Unlimited Development, Inc. (UDI)	100%	Centralia Manor	Centralia				22
23	Unlimited Development, Inc. (UDI)	100%			Centralia Estates	Centralia Estates	Retirement living ce	23
24	Unlimited Development, Inc. (UDI)	100%	Pittsfield Manor	Pittsfield				24
25	Unlimited Development, Inc. (UDI)	100%	Pekin Manor	Pekin				25
26	Unlimited Development, Inc. (UDI)	100%			Pekin Estates	Pekin	Retirement living ce	26
27	Unlimited Development, Inc. (UDI)	100%	Jerseyville Manor	Jerseyville				27
28	Unlimited Development, Inc. (UDI)	100%	Manor Court of Carbondale	Carbondale				28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Pekin Manor

0047969

Report Period Beginning:

10/1/2019

Ending:

9/30/2020

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 McCord	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%			2245 Seminary Street,	Galesburg	Lessor	9
10	Unlimited Development, Inc. (UDI)	100%			Pittsfield Lowry, LLC	Galesburg	Lessor	10
11	Unlimited Development, Inc. (UDI)	100%			Pekin El Camino, LLC	Galesburg	Lessor	11
12	Unlimited Development, Inc. (UDI)	100%			Keokuk Village Circle	Galesburg	Lessor	12
13	Unlimited Development, Inc. (UDI)	100%			The Kensington	Galesburg	Supportive Living	13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/2019 Ending: 9/30/2020

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								\$ 1,392	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	\$ 1,392		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 Pekin Manor# 0047969

Report Period Beginning:

10/1/2019Ending: 1/30/2020

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	18	Director Fees	Weighted Avg BDA	462,258	19	13,522	\$	47,580	\$ 1,392	1
2	19	Professional Fees	Weighted Avg BDA	462,258	19	26,790		47,580	2,757	2
3	20	Dues, Licenses and Subs	Weighted Avg BDA	462,258	19	256		47,580	26	3
4	21	General Admin Expense	Weighted Avg BDA	462,258	19	342		47,580	36	4
5	22	Employee Benefits	Weighted Avg BDA	462,258	19	147		47,580	15	5
6	26	Property Insurance	Weighted Avg BDA	462,258	19	19,075		47,580	1,963	6
7	35	Equipment Rental	Weighted Avg BDA	462,258	19	287		47,580	30	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					\$ 60,419	\$		\$ 6,219	25

SEE ACCOUNTANTS' PREPARATION REPORT

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							
	A. Directly Facility Related														
	Long-Term														
1	Cambridge Realty Capital						\$		\$			\$	1		
2	LTD. of Illinois		X	Facility purchase	\$28,646.12	6/1/12		6,249,800	5,097,058	10/1/2041	3.5500	183,105	2		
3													3		
4													4		
5													5		
	Working Capital														
6													6		
7													7		
8													8		
9	TOTAL Facility Related				\$28,646.12		\$	6,249,800	\$	5,097,058			\$	183,105	9
	B. Non-Facility Related*														
10													10		
11									Int Income Offset		(1,013)		11		
12													12		
13													13		
14	TOTAL Non-Facility Related						\$		\$			\$	(1,013)	14	
15	TOTALS (line 9+line14)						\$	6,249,800	\$	5,097,058			\$	182,092	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 25,779 Line # 36

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

FACILITY NAME Pekin Manor COUNTY Tazewell
FACILITY IDPH LICENSE NUMBER 0047969
CONTACT PERSON REGARDING THIS REPORT Ron Wilson
TELEPHONE (309) 343-1550 FAX #: (309) 343-2857

Enter the tax index number and real estate tax assessed for 2019 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 2019.

B. Real Estate Tax Cost Allocations

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.)

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,948

B. General Construction Type: Exterior BrickFrame Wood

Number of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	6.24 Acres	2006	\$ 450,000	1
2					2
3	TOTALS	#VALUE!		\$ 450,000	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	130		2006	1988	\$ 7,174,313	\$	40	\$ 179,358	\$ 179,358	\$ 2,600,682
5										
6										
7										
8										
	Improvement Type**									
9	Light Sign - Double Faced, Fire Alarm Panel			2006	43,700		10			43,700
10	Replace Defective Pipe for Dry System, Roof			2007	139,058	586	10-25 yrs	586		131,981
11	Roof Repair, Furnace Duct Repair, Sprinkler System			2008	179,648	4,936	10-25 yrs	4,936		115,482
12	A/C, Shower Room, Firewall, Wall/Ceiling, Kitchen Repairs			2009	78,867	3,042	5-15 yrs	3,042		68,576
13	Shower, Shower, Tile, AC, Carpet, Sprinkler, Sidewalks			2009	50,035	2,573	5-25 yrs	2,573		36,002
14	Water Heater, Landscaping/Lights			2009	12,030	200	10	200		12,030
15	Single Face Lighted Sign, Water Heater			2010	5,773	463	10	463		5,773
16	Physical Therapy Completion, Water Heater			2010	397,172	33,170	10-12 yrs	33,170		350,720
17	Apollo Tub Room - Sink/Mirror/Shower/Tile/Drywall/Drains/Faucets			2011	56,049	4,671	12	4,671		45,151
18	Water Heater, Condensor, Bathroom remodel			2011	47,199	3,974	10-15 yrs	3,974		36,839
19	PT Remodel, Dining Room, Sprinkler			2011	458,041	17,363	12-25 yrs	32,643	15,280	306,709
20	Sprinkler-New Tamper Switch/Relocate FDC Check Valve			2012	5,867	235	25	235		2,053
21	Kitchenette Rmdl-Sink/Vnyl Tile/Cabinet/Counter/CrnR Grds			2012	53,384	4,449	12	4,449		36,702
22	Nurse Station/Lounge Remodel-Paint/Vinyl/Counter/Cabinet			2012	150,956	12,580	12	12,580		103,782
23	Remodel-Paint/drywall/corner Plates			2012	4,570		5			4,570
24	Smoke Detectors-48/Pull Stations-6.5/Heat Detectors-10			2012	9,831	983	10	983		7,947
25	Water Heater			2012	3,717	372	10	372		3,005
26	Excavation of Lake			2012	13,885	1,386	10	1,386		11,687
27	Overbed Lights - 25			2012	6,266	627	10	627		5,013
28	Air Conditioners			2012	9,440		5			9,440
29	New Well for Lake			2012	7,760	931	8.4	931		7,294
30	Sidewalk/Landscaping			2012	3,050	203	15	203		1,626
31	Nurse Call System			2013	17,031	1,703	10	1,703		13,057
32	Double Egress Doors			2013	4,730	473	10	473		3,429
33	Water Heater			2013	5,147	515	10	515		3,689
34	Phone System			2013	2,637	264	10	264		1,803
35	Water Heater			2013	4,014	401	10	401		2,743
36	Storage Shed			2014	18,870	943	20	943		6,367

*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 Pekin Manor

0047969

Report Period Beginning:

10/1/2019

Ending:

9/30/2020

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Condensor/Furnance	2014	\$ 5,800	\$ 387	15	\$ 387	\$	\$ 2,386	37
38	Water Heater	2014	5,104	510	10	510		3,147	38
39	Pekin Manor Shower Remodel-Tile/Fixtures/Electrical/Drains	2014	66,251	5,521	12	5,521		33,586	39
40	Roof	2014	2,900	48	5	48		2,900	40
41	Landscaping	2014	22,225	2,220	10	2,220		13,335	41
42	Water Heater	2015	3,550	355	10	355		1,982	42
43	Water Heater	2015	6,420	642	10	642		3,531	43
44	Ceramic Tile-Service Corridor	2015	3,242	162	20	162		891	44
45	Concrete-Parking Lot	2015	3,300	220	15	220		1,118	45
46	Relocate Water Lines from Floor to Overhead	2015	62,335	2,493	25	2,493		12,673	46
47	Soffits - West Corridor	2015	43,300	4,330	10	4,330		22,011	47
48	Parking Lot Lights	2015	11,850	1,185	10	1,185		6,025	48
49	100 Hall Remodel-Tile/Fire Alarm/Carpet/Fixtures/Cabinets	2015	54,280	4,523	12	4,523		22,992	49
50	Carpet/VCT Tile 100 Hall	2016	11,368	1,137	10	1,137		5,401	50
51	Soffits over water lines	2016	4,400	440	10	440		1,943	51
52	Pond Excavation-Filled in with Dirt	2016	71,996	4,800	15	4,800		19,600	52
53	Breaker/Electrical Panel	2016	6,120	612	10	612		2,346	53
54	Water Heater	2017	3,927	393	10	393		1,408	54
55	Nurse Call System	2017	15,623	1,562	10	1,562		5,207	55
56	Shower Remodel-Garden Court-Tile, Grab Bars, Lighting, Drywa	2017	34,868	2,906	12	2,906		9,444	56
57	Water Heater - Hallway Mechanical Room	2018	6,575	658	10	658		1,809	57
58	Install Wireless Annunciator	2019	2,862	286	10	286		477	58
59	Water Heater - Mechanical Rm off Service Hallway	2019	4,338	434	10	434		615	59
60	Carpet/VCT/Vinyl - Living Rm/Dining Rm/Activity Rm/Nurses St	2019	84,907	7,076	12	7,076		7,666	60
61	Remodel - Painting - All Common Areas/Living Rm/Dining Rm/Halls								61
62	-Flooring Installation/Soffits to Cover Water Lines/Lighting	2019	408,430	34,036	12	34,036		36,872	62
63	Relocate Water Lines From in Floor to Above-Entire Facility	2019	174,690	14,558	12	14,558		15,771	63
64	Walk In Cooler/Condensor	2019	6,088	609	10	609		660	64
65	Window Treatments - Entire Facility	2019	13,698	1,141	12	1,141		1,236	65
66	Power To 3 Ground Flood Lights-East End/ & 5 Light Poles-West	2019	8,643	528	15	528		528	66
67	Parking Lot/Sidewalks-Concrete	2020	8,152	408	15	408		408	67
68	AC Unit 5 Ton	2020	3,185	159	5	159		159	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 10,123,467	\$ 191,382		\$ 386,020	\$ 194,638	\$ 4,215,979	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Pekin Manor

0047969

Report Period Beginning:

10/1/2019

Ending:

9/30/2020

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	
1 Totals from Page 12A, Carried Forward		\$ 10,123,467	\$ 191,382		\$ 386,020	\$ 194,638	\$ 4,215,979	1
2 Paint/Stain - Hallways/Doors/Door Jambs/Bumpers/Chair Rail/								2
3 Shower Rms/Garden Ct Dining Rm/Mechanical Rm/								3
4 Small Dining Rm/Entry Way	2020	44,480	2,780	12	2,780		2,780	4
5 Repair Leaks on 4 HVAC Split Systems	2020	2,703		10	135	135	135	5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 10,170,650	\$ 194,162		\$ 388,935	\$ 194,773	\$ 4,218,894	34

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	\$ 985,040	\$ 40,632	\$ 40,632	\$	3-15 yrs	\$ 850,400	71
72	Current Year Purchases	24,081	1,620	1,620		5-7 yrs	1,620	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,009,121	\$ 42,252	\$ 42,252	\$		\$ 852,020	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	\$ 42,610	\$	\$	\$	4	\$ 42,610	76
77										77
78										78
79										79
80	TOTALS			\$ 42,610	\$	\$	\$		\$ 42,610	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)	\$ 11,672,381	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 236,414	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 431,187	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 194,773	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,113,524	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 Chevy G3500 - 2006	34,100		34,100	87
88					88
89					89
90					90
91	TOTALS	\$ 49,000	\$	\$ 49,000	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- Facility Owned
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
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: \$ 13,146 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					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

Pekin Manor

Period Beginning 10/1/2019
Period End 9/30/2020

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment Rental	13,037
Other Equipment Rental	79
Home Office Allocation	30
Total - Line 16	13,146

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 4,125	\$	\$ 4,125
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	\$	\$ 4,125	\$	\$ 4,125
10	SUM OF line 9, col. 1 and 2 (e)	\$ 4,125			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' PREPARATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		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	39(3)	hrs	\$	1,798	\$ 137,871	\$	1,798	\$ 137,871	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		979	80,992		979	80,992	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		2,570	229,532		2,570	229,532	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				187,463		187,463	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	5,347	\$ 448,395	\$ 187,463	5,347	\$ 635,858	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	\$ 72,949	\$ 129,673	1
2	Cash-Patient Deposits	15,061	15,061	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 186,000)	388,210	399,910	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	92,205	111,088	6
7	Other Prepaid Expenses	2,318	10,899	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 570,743	\$ 666,631	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		450,000	13
14	Buildings, at Historical Cost	2,635,553	10,062,544	14
15	Leasehold Improvements, at Historical Cost	108,106	108,106	15
16	Equipment, at Historical Cost	730,672	1,051,731	16
17	Accumulated Depreciation (book methods)	(1,979,830)	(5,113,524)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Att Sch 17A		778,237	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,494,501	\$ 7,337,094	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,065,244	\$ 8,003,725	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 526,286	\$ 575,163	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,061	15,061	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	70,645	70,645	30
31	Accrued Taxes Payable (excluding real estate taxes)	54,575	54,575	31
32	Accrued Real Estate Taxes(Sch.IX-B)		90,491	32
33	Accrued Interest Payable		15,079	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Interdivision Payable	3,920,767	5,810,863	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,587,334	\$ 6,631,877	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,097,058	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Security Deposits	24,000	24,000	43
44	Medicare Advance - COVID	523,236	523,236	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 547,236	\$ 5,644,294	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,134,570	\$ 12,276,171	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,069,326)	\$ (4,272,446)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,065,244	\$ 8,003,725	48

Pekin Manor

Period Beginning 10/1/2019
Period End 9/30/2020

Schedule 17A

XV. Balance Sheet
Line 23 Long Term Assets Other (specify):

Description	Operating	After Consolidation
Real Estate Tax Escrow		21,895
Insurance Escrow		3,181
MIP Insurance Escrow		6,441
Reserve for Replacement		746,720
Total - Line 36	-	778,237

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,906,492)	1
2	Restatements (describe):		2
3	Prior Period Adjustment	404	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,906,088)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(163,238)	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)	\$ (163,238)	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)	\$ (3,069,326)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pekin Manor

0047969

Report Period Beginning: 10/1/2019

Ending:

9/30/2020

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	\$ 6,665,655	1
2	Discounts and Allowances for all Levels	(22,799)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,642,856	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	130,709	6
7	Oxygen	(310)	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 130,399	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	836,109	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,078	12
13	Barber and Beauty Care	2,411	13
14	Non-Patient Meals	965	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	(189)	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	824	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 841,198	23
	D. Non-Operating Revenue		
24	Contributions	346	24
25	Interest and Other Investment Income***	688	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,034	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Processing Fees	58	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 58	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,615,545	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,445,471	31
32	Health Care	2,884,130	32
33	General Administration	1,485,033	33
	B. Capital Expense		
34	Ownership	813,182	34
	C. Ancillary Expense		
35	Special Cost Centers	916,885	35
36	Provider Participation Fee	234,082	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,778,783	40
41	Income before Income Taxes (line 30 minus line 40)**	(163,238)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (163,238)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,455,123	44
45	Private Pay - Net Inpatient Revenue	1,251,535	45
46	Medicare - Net Inpatient Revenue	1,481,411	46
47	Other-(specify) Medicare Replacement/Managed Care	460,913	47
48	Other-(specify) Hospice	993,874	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,642,856	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

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	2,019	2,127	\$ 77,994	\$ 36.67	1
2	Assistant Director of Nursing	1,901	2,069	53,489	25.85	2
3	Registered Nurses	17,274	17,855	371,863	20.83	3
4	Licensed Practical Nurses	36,686	38,380	658,070	17.15	4
5	CNAs & Orderlies	102,367	107,154	1,229,422	11.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,786	8,166	89,093	10.91	10
11	Social Service Workers	5,018	5,314	87,892	16.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	30,914	32,714	322,608	9.86	15
16	Dishwashers					16
17	Maintenance Workers	7,521	8,170	111,051	13.59	17
18	Housekeepers	16,998	18,234	181,763	9.97	18
19	Laundry	6,150	6,334	61,968	9.78	19
20	Administrator	2,584	2,718	110,068	40.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,873	10,481	144,106	13.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,370	2,557	31,756	12.42	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	872	920	20,596	22.39	33
34	TOTAL (lines 1 - 33)	250,333	263,193	\$ 3,551,739 *	\$ 13.49	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	\$ 22,298	L1, C3	35
36	Medical Director	Monthly	19,202	L9, C3	36
37	Medical Records Consultant	Monthly	1,500	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,913	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)		\$ 51,913		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	194	\$ 13,473	L10, C3	50
51	Licensed Practical Nurses	117	5,628	L10, C3	51
52	Certified Nurse Assistants/Aides	1,255	45,188	L10, C3	52
53	TOTAL (lines 50 - 52)	1,566	\$ 64,289		53

SEE ACCOUNTANTS' PREPARATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 10,006 IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (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? 5-7 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 43,513 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. \$ 234,082
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. \$ 965
- (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