

		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>0047944</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Pittsfield 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>610 Lowry Street</u> <u>Pittsfield</u> <u>62363</u>																									
Number City Zip Code																									
County: <u>Pike</u>																									
Telephone Number: <u>(800) 373-5202</u> Fax # <u>(217) 285-5212</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> 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		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>04/26/06</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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	☐ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:																									
Name: <u>Ron Wilson</u> Telephone Number: <u>(309) 343-1550</u>																									
Email Address: _____																									
SEE ACCOUNTANTS' PREPARATION REPORT																									

Facility Name & ID Number Pittsfield Manor

0047944 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	89	Skilled (SNF)	89	32,574	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	89	TOTALS	89	32,574	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	13,557	10,234	2,984	26,775	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,557	10,234	2,984	26,775	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.20 %

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 4/01/06 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 89 and days of care provided 1,986

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCUAL ☒ 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 Pittsfield Manor # 0047944 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	251,172	30,834	10,101	292,107		292,107	(50,945)	241,162			1
2	Food Purchase		242,289		242,289		242,289	(44,262)	198,027			2
3	Housekeeping	140,889	43,397	5	184,291		184,291	(36,525)	147,766			3
4	Laundry	58,161	23,589		81,750		81,750	(16,202)	65,548			4
5	Heat and Other Utilities			98,404	98,404		98,404	(19,449)	78,955			5
6	Maintenance	81,261	26,401	59,647	167,309		167,309	(33,158)	134,151			6
7	Other (specify):*											7
8	TOTAL General Services	531,483	366,510	168,157	1,066,150		1,066,150	(200,541)	865,609			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,968,361	125,052	8,000	2,101,413		2,101,413	(222,525)	1,878,888			10
10a	Therapy											10a
11	Activities	77,501	1,474		78,975		78,975	(19,744)	59,231			11
12	Social Services	33,820			33,820		33,820		33,820			12
13	CNA Training											13
14	Program Transportation			2,719	2,719		2,719	(179)	2,540			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,079,682	126,526	22,719	2,228,927		2,228,927	(242,448)	1,986,479			16
	C. General Administration											
17	Administrative	102,784			102,784		102,784		102,784			17
18	Directors Fees							953	953			18
19	Professional Services			316,633	316,633		316,633	388	317,021			19
20	Dues, Fees, Subscriptions & Promotions			26,939	26,939		26,939	(5,588)	21,351			20
21	Clerical & General Office Expenses	75,328	15,632	54,791	145,751		145,751	(2,625)	143,126			21
22	Employee Benefits & Payroll Taxes			400,322	400,322		400,322	(48,890)	351,432			22
23	Inservice Training & Education			1,290	1,290		1,290		1,290			23
24	Travel and Seminar			898	898		898		898			24
25	Other Admin. Staff Transportation			2,719	2,719		2,719	(178)	2,541			25
26	Insurance-Prop.Liab.Malpractice			45,274	45,274		45,274	6,062	51,336			26
27	Other (specify):*											27
28	TOTAL General Administration	178,112	15,632	848,866	1,042,610		1,042,610	(49,878)	992,732			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,789,277	508,668	1,039,742	4,337,687		4,337,687	(492,867)	3,844,820			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 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			84,142	84,142		84,142	173,862	258,004			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							137,401	137,401			32
33	Real Estate Taxes			1,350	1,350		1,350	63,164	64,514			33
34	Rent-Facility & Grounds			487,200	487,200		487,200	(487,200)				34
35	Rent-Equipment & Vehicles			13,122	13,122		13,122	20	13,142			35
36	Other (specify):* MIP Insurance							24,352	24,352			36
37	TOTAL Ownership			585,814	585,814		585,814	(88,401)	497,413			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,874	1,874		1,874		1,874			38
39	Ancillary Service Centers		76,658	323,413	400,071		400,071		400,071			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			56	56		56	(56)				41
42	Provider Participation Fee			169,813	169,813		169,813		169,813			42
43	Other (specify):* Disallowed Costs			242,488	242,488		242,488	(235,925)	6,563			43
44	TOTAL Special Cost Centers		76,658	737,644	814,302		814,302	(235,981)	578,321			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,789,277	585,326	2,363,200	5,737,803		5,737,803	(817,249)	4,920,554			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

Pittsfield Manor

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

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total	9	10	
		1	2	3	4	5	6	7	8			
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory/Expenses			3,905	3,905		3,905		3,905			
	Radiology Expenses			2,658	2,658		2,658		2,658			
	Non-Allowable Expenses			235,925	235,925		235,925	(235,925)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special Cost Centers	0	0	242,488	242,488	0	242,488	(235,925)	6,563			

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	(492)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,902)	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	(37,854)	30		9
10	Interest and Other Investment Income	(704)	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	(2,007)	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	(1,500)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(217,719)	43		24
25	Fund Raising, Advertising and Promotional	(12,304)	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	(586,822)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (865,304)		\$	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)	48,055		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 48,055		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (817,249)		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		Amount	Sch. V Line Reference	
1	Offset Vending Income	\$ (56)	41	1
2	Disallow R/E Entity Professional Fees	(26,910)	19	2
3	Disallow AL Expenses-Dietary	(50,945)	1	3
4	Disallow AL Expenses-Food	(43,770)	2	4
5	Disallow AL Expenses-Housekeeping	(36,525)	3	5
6	Disallow AL Expenses-Laundry	(16,202)	4	6
7	Disallow AL Expenses-Utilities	(19,449)	5	7
8	Disallow AL Expenses-Maintenance	(33,158)	6	8
9	Disallow AL Expenses-Nursing	(222,525)	10	9
10	Disallow AL Expenses-Activities	(19,744)	11	10
11	Disallow AL Expenses-Program Transportation	(179)	14	11
12	Disallow AL Expenses-Licenses & Fees	(1,234)	20	12
13	Disallow AL Expenses-Telephone	(2,650)	21	13
14	Disallow AL Expenses-Employee Benefits	(48,900)	22	14
15	Disallow AL Expenses-Admin Staff Transportation	(178)	25	15
16	Disallow AL Expenses-Insurance	(11,335)	26	16
17	Disallow AL Expenses-Interest Expense	(34,586)	32	17
18	Disallow AL Expenses-Real Estate Tax Expense	(16,036)	33	18
19	Disallow AL License Fees	(2,440)	20	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
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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	(586,822)		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%	\$ 953	\$ 953	1
2	V	19	Professional Fees		Unlimited Development, Inc.	100.00%	1,888	1,888	2
3	V	20	Dues, Licenses and Subs		Unlimited Development, Inc.	100.00%	18	18	3
4	V	21	General Admin Expense		Unlimited Development, Inc.	100.00%	25	25	4
5	V	22	Employee Benefits		Unlimited Development, Inc.	100.00%	10	10	5
6	V	26	Property Insurance		Unlimited Development, Inc.	100.00%	1,344	1,344	6
7	V	35	Equipment Rental		Unlimited Development, Inc.	100.00%	20	20	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 4,258	\$ * 4,258	14

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

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	\$	Pittsfield Lowry, LLC	N/A	\$ 26,910	\$ 26,910	15
16	V	20	Dues, Fees, Subs & Prom		Pittsfield Lowry, LLC	N/A	75	75	16
17	V	26	Property Insurance		Pittsfield Lowry, LLC	N/A	16,053	16,053	17
18	V	30	Depreciation		Pittsfield Lowry, LLC	N/A	211,716	211,716	18
19	V	32	Interest Expense	241	Pittsfield Lowry, LLC	N/A	172,932	172,691	19
20	V	33	Property Taxes		Pittsfield Lowry, LLC	N/A	79,200	79,200	20
21	V	34	Facility Rent	487,200	Pittsfield Lowry, LLC	N/A		(487,200)	21
22	V	36	Mortgage Insurance		Pittsfield Lowry, LLC	N/A	24,352	24,352	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			\$ 487,441			\$ 531,238	\$ * 43,797	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Pittsfield Manor

0047944

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

Pittsfield Manor

0047944

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

Pittsfield Manor

0047944

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 Pittsfield Manor # 0047944 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								\$ 953	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	\$ 953		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

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	\$19,553.00	5/1/2012	4,557,600	3,860,608	6/1/2045	3.5500	138,346		2
3				SNF portion									3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related					\$19,553.00		4,557,600	\$ 3,860,608			\$ 138,346	9
	B. Non-Facility Related*												
10	Cambridge Realty Capital		X	Facility purchase -AL Portion	\$4,888.00	5/1/2012	1,139,400	965,152	6/1/2045	3.5500	34,586		10
11	LTD. of Illinois												11
12									Disallow AL Int Exp		(34,586)		12
13									Int Income Offset		(945)		13
14	TOTAL Non-Facility Related					\$4,888.00		1,139,400	\$ 965,152			\$ (945)	14
15	TOTALS (line 9+line14)							\$ 5,697,000	\$ 4,825,760			\$ 137,401	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 24,352 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 Pittsfield Manor COUNTY Pike
FACILITY IDPH LICENSE NUMBER 0047944
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: 41,400

B. General Construction Type: Exterior BrickFrame WoodNumber 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-22 Units

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-SNF	2.6 Acres	2006	\$ 144,000	1
	2 Facility-SNF	.06 Acres	2013	1,662	2
	3 TOTALS	#VALUE!		\$ 145,662	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	89		2006	1990	\$ 5,262,410	\$	40	\$ 131,558	\$ 131,558	\$ 1,907,610
5										
6										
7										
8										
	Improvement Type**									
9	Landscaping		2006		4,720		10			4,720
10	Water Heaters, Replaced Sheetrock Ceilings (gypsum)		2008		12,251		10			12,251
11	Shtrock wlls/repl ceiling/repl tiles, Wall light/bdside tbls/chairs/nightstand		2008		98,212	5,361	10-15 yrs	5,361		82,129
12	Water Heater, Roof, Furnance and A/C, Gutters, Fire sprinkler		2009		372,840	8,021	10-25 yrs	8,021		281,801
13	Sprinkler System/Carpet/Carpet/Carpeting		2009		22,969	197	5-25 yrs	197		20,241
14	Parker Tub Rm-Sink,Mirror,toilet,shwr walls,flr,drywall,drains,plumbing		2011		44,775	3,731	12	3,731		34,825
15	Parking Lot Overlay and Sealcoat		2011		52,770		8			52,770
16	Hallway-Handrails/whlchair guards/covebs/paint/light/insulation/wall gua		2012		57,129	4,761	12	4,761		40,864
17	Water Heater		2012		3,691	369	10	369		2,953
18	Water Softener		2012		2,522	253	10	253		2,018
19	Water Heater		2012		3,760	376	10	376		2,977
20	Cable TV System		2013		5,014	502	10	502		3,761
21	Water Softener		2013		2,633	263	10	263		1,864
22	Physical Therapy Addition (contracted total)		2013		269,325		12	22,444	22,444	153,363
23	Dining Room Addition (contracted total)		2013		238,316		12	19,860	19,860	135,710
24	Water Heater		2015		3,705	371	10	371		2,069
25	Water Heater		2015		4,012	402	10	402		2,073
26	AC Unit/Coil		2015		3,905	390	10	390		2,017
27	AC Unit-Kitchen		2016		4,762	952	5	952		3,968
28	Electric Panel		2017		3,100	207	15	207		758
29	Bathroom 2 Remodel-Tile/Shower/Fixtures/Paint		2017		28,600	2,384	12	2,384		7,746
30	Coil-AC Unit - Laundry Room and Front Hallway		2018		4,482	298	15	298		622
31	Handrails - 200 Hallway		2018		7,457	498	15	498		1,036
32	Dining Room - Vinyl Plank Flooring/Lights		2019		26,145	2,614	10	2,614		3,703
33	New Flooring/Lighting - 200 Hall & New Blinds-Front Windows		2019		7,186	718	10	718		778
34										
35										
36										

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

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

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pittsfield Manor

0047944

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	
37 Kohler Generator	2019	4,715	786	5	786	\$	\$ 786	37
38 Wall Guards/Door Guards/End Caps Throughout Facility	2020	3,681	245	10	245		245	38
39 Water Heater - Service Hallway Water Heater Room	2020	3,550	237	10	237		237	39
40 AC Unit - 400 Hall	2020	3,465	173	5	173		173	40
41 Landscaping-Front of Nursing Home	2020	8,500	496	10	496		496	41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 6,570,602	\$ 34,605		\$ 208,467	\$ 173,862	\$ 2,766,564	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	\$ 693,072	\$ 34,618	\$ 34,618	\$	3-15 yrs	\$ 629,433	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 693,072	\$ 34,618	\$ 34,618	\$		\$ 629,433	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2003 GMC G350 Van	2006	\$ 29,848	\$	\$	\$	4	\$ 29,848	76
77	Patient Care	2017 Ford Starcraft Bus	2017	59,678	14,919	14,919		4	43,515	77
78										78
79										79
80	TOTALS			\$ 89,526	\$ 14,919	\$ 14,919	\$		\$ 73,363	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)	\$ 7,498,862	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 84,142	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 258,004	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 173,862	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,469,360	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					87
88					88
89					89
90					90
91	TOTALS	\$ 14,900	\$	\$ 14,900	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$ 19,517	92
93			93
94			94
95		\$ 19,517	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: \$ 13,142 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

Pittsfield 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	11,532
Other Equipment Rental	1,590
Home Office Allocation	20
Total - Line 16	13,142

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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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)	\$			

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	\$	1,686	\$ 145,204	\$	1,686	\$ 145,204	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		336	19,142		336	19,142	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		1,958	159,067		1,958	159,067	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				76,658		76,658	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	3,980	\$ 323,413	\$ 76,658	3,980	\$ 400,071	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	\$ 47,724	\$ 131,680	1
2	Cash-Patient Deposits	20,404	20,404	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 488,000)	625,099	640,149	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	74,593	90,559	6
7	Other Prepaid Expenses	3,768	15,436	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 771,588	\$ 898,228	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		145,662	13
14	Buildings, at Historical Cost	796,387	6,570,602	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	495,365	782,598	16
17	Accumulated Depreciation (book methods)	(981,275)	(3,469,360)	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 Att Sch 17A	19,517	919,867	22
23	Other(specify): See Att Sch 17A		642,032	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 329,994	\$ 5,591,401	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,101,582	\$ 6,489,629	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 97,604	\$ 151,108	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,404	20,404	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	57,980	57,980	30
31	Accrued Taxes Payable (excluding real estate taxes)	39,734	39,734	31
32	Accrued Real Estate Taxes(Sch.IX-B)		60,449	32
33	Accrued Interest Payable		14,276	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Interdivision Payable	3,421,710	5,347,990	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,637,432	\$ 5,691,941	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,825,760	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Security Deposits	40,500	40,500	43
44	Medicare Advance-COVID	290,157	290,157	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 330,657	\$ 5,156,417	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,968,089	\$ 10,848,358	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,866,507)	\$ (4,358,729)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,101,582	\$ 6,489,629	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Pittsfield Manor

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

Schedule 17A

XV. Balance Sheet

Line 22 Long Term Assets Other (specify):

	Operating	After Consolidation
Land-Assisted Living		36,000
Building-Assisted Living		1,315,602
Reserve for Depr-Building-Assisted Living		(476,906)
Dining Room Addition-Assisted Living		59,579
Reserve for Depr-Dining Room Addition-Assisted Living		(33,925)
2006 Toyota Corolla - 2006		14,900
Reserve for Depr-2006 Toyota Corolla - 2006		(14,900)
Construction In Progress	19,517	19,517
TOTAL	19,517	919,867

Line 23 Other

	Operating	After Consolidation
Replacement Reserve		538,345
Real Estate Tax Escrow		59,802
Insurance Escrow		16,027
MIP Escrow		27,858
TOTAL		642,032

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,029,775)	1
2	Restatements (describe):		2
3	Prior Period Adjustments	88,000	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,941,775)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	75,268	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)	\$ 75,268	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,866,507)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pittsfield Manor

0047944

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	\$ 5,103,325	1
2	Discounts and Allowances for all Levels	(11,568)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,091,757	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	142,292	6
7	Oxygen	2,940	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 145,232	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	564,676	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	465	12
13	Barber and Beauty Care	1,008	13
14	Non-Patient Meals	492	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	466	19
20	Radiology and X-Ray		20
21	Other Medical Services	4,947	21
22	Laundry	14	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 572,068	23
	D. Non-Operating Revenue		
24	Contributions	480	24
25	Interest and Other Investment Income***	704	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,184	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached Schedule 19A</u>	2,830	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,830	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,813,071	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,066,150	31
32	Health Care	2,228,927	32
33	General Administration	1,042,610	33
	B. Capital Expense		
34	Ownership	585,814	34
	C. Ancillary Expense		
35	Special Cost Centers	644,489	35
36	Provider Participation Fee	169,813	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,737,803	40
41	Income before Income Taxes (line 30 minus line 40)**	75,268	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 75,268	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,163,311	44
45	Private Pay - Net Inpatient Revenue	1,754,849	45
46	Medicare - Net Inpatient Revenue	990,710	46
47	Other-(specify) <u>Medicare Replacement/Managed Care</u>	34,543	47
48	Other-(specify) <u>Hospice</u>	148,344	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,091,757	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

Pittsfield Manor

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

Schedule 19A

XVII. Income Statement
Line 28a Other Income

Rental Description	Amount
Late Fees	90
Processing Fee	300
Transportation Fee	40
Maintenance Fee Income	2,400
Total - Line 16	2,830

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,132	1,218	\$ 39,244	\$ 32.23	1
2	Assistant Director of Nursing	1,233	1,233	27,544	22.34	2
3	Registered Nurses	13,544	14,292	304,013	21.27	3
4	Licensed Practical Nurses	22,671	23,680	444,657	18.78	4
5	CNAs & Orderlies	104,137	105,093	1,078,701	10.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,460	6,784	77,501	11.42	10
11	Social Service Workers	2,355	2,511	33,820	13.47	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,029	18,933	251,172	13.27	15
16	Dishwashers					16
17	Maintenance Workers	5,181	5,486	81,261	14.81	17
18	Housekeepers	13,724	14,014	140,889	10.05	18
19	Laundry	5,606	5,774	58,161	10.07	19
20	Administrator	2,344	2,552	102,784	40.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,992	5,280	75,328	14.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,080	2,221	41,003	18.46	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,886	3,082	33,199	10.77	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	206,374	212,152	\$ 2,789,277 *	\$ 13.15	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	\$ 10,101	L1, C3	35
36	Medical Director	Monthly	12,000	L9, C3	36
37	Medical Records Consultant	Monthly	1,500	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,224	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)		\$ 28,825		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Pittsfield Manor

STATE OF ILLINOIS

0047944

Report Period Beginning:

10/1/2019

Page 21

Ending: 9/30/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Billye Titus	Administrator	None	\$ 102,784
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 102,784

B. Administrative - Other

Description	Amount
N/A	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$

C. Professional Services

Vendor/Payee	Type	Amount
LTC Support Services, LLC	Support Services	\$ 142,128
RFMS, Inc.	Administrative Services	132,000
Templin Healthcare Accounting	Accounting Services	3,547
RSM US LLP	Accounting Services	23,501
Healthlink	Computer Services	472
Fudge Broadwater	Legal Services	158
Davis & Campbell LLC	Legal Services	1,387
Polsinelli	Legal Services	11,940
Filbert Law Office	Legal Services	1,500
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 316,633

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 28,083
Unemployment Compensation Insurance	1,302
FICA Taxes	207,675
Employee Health Insurance	146,790
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401k	4,445
Other Employee Benefits	12,027
Less: AL Allocated Expenses	(48,900)
Indirect costs	10
TOTAL (agree to Schedule V, line 22, col.8)	\$ 351,432

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 1,988
Advertising: Employee Recruitment	10,950
Health Care Worker Background Check (Indicate # of checks performed 127)	1,268
Patient Background Checks 58	580
Other Licenses & Fees	1,798
Subscriptions	611
IHCA Dues	7,304
Less: AL Allocated Expenses	(1,234)
Indirect costs	93
Less: Public Relations Expense	(2,007)
Non-allowable advertising (	
Yellow page advertising (	
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 21,351

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	898
Entertainment Expense (	
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 898

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

HFS 3745 (N-4-99)

IL478-2471

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. 7,304 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? N/A

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,876 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. \$ 169,813
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. \$ 492

(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 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