

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: 0047225

Facility Name: Centralia Manor

Address: 1910 E McCord Rt161E Centralia 62801
Number City Zip Code

County: Marion

Telephone Number: (618) 533-1200 Fax # (618) 533-1257

HFS ID Number:

Date of Initial License for Current Owners: 06/29/05

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501 (c) (3)

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Brian Burger Telephone Number: (309) 343-1550
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/2024 to 9/30/2025 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.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Brian Burger
(Title) Chief Financial Officer

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP P.O. Box 326, Plainfield, IL 60544-0326
(Telephone) (630) 361-2868 Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Centralia Manor # 0047225 Report Period Beginning: 10/1/2024 Ending: 9/30/2025

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	120	Skilled (SNF)	120	43,800	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	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	2,203	9,799			5,519	5,426	1,296	24,243	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	2,203	9,799			5,519	5,426	1,296	24,243	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 55.35%

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 7/1/05

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 7/1/05 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter certified beds.
number of certified beds 120

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐

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

Tax Year: 9/30/2025 Fiscal Year: 9/30/2025

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

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	319,652	30,184	15,106	364,942		364,942		364,942			1
2	Food Purchase		283,659		283,659		283,659	(1,710)	281,949			2
3	Housekeeping	161,479	29,215	63	190,757		190,757		190,757			3
4	Laundry	93,366	16,389	76	109,831		109,831		109,831			4
5	Heat and Other Utilities			160,459	160,459		160,459		160,459			5
6	Maintenance	69,419	14,825	105,181	189,425		189,425		189,425			6
7	Other (specify):*											7
8	TOTAL General Services	643,916	374,272	280,885	1,299,073		1,299,073	(1,710)	1,297,363			8
	B. Health Care and Programs											
9	Medical Director			32,000	32,000		32,000		32,000			9
10	Nursing and Medical Records	3,263,341	188,378	9,623	3,461,342		3,461,342		3,461,342			10
10a	Therapy											10a
11	Activities	93,660	10,512		104,172		104,172		104,172			11
12	Social Services	82,515			82,515		82,515		82,515			12
13	CNA Training			5,216	5,216		5,216		5,216			13
14	Program Transportation			7,379	7,379		7,379		7,379			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,439,516	198,890	54,218	3,692,624		3,692,624		3,692,624			16
	C. General Administration											
17	Administrative	94,209			94,209		94,209		94,209			17
18	Directors Fees							1,718	1,718			18
19	Professional Services			387,712	387,712		387,712	1,294	389,006			19
20	Dues, Fees, Subscriptions & Promotions			50,095	50,095		50,095	(3,687)	46,408			20
21	Clerical & General Office Expenses	156,063	29,336	72,533	257,932		257,932	1,665	259,597			21
22	Employee Benefits & Payroll Taxes			677,882	677,882		677,882		677,882			22
23	Inservice Training & Education			1,431	1,431		1,431		1,431			23
24	Travel and Seminar			52	52		52		52			24
25	Other Admin. Staff Transportation			7,381	7,381		7,381		7,381			25
26	Insurance-Prop.Liab.Malpractice			133,148	133,148		133,148	23,611	156,759			26
27	Other (specify):*											27
28	TOTAL General Administration	250,272	29,336	1,330,234	1,609,842		1,609,842	24,601	1,634,443			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,333,704	602,498	1,665,337	6,601,539		6,601,539	22,891	6,624,430			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			142,306	142,306		142,306	246,264	388,570			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							232,335	232,335			32
33	Real Estate Taxes							162,000	162,000			33
34	Rent-Facility & Grounds			852,000	852,000		852,000	(852,000)				34
35	Rent-Equipment & Vehicles			10,196	10,196		10,196		10,196			35
36	Other (specify):* Mortgage Ins							32,448	32,448			36
37	TOTAL Ownership			1,004,502	1,004,502		1,004,502	(178,953)	825,549			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			8,351	8,351		8,351		8,351			38
39	Ancillary Service Centers		322,239	544,625	866,864		866,864		866,864			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			1,948	1,948		1,948	(1,470)	478			41
42	Provider Participation Fee			345,735	345,735		345,735		345,735			42
43	Other (specify):* Disallowed Costs	59,957		158,612	218,569		218,569	(218,569)				43
44	TOTAL Special Cost Centers	59,957	322,239	1,059,271	1,441,467		1,441,467	(220,039)	1,221,428			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,393,661	924,737	3,729,110	9,047,508		9,047,508	(376,101)	8,671,407			45

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

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	(1,710)	2		4
5	Telephone, TV & Radio in Resident Rooms	(19,649)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(26)	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	(65)	20		17
18	Fines and Penalties	(50,781)	43		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	(31,961)	43		24
25	Fund Raising, Advertising and Promotional	(38,372)	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	(113,622)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (256,186)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(119,915)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (119,915)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (376,101)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (3,761)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Offset Vending Expenses Against Income	(1,470)	41	3
4	Disallow R/E Entity Professional Fees	(30,585)	19	4
5	Disallow Lab Expense	(10,865)	43	5
6	Disallow X-Ray Expense	(5,905)	43	6
7	Disallow Marketing Wages	(59,957)	43	7
8	Disallow Loss on Disposal	(1,079)	43	8
9				9
10				10
11				11
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43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(113,622)		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%	\$ 1,718	\$ 1,718	1
2	V	19	Professional Fees		Unlimited Development, Inc.	100.00%	1,294	1,294	2
3	V	20	Dues, Licenses and Subs		Unlimited Development, Inc.	100.00%	64	64	3
4	V	21	General Admin Expense		Unlimited Development, Inc.	100.00%	1,665	1,665	4
5	V	26	Property Insurance		Unlimited Development, Inc.	100.00%	1,359	1,359	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 6,100	\$ * 6,100	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	\$	Centralia East McCord, LLC	N/A	\$ 30,585	\$ 30,585	15
16	V	20	Dues, Fees, Subs & Prom		Centralia East McCord, LLC	N/A	75	75	16
17	V	26	Property Insurance		Centralia East McCord, LLC	N/A	22,252	22,252	17
18	V	30	Depreciation		Centralia East McCord, LLC	N/A	246,264	246,264	18
19	V	32	Interest Expense	65	Centralia East McCord, LLC	N/A	232,426	232,361	19
20	V	32	Loan Fee Amortization		Centralia East McCord, LLC	N/A			20
21	V	33	Property Taxes		Centralia East McCord, LLC	N/A	162,000	162,000	21
22	V	34	Facility Rent	852,000	Centralia East McCord, LLC	N/A		(852,000)	22
23	V	36	Mortgage Insurance		Centralia East McCord, LLC	N/A	32,448	32,448	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			\$ 852,065			\$ 726,050	\$ * (126,015)	39

Ownership Listing-1

ID# 0047225

Ending: 9/30/2025

-Names of trust beneficiaries must be listed.

Facility Name & ID Number

Centralia Manor

0047225

Report Period Beginning:

10/1/2024

Ending:

9/30/2025

VII. RELATED PARTIES

A. (Continued)

Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	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

Centralia Manor

0047225

Report Period Beginning:

10/1/2024

Ending:

9/30/2025

VII. RELATED PARTIES

A. (Continued)

Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	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%	Vable 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 Gals	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

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	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 McCor	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

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								\$ 1,718	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	\$ 1,718		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

Ending: 1/30/2025

(309) 343-2857

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	\$39,235.40	6/1/11		8,626,000	6,414,589	7/1/2046	4.2000	211,650	2		
3													3		
4													4		
5													5		
	Working Capital														
6													6		
7													7		
8													8		
9	TOTAL Facility Related				\$39,235.40		\$	8,626,000	\$	6,414,589			\$	211,650	9
	B. Non-Facility Related*														
10										Amortization Exp		20,776	10		
11										Interest Inc Offset		(91)	11		
12													12		
13													13		
14	TOTAL Non-Facility Related						\$		\$			\$	20,685	14	
15	TOTALS (line 9+line14)						\$	8,626,000	\$	6,414,589			\$	232,335	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 32,448 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.)

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	137,302	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2024		\$	166,623	2
3. Under or (over) accrual (line 2 minus line 1).				\$	29,321	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	132,679	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.				\$		6
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	162,000	7
Assessed Value from Real Estate Tax Bill:	2024	2,140,000	8			
Real Estate Tax Bill for Calendar Year:	2020	207,662	9			
	2021	210,413	10			
	2022	212,046	11			
	2023	171,934	12			
	2024	166,623	13			
This facility was purchased from an unrelated for-profit entity during 2005. A tax exemption has not yet been obtained.						
Amount accrued includes the taxes for 9 months based on fiscal year end. Estimate is based on prior year tax bill.						
Taxes paid during year represents the entire 2024 bill.						

FOR BHF USE ONLY		
14	FROM R. E. TAX STATEMENT FOR 2024 \$	14
15	PLUS APPEAL COST FROM LINE 5 \$	15
16	LESS REFUND FROM LINE 6 \$	16
17	AMOUNT TO USE FOR RATE CALCULATION \$	17

NOTES:

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,758 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (X) (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? (X) (a) Own the Equipment (X) (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. List the bed capacity for the building if it differs from the licensed total. N/A
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
I. Are you presently operating under a sublease agreement? No
J. 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.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES X 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:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	Facility	6.4 Acres		2005		\$ 275,000	
2							
3	TOTALS	#VALUE!				\$ 275,000	

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	120		2005		\$ 9,142,000	\$	40	\$ 228,551	\$ 228,551	\$ 4,628,142
5										
6										
7										
8										
	Improvement Type**									
9	Sidewalks		2005		11,858		15			11,858
10	Parking Lot Lighting		2006		7,450		15			7,450
11	Roof		2007		5,555		10			5,555
12	Roof Replacement, Electric Sign,Shower room/VCT Rstrooms-Svc area		2008		162,223		10			162,223
13	New Roof, New Sign, Carpet, PT addition		2008		279,206	7,997	10-25 yrs	7,997		215,228
14	Air Conditioner, Water Heater, Dining Room Remodel (Contracted Total		2009		223,723		10-12 yrs			223,723
15	Water Heater, Window Valances, Windows		2010		36,000	874	5-15 yrs	874		36,000
16	Shower Rooms/Activity Room Cabinets/Armour/Painting/Flooring/Casca		2010		162,466		12			162,466
17	Hot Water Heater, Sprinklers		2011		25,227	709	10-25 yrs	709		17,486
18	Sprinkler System-Dry Pipe System		2011		35,800	1,432	25	1,432		19,809
19	Heatcraft Condensing Unit		2012		4,935	329	15	329		4,496
20	Fire Alarm Control Panel/Remote Annuciator/Maglock work		2012		6,300		10			6,300
21	Wood Blinds - 90		2012		5,875		5			5,875
22	AC System		2012		5,840		10			5,840
23	VCT Tile		2012		14,372		10			14,372
24	Lighted Sign 3X6 Single Faced		2012		3,200		10			3,200
25	Spectrim Crown Valance- 123		2012		50,793		5			50,793
26	Water Heater		2013		5,989		10			5,989
27	Water Heater		2013		3,623		10			3,623
28	AC Unit		2014		5,330		5			5,330
29	Water Heater		2014		4,177		10			4,177
30	Water Heater		2015		5,210	174	10	174		5,210
31	Water Heater		2015		3,672	306	10	306		3,672
32	Dry Pipe Valve		2015		3,857	258	15	258		2,593
33	Single Face Lighted Sign		2015		4,950	454	10	454		4,950
34	Sprinkler Repair-Piping		2015		9,613	882	10	882		9,613
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

Facility Name & ID Number Centralia Manor

0047225

Report Period Beginning:

10/1/2024

Ending:

9/30/2025

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	Roofing-Pauls Office Building	2015	\$ 17,559	\$ 1,610	10	\$ 1,610	\$	\$ 17,559	37
38	Landscaping/New Edging/Rock Pavers	2015	20,314	1,724	15	1,923	199	19,141	38
39	Physical Therapy Addition	2015	696,185		40	17,406	17,406	171,147	39
40	Front Doors	2016	35,428	1,904	15-20 Yrs	1,904		18,608	40
41	Water Heater	2016	9,466	946	10	946		9,150	41
42	Awning	2016	7,052	706	10	706		6,758	42
43	Asphalt Parking Lot	2016	358,554		8			358,554	43
44	Landscaping-Front of Building	2016	19,428	1,943	10	1,943		18,295	44
45	Building Remodel: Flooring-Tile/VCT/Carpet/Paint/Wallcoverings								45
46	Wall Lights/Chandeliers/Lamps/Bed Lights/Telephone System								46
47	Gen Contr/Plumbing/Electrical/Carpentry/Fire Sprinkler Install								47
48	Electrical Work-Nurse Station/Patient Rooms/Breakers								48
49	Drapes, Poles	2016	939,643	72,962	5-15 Yrs	72,962		875,975	49
50	Fencing-Wrought Iron	2016	18,360	1,836	10	1,836		17,289	50
51	Add-On to Fire Alarm System	2016	6,959	696	10	696		6,147	51
52	Fire Panel	2017	4,434	445	10	445		3,658	52
53	Piping in Dry System	2018	5,120	512	10	512		3,968	53
54	Furnace-Outside Unit 100 Hall	2018	4,136	276	15	276		2,137	54
55	Message Centers	2018	7,040	704	10	704		5,280	55
56	AC Unit/Coil-Kitchen	2018	4,294		5			4,294	56
57	Water Heater - Mechanical Room off Service Hall	2018	3,908	390	10	390		2,898	57
58	Six PTAC Units	2018	3,990		5			3,990	58
59	New PTAC Units	2018	2,525		5			2,525	59
60	New Water Heater - Off Nurses Station	2018	5,799	580	10	580		4,059	60
61	New Water Heater - West Mechanical Room	2019	6,486	649	10	649		4,108	61
62	Dry Sprinkler Heads-9/Under Exrerior Canopy/Freezer Unit	2020	3,985	398	10	398		2,125	62
63	Sprinkler Dry System Pipe Replacement-All 3 Dry Systems in Atti	2020	12,425	830	15	830		4,280	63
64	2 New Water Heaters	2021	16,459	1,646	10	1,646		7,681	64
65	Water Heater - Mechanical Room	2021	3,051	306	10	306		1,348	65
66	Water Heater - Mechanical Room	2021	9,128	913	10	913		4,032	66
67	Dry Sprinkler Repair on Backup System North Side	2021	3,487	291	12	291		1,235	67
68	New Direct TV System	2021	20,100	2,010	10	2,010		8,543	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 12,474,559	\$ 107,692		\$ 353,848	\$ 246,156	\$ 7,210,757	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 12,474,559	\$ 107,692		\$ 353,848	\$ 246,156	\$ 7,210,757	1
2	3 New PTAC Units with Thermostats	2024	2,599	520	5	520		563	2
3	Gree Split System for TV Room Hall 500	2024	5,283	528	10	528		748	3
4	New Condensor/Air Handler/Heater	2024	8,691	580	15	580		821	4
5	New 4 Ton AC Unit/Condensor	2024	6,634	1,327	5	1,327		1,548	5
6	Install Disconnect for Generator	2025	6,467	485	10	485		485	6
7	Install New Water Heater by Kitchen	2025	4,900	163	10	163		163	7
8	Install New Nurse Call System - Entire Facility	2025	42,144	351	10	351		351	8
9	Install New Circuit for Subpanel	2025	5,250	44	10	44		44	9
10	Install New Drain Line from Pond to Road	2025	23,000	192	10	192		192	10
11	6 New PTAC Units	2025	5,493	458	5	458		458	11
12	5 New PTAC Units	2025	4,865	129	5	129		129	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)		\$ 12,589,885	\$ 112,469		\$ 358,625	\$ 246,156	\$ 7,216,259	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	\$209,345	\$21,023	\$21,131	\$108	5-15 yrs	\$141,847	71
72	Current Year Purchases	91,913	8,479	8,479		5-10 yrs	8,479	72
73	Fully Depreciated Assets	554,857					554,857	73
74								74
75	TOTALS	\$856,115	\$29,502	\$29,610	\$108		\$705,183	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	2017 Ford E350	2017	\$56,102	\$	\$	\$	4	\$56,102	76
77	Patient Care	2017 Dodge Grand Caravan	2025	16,075	335	335		4	335	77
78										78
79										79
80	TOTALS			\$72,177	\$335	\$335	\$		\$56,437	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)	\$13,793,177	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$142,306	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$388,570	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$246,264	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$7,977,879	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	2003 Chevy G3500	\$29,700	\$	\$29,700	86
87					87
88					88
89					89
90					90
91	TOTALS	\$29,700	\$	\$29,700	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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.

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
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?
16. Rental Amount for movable equipment: \$10,196
- Description: Medical Equipment \$9,694; Other \$502
- (Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☐ NO

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	N/A				18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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

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

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
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 5,216	\$	\$ 5,216
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	\$	\$ 5,216	\$	\$ 5,216
10	SUM OF line 9, col. 1 and 2 (e)	\$ 5,216			

- (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.

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	

- (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	\$	4,052	\$ 194,415	\$	4,052	\$ 194,415	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,418	85,199		1,418	85,199	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		5,187	265,011		5,187	265,011	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				322,239		322,239	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	10,657	\$ 544,625	\$ 322,239	10,657	\$ 866,864	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (24,610)	\$ 257,998	1
2	Cash-Patient Deposits	9,898	9,898	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 15,000)	1,010,748	1,082,611	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	132,107	158,691	6
7	Other Prepaid Expenses	1,988	16,781	7
8	Accounts Receivable (owners or related parties)	14,185,218	12,998,801	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 15,315,349	\$ 14,524,780	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		275,000	13
14	Buildings, at Historical Cost	2,730,686	12,586,898	14
15	Leasehold Improvements, at Historical Cost		2,987	15
16	Equipment, at Historical Cost	606,130	928,292	16
17	Accumulated Depreciation (book methods)	(2,836,613)	(7,977,879)	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 Schedule 17A		1,554,044	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 500,203	\$ 7,369,342	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 15,815,552	\$ 21,894,122	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 307,796	\$ 391,270	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,898	9,898	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	107,711	107,711	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		132,679	32
33	Accrued Interest Payable		17,373	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 425,405	\$ 658,931	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,414,589	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Security Deposits	19,333	19,333	43
44	Medicare Advance-COVID	518,420	518,420	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 537,753	\$ 6,952,342	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 963,158	\$ 7,611,273	46
47	TOTAL EQUITY(page 18, line 24)	\$ 14,852,394	\$ 14,282,849	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 15,815,552	\$ 21,894,122	48

Facility Name:Centralia Manor

IDPH License ID Number:0047225

Fiscal Year End:9/30/2025

Schedule 17A

XV. Balance Sheet

Line 23 Long Term Assets Other (specify):

Description	Operating	After Consolidation
Real Estate Tax Escrow		563,081
Insurance Escrow		2,000
MIP Insurance Escrow		50,131
Reserve for Replacement		649,529
Capitalized Loan Fee		633,172
Amortization Loan Fee		(343,869)
Total - Line 23	-	1,554,044

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 15,702,739	1
2	Restatements (describe):		2
3	Prior Period Adjustments - Intercompany Adj	2,814	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 15,705,553	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(853,159)	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)	\$ (853,159)	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)	\$ 14,852,394	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Centralia Manor

0047225

Report Period Beginning: 10/1/2024

Ending: 9/30/2025

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	\$ 8,136,316	1
2	Discounts and Allowances for all Levels	(54,583)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,081,733	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	86,814	6
7	Oxygen	4,617	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 91,431	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,470	12
13	Barber and Beauty Care	704	13
14	Non-Patient Meals	1,710	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	13,916	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	3,134	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 20,934	23
	D. Non-Operating Revenue		
24	Contributions	225	24
25	Interest and Other Investment Income***	26	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 251	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,194,349	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,299,073	31
32	Health Care	3,692,624	32
33	General Administration	1,609,842	33
	B. Capital Expense		
34	Ownership	1,004,502	34
	C. Ancillary Expense		
35	Special Cost Centers	1,095,732	35
36	Provider Participation Fee	345,735	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,047,508	40
41	Income before Income Taxes (line 30 minus line 40)**	(853,159)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (853,159)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 718,358.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	2,375,515.00	45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	1,368,023.00	48
49	Medicare Part A	3,204,835.00	49
50	Other-(specify) Medicare Replacement/Managed Care MCA	301,039.00	50
51	Other-(specify) Hospice	113,963.00	51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,081,733	56

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	1,749	1,943	\$ 93,429	\$ 48.08	1
2	Assistant Director of Nursing	1,207	1,347	57,078	42.37	2
3	Registered Nurses	15,423	16,640	650,027	39.06	3
4	Licensed Practical Nurses	17,377	19,036	584,459	30.70	4
5	CNAs & Orderlies	76,412	83,168	1,841,226	22.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,774	1,889	37,507	19.86	9
10	Activity Assistants	3,479	3,739	56,153	15.02	10
11	Social Service Workers	3,820	4,156	82,515	19.85	11
12	Dietician					12
13	Food Service Supervisor	2,050	2,189	53,587	24.48	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,394	16,799	266,065	15.84	15
16	Dishwashers					16
17	Maintenance Workers	3,574	3,909	69,419	17.76	17
18	Housekeepers	9,164	9,928	161,479	16.27	18
19	Laundry	5,631	6,101	93,366	15.30	19
20	Administrator	1,654	1,852	94,209	50.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,979	6,575	156,063	23.74	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,074	2,207	37,122	16.82	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	1,943	2,079	59,957	28.84	33
34	TOTAL (lines 1 - 33)	168,704	183,557	\$ 4,393,661 *	\$ 23.94	34

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	\$ 15,106	L1, C3	35
36	Medical Director	Monthly	32,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,660	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)		\$ 55,766		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Jennifer Winka-Sursa	Administrator	None	\$ 60,249
Teresa Fisher	Administrator	None	33,960
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 94,209
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
RFMS, Inc.	Administrative Services	\$	180,180
LTC Support Services, LLC	Support Services		173,448
RSM US LLP	Accounting Services		21,292
Templin Healthcare Accounting	Accounting Services		4,428
Guided Care	MCO Guide		1,000
Polsinelli	Legal Services		7,364
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 387,712
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	50,220
Unemployment Compensation Insurance			22,671
FICA Taxes			326,715
Employee Health Insurance			250,500
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
401k			15,982
Other Employee Benefits			11,794
TOTAL (agree to Schedule V, line 22, col.8)			\$ 677,882
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	1,992
Advertising: Employee Recruitment			21,201
Health Care Worker Background Check (Indicate # of checks performed 12)			456
Patient Background Checks 480			12,016
Association Dues (total from pg 22, #4)			10,602
Subscriptions			1,330
Other Licenses & Fees			2,498
Indirect costs			139
Less: Public Relations Expense			(65)
PAC and Lobbying payments			(3,761)
All non-allowable advertising ()			
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 46,408
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			52
Seminar Expense			
Entertainment Expense ()			
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	52

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT**

****See instructions.**

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name

IL HEALTHCARE ASSOCIATION (IHCA)

Amount

6,841

6,841 Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS
OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

IL HEALTHCARE ASSOCIATION (IHCA)

3,761

3,761 Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

IL HEALTHCARE ASSOCIATION (IHCA)

10,602

10,602 Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense
and the location of this expense on Sch. V.

\$ 43,036

Line 10
- (6)

Have all costs reported on this form been determined using accounting procedures
consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department
during this cost report period.

\$ 345,735

This amount is to be recorded on line 42 of Schedule V.
- (8)

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.

- (9)

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
- (10)

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.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V.

\$ N/A

Has any meal income been offset against
related costs?

Yes

Indicate the amount.

\$ 1,710
- (12)

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
- (13)

Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name: RSM US LLP
- (14)

Have all costs which do not relate to the provision of long term care been adjusted out
of Schedule V?

Yes
- (15)

Has a schedule for the legal fees reported on the cost report been provided by the facility?

Yes

See page 39 of the instructions for details.

Attach invoices and a summary of services for all architect and appraisal fees.