

		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: <u>0033159</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Clinton Manor Living Ctr SNF</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2025</u> to <u>12/31/2025</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>111 East Illinois St</u> <u>New Baden</u> <u>62265</u>																									
Number City Zip Code																									
County: <u>Clinton</u>																									
Telephone Number: <u>618-588-3826</u> Fax # ()																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>James G. Hull, CPA</u> <u>Owner</u></td></tr><tr><td>(Firm Name & Address) <u>WDM Computer Services, Inc.</u> <u>1900 Harrison St., Quincy, IL 62301</u></td></tr><tr><td>(Telephone) <u>217-228-1950</u> Fax # <u>217-222-6053</u></td></tr><tr><td>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Print Name and Title) <u>James G. Hull, CPA</u> <u>Owner</u>	(Firm Name & Address) <u>WDM Computer Services, Inc.</u> <u>1900 Harrison St., Quincy, IL 62301</u>	(Telephone) <u>217-228-1950</u> Fax # <u>217-222-6053</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630												
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Date of Initial License for Current Owners: <u>01/01/88</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 _____</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 _____	☐ Corporation	☐ Other _____		☒ "Sub-S" Corp.			☐ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☐ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>James G. Hull, CPA</u> Telephone Number: <u>217-228-1950</u>																									
Email Address: _____																									

Facility Name & ID Number Clinton Manor Living Ctr SNF # 0033159 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	<u>33</u>	Skilled (SNF)	<u>33</u>	<u>12,045</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>4</u>	Intermediate (ICF)	<u>4</u>	<u>1,460</u>	3
4	<u>51</u>	Intermediate/DD	<u>51</u>	<u>18,615</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>88</u>	TOTALS	<u>88</u>	<u>32,120</u>	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	1,597	2,460			1,635	1,339		7,031	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD	18,045							18,045	11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	19,642	2,460			1,635	1,339		25,076	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 78.07%

D. How many bed reserve days during this year were paid by the Department? n/a (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) n/a

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 ☐

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 01/01/88

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

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 33

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

MODIFIED ACCRUAL ☒ CASH* ☐ CASH* ☐

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

Tax Year: 12/31/25 Fiscal Year: 12/31/25

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

Facility Name & ID Number Clinton Manor Living Ctr SNF # 0033159 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	488,444	39,796	8,248	536,488		536,488		536,488			1
2	Food Purchase		335,831		335,831		335,831	(1,056)	334,775			2
3	Housekeeping	302,624	35,203		337,827		337,827		337,827			3
4	Laundry	132,347	26,425		158,772		158,772		158,772			4
5	Heat and Other Utilities			159,818	159,818		159,818		159,818			5
6	Maintenance	371,659	104,821	227,658	704,138		704,138		704,138			6
7	Other (specify):*											7
8	TOTAL General Services	1,295,074	542,076	395,724	2,232,874		2,232,874	(1,056)	2,231,818			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	6,550,903	429,005	26,099	7,006,007		7,006,007		7,006,007			10
10a	Therapy	54,611		418,113	472,724	(10,973)	461,751		461,751			10a
11	Activities	58,439	63,223		121,662		121,662		121,662			11
12	Social Services	256,582		20,271	276,853		276,853	(95,282)	181,571			12
13	CNA Training			940	940		940		940			13
14	Program Transportation		49,894		49,894		49,894		49,894			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	6,920,535	542,122	501,423	7,964,080	(10,973)	7,953,107	(95,282)	7,857,825			16
	C. General Administration											
17	Administrative	194,403		292,965	487,368		487,368	(292,965)	194,403			17
18	Directors Fees											18
19	Professional Services			637,709	637,709		637,709	(531,150)	106,559			19
20	Dues, Fees, Subscriptions & Promotions			268,764	268,764		268,764	(73,780)	194,984			20
21	Clerical & General Office Expenses	535,723	74,561	47,132	657,416		657,416		657,416			21
22	Employee Benefits & Payroll Taxes			1,719,636	1,719,636		1,719,636		1,719,636			22
23	Inservice Training & Education			60,056	60,056		60,056		60,056			23
24	Travel and Seminar			31,819	31,819		31,819		31,819			24
25	Other Admin. Staff Transportation		6,170		6,170		6,170		6,170			25
26	Insurance-Prop.Liab.Malpractice			125,322	125,322		125,322		125,322			26
27	Other (specify):*			57,250	57,250		57,250	(20,440)	36,810			27
28	TOTAL General Administration	730,126	80,731	3,240,653	4,051,510		4,051,510	(918,335)	3,133,175			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,945,735	1,164,929	4,137,800	14,248,464	(10,973)	14,237,491	(1,014,673)	13,222,818			29

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

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			205,805	205,805		205,805	(324)	205,481			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			55,998	55,998		55,998	(11,789)	44,209			32
33	Real Estate Taxes			36,247	36,247		36,247	160	36,407			33
34	Rent-Facility & Grounds			1,803	1,803		1,803		1,803			34
35	Rent-Equipment & Vehicles			57,485	57,485		57,485		57,485			35
36	Other (specify):*			2,582	2,582		2,582		2,582			36
37	TOTAL Ownership			359,920	359,920		359,920	(11,953)	347,967			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		117,103		117,103	10,973	128,076		128,076			39
40	Barber and Beauty Shops			2,200	2,200		2,200		2,200			40
41	Coffee and Gift Shops		9,814		9,814		9,814		9,814			41
42	Provider Participation Fee			253,299	253,299		253,299		253,299			42
43	Other (specify):*			35,177	35,177		35,177	(35,174)	3			43
44	TOTAL Special Cost Centers		126,917	290,676	417,593	10,973	428,566	(35,174)	393,392			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	8,945,735	1,291,846	4,788,396	15,025,977		15,025,977	(1,061,800)	13,964,177			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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(235)	30		9
10	Interest and Other Investment Income	(11,789)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,056)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,306)	27		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				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(5,756)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(29,418)	43		24
25	Fund Raising, Advertising and Promotional	(73,381)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(19,134)	27		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(95,610)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (237,685)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (237,685)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology	x		(10,973)	10a	42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ (10,973)		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3	New Cila Lot Prop Tax		33	3
4	CSS Labor-Admin Progr.	(95,282)	12	4
5	Property Tax Adjustment	160	33	5
6	Pinnacle HOA	(154)	20	6
7	Adj Deprec to Straight Line	(89)	30	7
8	Credit Card Fee	(95)	20	8
9	HomeOwners Assoc-Non NH Related	(150)	20	9
10				10
11				11
12				12
13				13
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15				15
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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	(95,610)		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

[illegible]

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
Michael Brave	25			Brave Inc.	New Baden	Management
Ann Reis	25	Carlyle Healthcare Center	Carlyle	DAR Mngmt	Quincy	Management
		St. Vincent's Home. Inc.	Quincy	Wdm Computer Serv	Quincy	Data Processing
Blain Richard	25			RDR Mngmt	Albers	Management
Michael Greer	12.5			Greer Mngmt	Trenton	Management

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	17	Management	\$ 292,965	Brave Management	0.00%	\$	\$ (292,965)	1
2	V	19	Management	175,500	D. A. Reis LLC	0.00%		(175,500)	2
3	V	19	Data Processing	58,175	WDM Computer Services, Inc.	0.00%	58,175		3
4	V	19	Management	175,500	RDR Management	0.00%		(175,500)	4
5	V	19	Management	165,750	Greer Management	0.00%		(165,750)	5
6	V	19	Management	14,400	Gail Greer	12.50%		(14,400)	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 882,290			\$ 58,175	\$ * (824,115)	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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								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			\$			\$ 0	\$ *	39

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

Ownership Listing-1

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)			Management
-Owners of companies must be listed instead of company names.			Operator/Licensee Building Co. Co./Home Office

VII. RELATED PARTIES

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

	1		2		3			
	RELATED NURSING HOMES		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
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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	Michael Greer	Secretary	Owner	12.50	0	14	33.00	Wages	\$	17-1	1
2	Blain Richard	Vice President	Owner	25.00	0	10	25.00	Wages		17-1	2
3	Ann Reis	n/a	Owner	25.00	0	0	0.00	n/a		17-1	3
4	Dave Reis	Treasurer	Board Member	0.00	0	10	25.00	Wages		17-1	4
5	Michael Brave	President	President	25.00	0	40	100.00	Wages	30,950	17-1	5
6	RDR Mngmt	Management	Management	0.00	0	5	12.00	Mngt Fees	175,500	19-3	6
7	DAR Mngt	Management	Management	0.00	0	5	12.00	Mngt Fees	175,500	19-3	7
8	Greer Mngt	Management	Management	0.00	0	5	12.00	Mngt Fees	165,750	19-3	8
9	Brave, Inc.	Management	Management	0.00	0	5	12.00	Mngt Fees	292,965	17-3	9
10	Gail Greer	n/a	Owner	12.50	0	0	0.00	Mngt Fees	14,400	19-3	10
11	See Attatched List (Pg 28)										11
12											12
13								TOTAL	\$ 855,065		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

Facility Name & ID Number Clinton Manor Living Ctr SNF # 0033159 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Clinton Manor Living Ctr SNF # 0033159 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

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	First National Bank-27300		X	Refinance	\$21,283.00	03/10/17	\$ 1,943,810	\$ 65,760	03/10/26	4.5000	\$ 11,957	1
2	First National Bank-27100		X	Refinance			500,000	436,666			18,606	2
3	First County Bank-21400		X	Working Capital	\$1,869.20	11/13/13	150,000		11/13/24	4.3500		3
4	See List		X	See List	See List	See List	192,752	48,249	See List	Various	3,603	4
5												5
	Working Capital											
6	Central Bank-27000		X	Working Cash-Cap Ex	\$5,016.00	12/16/2020		277,066	12/16/2030	Various	10,164	6
7	First National Bank		X	Working Cash		05/11/22	300,000	300,000	05/11/2023	Various	11,669	7
8												8
9	TOTAL Facility Related				\$28,168.20		\$ 3,086,562	\$ 1,127,740			\$ 55,998	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 3,086,562	\$ 1,127,740			\$ 55,998	15

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

* 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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2024 report.			\$	34,507	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.)			\$	35,457	2
3. Under or (over) accrual (line 2 minus line 1).			\$	950	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	35,457	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	36,407	7
Assessed Value from Real Estate Tax Bill:	2024	479,040	8		
Real Estate Tax Bill for Calendar Year:	2020	30,006	9		
	2021	30,998	10		
	2022	32,101	11		
	2023	33,333	12		
	2024	34,507	13		
				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.

FACILITY NAME	Clinton Manor Living Ctr SNF	COUNTY	Clinton
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CONTACT PERSON REGARDING THIS REPORT Jamie Hull

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u> <u>Nursing Home</u>

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,794 B. General Construction Type: Exterior Brick Frame Wood, Steel, Concrete Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

F. List the bed capacity for the building if it differs from the licensed total.
G. Have you properly capitalized all major repairs and equipment purchases?
H. Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement?
J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO 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 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	
A. Land.		Use	Square Feet	Year Acquired	Cost		
1		Nursing Home	26,669	1987	\$ 66,000	1	
2						2	
3		TOTALS	26,669		\$ 66,000	3	

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	69		1987	1969	\$ 594,000	\$	30	\$		\$ 594,000	4
5	12		1991	1991	511,306		30			511,306	5
6											6
7											7
8											8
	Improvement Type**										
9	SPRINKLER			1990	3,143		20			3,143	9
10	LAND IMPROVEMENT			1992	5,410		10			5,410	10
11	BUILDING IMPROVEMENT			1992	37,505		20,10			37,505	11
12	BUILDING IMPROVEMENT			1992	26,098		20			26,098	12
13	CON			1992	3,000		30			3,000	13
14	BUILDING IMPROVEMENT			1994	12,580		20,10			12,580	14
15	PLUMBING			1995	12,201		20			12,201	15
16	LANDSCAPING			1997	1,675		10			1,675	16
17	BOILER			1997	8,858		8			8,858	17
18	REMODEL OF DINING ROOM			1997	35,389		20			35,389	18
19	HEETING/COOLING SYSTEM			1999	13,826		10			13,826	19
20	FIRE ALARM UPGRADE			2001	2,610		10			2,610	20
21	FRONT ADDITION			2001	115,835		20			115,835	21
22	DINING ROOM REMODEL			2001	84,135		20			84,135	22
23	Kitchen Improvements			2004	3,852		20			3,852	23
24	Flooring			2004	2,790		10			2,790	24
25	Laundry Building			2004	106,437		20			106,437	25
26	Bathroom Flooring			2005	3,650	46	20	46		3,650	26
27	Concrete			2005	2,367		10			2,367	27
28	Flooring			2005	3,032	88	20	88		3,032	28
29	Bathroom Remodel			2005	3,550	133	20	133		3,550	29
30	Roof Repairs			2005	4,225	141	20	141		4,225	30
31	Flooring			2006	5,960	298	20	298		5,960	31
32	New A/C Units			2006	6,141		15			6,141	32
33	New Office Building			2006	93,901	3,130	30	3,130		59,990	33
34	Flooring			2007	6,293		8			6,293	34
35	Entrance Canopy			2007	3,765	188	20	188		3,436	35
36	Replace Roof			2007	36,366	909	40	909		16,440	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

Facility Name & ID Number Clinton Manor Living Ctr SNF

0033159

Report Period Beginning:

01/01/2025 Ending: 12/31/2025

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	Range Hood	2008	\$ 8,586	\$	7	\$	\$	8,586	37
38	Alarm System	2008	7,224		8			7,224	38
39	New Patio	2009	3,346		15			3,346	39
40	Sprinkler	2010	33,827	1,353	25	1,353	(0)	21,649	40
41	Nursing Cabinets	2010	2,003	78	15	78	(0)	2,003	41
42	New Deck and Siding	2010	11,361	456	25	454	(2)	7,143	42
43	Hanover Office Building	1997	45,776	1,526	30	1,526	0	43,615	43
44	Storage Builgind	2011	18,949	486	39	486	0	6,924	44
45	Fire Door	2012	4,152	106	39	106	(0)	1,481	45
46	Accessibility System	2013	4,265	213	20	213	(0)	2,719	46
47	Shower Room 1-Plumbing	2013	8,900	228	39	228	(0)	2,891	47
48	Shower Room 1-Labor	2013	4,019	103	39	103	(0)	1,306	48
49	Shower Room 1-Materials	2013	4,836	124	39	124	0	1,570	49
50	Shower Room 1-Tile	2013	8,659	222	39	222		2,812	50
51	Shower Room 1-Drawings	2013	415	11	39	11	0	135	51
52	Shower room 2-Plumbing	2013	5,166	132	39	132	(0)	1,656	52
53	Shower Room 2-Labor	2013	3,690	95	39	95	0	1,182	53
54	Shower Room 2-Materials	2013	4,686	120	39	120	(0)	1,502	54
55	Shower Room 2-Electric	2013	3,510	90	39	90		1,125	55
56	Shower Room 2-Tile	2013	8,876	228	39	228	0	2,845	56
57	Shower Room 2-Crawings	2013	415	11	39	11	0	134	57
58	Landscaping	2015	5,292	353	15	353	0	3,763	58
59	Landscaping	2015	2,178	145	15	145	(0)	1,537	59
60	Landscaping	2015	9,707	647	15	647	(0)	6,849	60
61	New Addition-Sprinkler	2015	32,400	1,620	20	1,620		16,335	61
62	New Addition-Flooring	2015	20,860	1,043	20	1,043	0	10,517	62
63	New Addition-landscaping	2015	8,524	568	15	568	(0)	5,730	63
64	New Addition-Roof	2015	10,370	518	20	518	(0)	5,228	64
65	New Addition-Doors/Windows	2015	17,376	869	20	869	0	8,760	65
66	New Addition-Plumbing	2015	49,930	2,497	20	2,497	0	25,173	66
67	New Addition-Electrical	2015	87,738	4,387	20	4,387	0	44,234	67
68	New Addition-General Material/Labor	2015	182,981	4,692	39	4,692	0	47,310	68
69	Flooring-Therapy Room, Dining area, & 2 ICF/DD Hallways	2016	17,117	1,148	15	1,141	(7)	10,614	69
70	TOTAL (lines 4 thru 69)		\$ 2,387,032	\$ 29,002		\$ 28,994	\$ (9)	\$ 2,003,632	70

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

Facility Name & ID Number Clinton Manor Living Ctr SNF

0033159

Report Period Beginning:

01/01/2025 Ending: 12/31/2025

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	
1	Totals from Page 12A, Carried Forward		\$ 2,387,032	\$ 29,002		\$ 28,994	\$ (9)	\$ 2,003,632	1
2	Parking Lot Repaving	2016	19,373	1,299	15	1,292	(7)	12,014	2
3	Sprinkler work new addition	2016	2,108	105	20	105	(0)	1,045	3
4	Railing Outside new addition	2016	3,550	177	20	177	(0)	1,760	4
5	Door to Family 3	2016	8,846	442	20	442	(0)	4,276	5
6	Wall Protection/Handrails outside walkway from new addition	2016	5,052	253	20	253	0	2,400	6
7	Flooring-Family 1 ICF/DD Group Area	2016	6,412	321	20	321	0	3,019	7
8	SNF Dining Flooring & DD Handrails	2017	10,054	503	20	503	0	4,524	8
9	Flooring-SNF Hallway and Bath	2017	8,142	409	20	407	(2)	3,645	9
10	SNF Handrails	2017	3,282	164	20	164	(0)	1,435	10
11	Flooring-Back Hall	2017	11,500	575	20	575	0	5,031	11
12	Heating Unit	2017	18,284	914	20	914	(0)	7,999	12
13	Rm Heat/Cool in SNF Ctr DD	2017	16,417	821	20	821	0	7,046	13
14	Lighting in SNF Hallways	2017	5,058	254	20	253	(1)	2,180	14
15	Flooring-SNF Dining Area	2017	5,637	283	20	282	(1)	2,406	15
16	Windows/Door-Snf Dining Room	2017	10,002	667	15	667	0	5,724	16
17	Dining Room Carpentry	2017	22,077	2,530	8	2,530		22,077	17
18	Dining Room Cabinets	2017	10,722	1,229	8	1,229		10,722	18
19	Dining Room Electrical	2017	5,150	343	15	343	(0)	2,775	19
20	New House-Office	2017	88,209	2,262	39	2,262	0	18,283	20
21	New House/Office-Heating	2017	8,000	533	15	533	(0)	4,311	21
22	New House/Office-Cabinets	2017	3,700	424	8	424	0	3,700	22
23	CMLC Sprinklers	2017	25,851	1,293	20	1,293	0	10,448	23
24	Heat/Air Family 1	2017	12,657	844	15	844	0	6,821	24
25	Parking Lot Repaving	2018	23,503	1,567	15	1,567	0	12,012	25
26	Flooring-Spa room	2018	7,136	476	15	476	0	3,528	26
27	2 SNF Bedroom Flooring	2018	2,456	164	15	164	0	1,173	27
28	Life Safety Elec Upgrade	2018	12,335	617	20	617	0	4,677	28
29	New Security System	2018	28,070	1,404	20	1,404	0	10,059	29
30	Flooring-DD Shower/CTR H	2019	2,480	165	15	165	(0)	1,116	30
31	DD Shower Room Floor	2019	6,605	440	15	440	(0)	2,935	31
32	Replace Sprinklers	2019	26,439	1,322	20	1,322	0	8,703	32
33	Lot Resurface-SNF Front & C	2019	14,458	964	15	964	0	6,345	33
34	TOTAL (lines 1 thru 33)		\$ 2,820,597	\$ 52,764		\$ 52,746	\$ (18)	\$ 2,197,821	34

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

Facility Name & ID Number Clinton Manor Living Ctr SNF

0033159

Report Period Beginning:

01/01/2025 Ending: 12/31/2025

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	
1	Totals from Page 12B, Carried Forward		\$ 2,820,597	\$ 52,764		\$ 52,746	\$ (18)	\$ 2,197,821	1
2	Family 1, East Hall Floor	2019	5,730	382	15	382	0	2,515	2
3	DD Bath Remodel-Plumbing	2019	4,875	325	15	325	(0)	2,112	3
4	DD Bath Remodel-Floor	2019	10,730	717	15	715	(2)	4,633	4
5	Courtyard Concrete	2019	8,163	544	15	544	(0)	3,492	5
6	SNF Shower Flooring	2019	4,940	329	15	329	(0)	2,058	6
7	F Sprinkler Install	2019	17,739	1,189	15	1,183	(6)	7,334	7
8	DD Family 1 Flooring	2019	1,028	69	15	69	0	417	8
9	SPA HVAC	2019	8,556	428	20	428	0	2,995	9
10	SPA Labor/Materials	2019	48,374	2,419	20	2,419	0	16,931	10
11	Spa-Ceiling	2019	1,850	93	20	93	0	648	11
12	Spa-Flooring	2019	7,136	357	20	357	0	2,497	12
13	Coffee House Awning	2019	15,448	1,030	15	1,030	0	6,523	13
14	Coffee House Parking Lot	2019	17,479	1,165	15	1,165	(0)	7,283	14
15	DD HALLWAY CEILING	2020	7,875	394	20	394	0	2,264	15
16	Shed Lights and wiring	2020	1,210	121	10	121	(0)	686	16
17	Landscaping-front	2020	10,312	687	15	687	(0)	3,552	17
18	HOMESCAPE LANDSC-SNF DEC	2021	20,434	1,362	15	1,362	(0)	6,130	18
19	New Admin Office/Entry	2021	339,020	8,693	39	8,693	0	35,496	19
20	Admin Office HVAC	2021	19,822	508	39	508	(0)	2,075	20
21	Admin Office ELEC	2021	40,269	1,032	39	1,033	1	4,216	21
22	Admin Office Sec System	2021	14,577	374	39	374	0	1,526	22
23	Admin Office Sprinkler	2021	24,300	623	39	623	(0)	2,544	23
24	New Parking Lot	2021	177,359	11,824	15	11,824	0	48,281	24
25	Business Office Flooring	2023	9,923	662	15	662	0	1,544	25
26	New Shower in SNF Shower Room	2023	10,588	706	15	706	0	1,647	26
27	CMLC OFFICE Building Flooring	2023	2,299	153	15	153	(0)	345	27
28	NEW CABINETS In DD Family 1 Group Room	2023	7,037	704	10	704	0	1,466	28
29	CMLC FLOORING	2024	4,242	288	15	288	0	455	29
30	CEILING TILE	2024	14,730	737	20	737	1	1,043	30
31	RAMP AND STAIRCASE	2024	10,813	541	20	541	0	631	31
32	FIRE ALARM SYSTEM	2024	49,583	9,917	5	9,917	0	10,743	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,737,038	\$ 101,135		\$ 101,112	\$ (23)	\$ 2,381,903	34

**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	\$ 978,248	\$ 83,640	\$ 83,640	\$	10	\$ 527,463	71
72	Current Year Purchases	2,672	24	24		20	113	72
73	Fully Depreciated Assets	953,911				10	953,902	73
74								74
75	TOTALS	\$ 1,934,831	\$ 83,664	\$ 83,664	\$		\$ 1,481,478	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	Facility Use	2003 Ford Van	2003	\$ 40,507	\$	\$	\$	5	\$ 40,507	76
77	See List	See List	See List	333,533	20,918	20,706	(212)	5	288,795	77
78										78
79										79
80	TOTALS			\$ 374,040	\$ 20,918	\$ 20,706	\$ (212)		\$ 329,302	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)	\$ 6,111,908	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 205,716	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 205,481	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (235)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,192,683	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	Cila Div	\$ 1,636,041	\$ 60,358	\$ 1,231,318	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 1,636,041	\$ 60,358	\$ 1,231,318	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____
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: _____*

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: \$ 57,485 Description: Copier Rent \$17,589.36 Medwiser Equip Rental \$38,586.15, Dietary Equipment Rent \$1,309.66.
(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.

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2026	\$
13.	/2027	\$
14.	/2028	\$

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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	10a-3	hrs	\$	1,601	\$ 83,058	\$	1,601	\$ 83,058	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,537	116,625		1,537	116,625	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		2,401	116,305		2,401	116,305	4
5	Physician Care		visits							5
6	Dental Care	10-3	visits			5,221			5,221	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts				117,103		117,103	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)									
10		10-3	hrs		304	16,186		304	16,186	10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See List	10a-3				102,125			102,125	13
14	TOTAL			\$	5,843	\$ 439,520	\$ 117,103	5,843	\$ 556,623	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.				
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	\$	\$ 184,715	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		1,113,028	3
4	Supply Inventory (priced at <u>Fifo</u>)		55,846	4
5	Short-Term Investments			5
6	Prepaid Insurance		81,906	6
7	Other Prepaid Expenses		8,400	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$ 1,443,895	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		203,275	13
14	Buildings, at Historical Cost		3,231,420	14
15	Leasehold Improvements, at Historical Cost		2,146,888	15
16	Equipment, at Historical Cost		2,300,641	16
17	Accumulated Depreciation (book methods)		(5,415,590)	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): <u>CIP</u>		647,493	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 3,114,127	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$ 4,558,022	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$ 331,598	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		300,000	29
30	Accrued Salaries Payable		741,522	30
31	Accrued Taxes Payable (excluding real estate taxes)		74,360	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		3,468	33
34	Deferred Compensation			34
35	Federal and State Income Taxes		(82,276)	35
	Other Current Liabilities(specify):			
36	<u>Group Ins</u>		(35,553)	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$ 1,333,119	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		114,009	39
40	Mortgage Payable		824,756	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 938,765	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 2,271,884	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,286,138	\$ 2,286,138	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,286,138	\$ 4,558,022	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,650,121	1
2	Restatements (describe):		2
3	Prior Year Adj	5,100	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,655,221	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	320,406	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	(683,143)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) CILA Division	(6,346)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (369,083)	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)	\$ 2,286,138	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Clinton Manor Living Ctr SNF

0033159

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

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	\$ 14,877,114	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,877,114	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	255,729	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 255,729	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	6,433	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	13,428	17
18	Sale of Supplies to Non-Patients	(4,348)	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 15,513	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,789	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,789	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See List	185,182	28
28a	Rebates	1,056	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 186,238	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,346,383	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,232,874	31
32	Health Care	7,964,080	32
33	General Administration	4,051,510	33
	B. Capital Expense		
34	Ownership	359,920	34
	C. Ancillary Expense		
35	Special Cost Centers	164,294	35
36	Provider Participation Fee	253,299	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,025,977	40
41	Income before Income Taxes (line 30 minus line 40)**	320,406	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 320,406	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 338,864.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	573,436.00	45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	436,258.00	48
49	Medicare Part A	792,705.00	49
50	Other-(specify) DD Medicaid	12,735,850.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify) Rounding	1.00	55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 14,877,114	56

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,086	2,297	\$ 149,075	\$ 64.90	1
2	Assistant Director of Nursing	38	366	23,896	65.29	2
3	Registered Nurses	26,907	28,500	1,315,794	46.17	3
4	Licensed Practical Nurses	28,306	30,613	1,246,726	40.73	4
5	CNAs & Orderlies	39,166	41,873	1,055,558	25.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	930	1,203	54,611	45.40	8
9	Activity Director					9
10	Activity Assistants	2,109	2,125	56,663	26.66	10
11	Social Service Workers	6,000	6,418	256,582	39.98	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,978	2,086	80,810	38.74	14
15	Cook Helpers/Assistants	17,460	18,834	380,756	20.22	15
16	Dishwashers	1,498	1,562	26,878	17.21	16
17	Maintenance Workers	8,575	11,618	371,659	31.99	17
18	Housekeepers	15,007	16,245	302,624	18.63	18
19	Laundry	6,329	6,684	132,347	19.80	19
20	Administrator	2,086	2,086	163,820	78.53	20
21	Assistant Administrator					21
22	Other Administrative	1,669	1,669	30,950	18.54	22
23	Office Manager					23
24	Clerical	15,461	16,925	535,356	31.63	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)	8,118	9,040	333,675	36.91	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	82,242	88,050	2,365,188	26.86	30
31	Medical Records					31
32	Other Health C: <u>Day Training</u>	92	105	1,776	16.91	32
33	Other(specify) <u>Transportation</u>	1,924	2,135	60,991	28.57	33
34	TOTAL (lines 1 - 33)	267,981	290,434	\$ 8,945,735 *	\$ 30.80	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	144	\$ 8,248	1-3	35
36	Medical Director	Contract	36,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	4,692	10-3	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	216	20,271	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	360	\$ 69,212		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

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

** See instructions.

Facility Name & ID Number		Clinton Manor Living Ctr SNF		STATE OF ILLINOIS		Report Period Beginning:		01/01/2025		Page 21		Ending:		12/31/2025																	
XIX. SUPPORT SCHEDULES																															
A. Administrative Salaries				Ownership				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions																			
Name		Function		%		Amount		Description		Amount		Description		Amount																	
Cheryl Smith		Administrator		0		\$ 163,453		Workers' Compensation Insurance		\$ 122,173		IDPH License Fee		\$ 1,990																	
Michael Brave		CEO		25		30,950		Unemployment Compensation Insurance		49,559		Advertising: Employee Recruitment		18,972																	
								FICA Taxes		671,589		Health Care Worker Background Check																			
								Employee Health Insurance		838,565		(Indicate # of checks performed)		9,756																	
								Employee Meals				Patient Background Checks																			
								Illinois Municipal Retirement Fund (IMRF)*				Association Dues (total from pg 22, #4)		31,053																	
								Deferred Compensation				Promo Public Relations		73,381																	
								401 (k) Match		17,371		Employee Drug Tests																			
								Employee Physicals		16,140		Marketing Expense		2,210																	
								Employee Benefits-Other				See List Attached		131,003																	
								Employee Uniforms				Less: Public Relations Expense		(73,381)																	
								Employee B-Days		4,240		PAC and Lobbying payments		()																	
								Rounding		(1)		All non-allowable advertising		()																	
								TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,719,636		TOTAL (agree to Sch. V, line 20, col. 8)		\$ 194,984																	
TOTAL (agree to Schedule V, line 17, col. 1)								E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**																			
(List each licensed administrator separately.)				\$ 194,403																											
B. Administrative - Other																															
Description						Amount																									
Brave, Inc						\$ 292,965																									
TOTAL (agree to Schedule V, line 17, col. 3)				\$ 292,965																											
(Attach a copy of any management service agreement)																															
C. Professional Services																															
Vendor/Payee		Type				Amount		Description		Line #		Amount		Description		Amount															
RDR Management		Management				\$ 175,500		n/a				\$		Out-of-State Travel		\$															
D.A Reis LLC		Management				175,500																									
Greer Management		Management				165,750																									
WDM Computer Svcs		Data Processing				58,176								In-State Travel																	
Timetrak		Software Support				720																									
Creaseon & Edwards		Accounting Consult																													
Google		Software Support				12,376																									
Arentfox, Schiff LLP		Legal				15,282								Seminar Expense																	
Giffen, Winning, Bodewes		Legal				4,569								See list		31,819															
See List Attached		See List				15,436																									
Gail Greer		Management				14,400																									
Rounding														Entertainment Expense		()															
TOTAL (agree to Schedule V, line 19, column 3)								TOTAL				\$				(agree to Sch. V, line 24, col. 8)															
(For legal fee disclosure, see page 39 of instructions)				\$ 637,709												TOTAL				\$ 31,819											
* Attach copy of IMRF notifications																**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	Amount
HEALTH CARE COUNCIL OF IL (HCCI)	2,849
ILLINOIS ASSOC OF REHABILITATION FACILITIES (IARF)	19,836
IL HEALTHCARE ASSOCIATION (IHCA)	8,368
	31,053 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.

HEALTH CARE COUNCIL OF IL (HCCI)	
ILLINOIS ASSOC OF REHABILITATION FACILITIES (IARF)	
IL HEALTHCARE AS	
	Total
- (4)

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

HEALTH CARE COUNCIL OF IL (HCCI)	2,849
ILLINOIS ASSOC OF REHABILITATION FACILITIES (IARF)	19,836
IL HEALTHCARE AS	8,368
	31,053 Total
- (5)

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

\$	108,914	Line	10-2
----	---------	------	------
- (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.

\$	253,299
----	---------

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?

Yes

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?

n/a
- (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.

\$	No	Has any meal income been offset against related costs?	Indicate the amount.	\$	
----	----	--	----------------------	----	--
- (12)

Travel and Transportation

a. Are there costs included for out-of-state travel?

Yes

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.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

95

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.

\$
- (13)

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

no

Firm Name:
- (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.

The following is a breakdown of Schedule V Line 6 Column 3

Repairs & Maint. Dietary	\$ 1,566.62
Repairs & Maint. Laundry	\$ 3,057.81
Repairs & Maint. Housekeeping	\$ 321.05
Repairs & Maint. Outside services	\$ 103,309.61
Repairs & Maint. Building	\$ 20,438.20
Repairs & Maint. Equipment	\$ 93,995.20
Repairs & Maint. Wheelchairs	\$ -
Repairs & Maint. Ground	\$ -
Repairs & Maint. Groc.Annuln.	\$ 4,950.00
	<u>\$ 227,638.49</u>

The following is a breakdown of Schedule V Line 21 Column 3

Telephone	\$ 41,849.18
Capitol	\$ -
Printing Exp.	\$ -
Postage	\$ 5,183.24
	<u>\$ 47,032.42</u>

The following is a breakdown of Schedule V Line 36 Column 3

Amortization of Loan Costs	\$ -
Fines/Penalties	\$ -
Rounding	\$ -

The following is a breakdown of Schedule V Line 43 Column 6

Dial Debt Expense	\$ 29,418.00
Contributions	\$ 5,756.33
Rounding	\$ -
	<u>\$ 35,174.33</u>

The following is a breakdown of Schedule V Line 27 Column 3

Sales Tax	\$ 1,305.97
Sales Replacement Tax	\$ 19,134.00
Meetings Exp. (food)	\$ 30,216.02
Mail Exp	\$ 3,945.19
Bank Fees	\$ 2,468.86
Rounding	\$ -
	<u>\$ 57,250.04</u>

The following is a breakdown of Schedule V Line 28 Column 2

Mileage reimbursement (administrative)	\$ 8,170.22
	<u>\$ 8,170.22</u>

The following is a breakdown of Schedule XVIII Line 28a

Misc. Revenue	\$ 3,699.10
Uniform Sales	\$ 1,669.20
Income from Transportation and quality directive payment	\$ 450.00
Education Reimbursement	\$ 9,142.86
Admna Program Cst	\$ 37,476.24
CNA Incentive Program	\$ 95,281.77
Rounding	\$ 37,462.57
	<u>\$ 185,181.74</u>

The following is a breakdown of Schedule XIX, Section F

ILFIR	License	\$ 102.25
Contental Testing	License	\$ 209.25
Soc of State	License	\$ 1,849.70
CMS Reverify	License	\$ 750.00
Village of New Baden	License	\$ 23.00
Clinton Co Health	License	\$ 155.00
Bellville News/Democrat	Subscription	\$ 2,061.80
Amason	Subscription	\$ 119.00
INHAA	Dues	\$ 125.00
Quiken	Subscription	\$ 77.88
Ashley	Subscription	\$ 2,859.12
Foreign Trans Fee	Dfesa	\$ 5.26
CompuType	Software	\$ 16,603.90
DRFIR	License	\$ 1,380.00
MamiCare	Software	\$ 864.54
MTC	Software	\$ 46,903.42
Point Click Care	Software	\$ 57,016.30
QR Code Generator	Software	\$ 175.62
Survey Monkey	Software	\$ 468.00
Techknow Solutions	Software	\$ 1,789.00
W21099 Filing	Software	\$ 1,275.74
Collaborative Healthcare	Healthcare Fee	\$ 1,140.00
O'Fallon Shiloh Chamber	Membership Fee	\$ 700.00
IL Nursing Home Administrator Assn	Membership Fee	\$ 75.00
Michael Hovee	SW Lic. Fee	\$ 102.25
Michael Hovee	NHA License Fee	\$ 61.35
Monards	Sum Membership	\$ 110.00
Rounding		\$ (1.00)
		<u>\$ 131,003.38</u>

The following is a breakdown of Schedule XIX, Section C.

Innovation	Software Support	\$ 12,443.49
Trust Qen	Event Notice	\$ 160.00
Christopher Crivelli	Leadership Training	\$ 2,400.00
Elder Alternative	Elder Care Consulting	\$ 195.00
Empower	Retirement Services	\$ 237.50
Rounding		\$ -
		<u>\$ 13,435.99</u>

Schedule XIII, Section A.

Cna's are responsible for their own training and testing.

Schedule XI, Section D.

Use	Make, Model and Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
79 Facility Use	2001 FORD F150	2011	\$6,365.00	-	\$0.00	\$0.00	5	\$6,365.00
81 Facility Use	15 DODGE CARAVAN (2CARDG	2015	\$43,500.00	-	\$0.00	\$0.00	5	\$43,500.00
83 Facility Use	2017 DODGE CARAVAN	2017	\$38,225.97	-	\$0.00	\$0.00	5	\$38,225.97
85 Facility Use	1610 CARAVAN SXT	2018	\$23,010.25	-	\$0.00	\$0.00	5	\$23,010.25
86 Facility Use	19 FORD E350	2018	\$60,127.25	-	\$0.00	\$0.00	5	\$60,127.25
87 Facility Use	2019 DODGE RAM VAN-04929	2019	\$28,761.39	\$0.00	\$0.00	\$0.00	5	\$28,761.39
88 Facility Use	2020 RAM 1500 CREW	2021	\$41,050.83	\$203.98	\$8,203.98	\$0.00	5	\$27,051.51
89 Facility Use	2014 DODGE CARAVAN	2021	\$20,962.38	\$0.00	\$0.00	\$0.00	5	\$20,962.38
90 Facility Use	2024 CHRYSLER VOYAGER897	2024	\$62,509.59	12,713.82	\$12,501.91	-\$211.91	5	\$21,189.68
				<u>\$20,917.80</u>	<u>\$20,705.00</u>	<u>-\$211.91</u>		<u>\$386,795.11</u>

Brave, Inc.	GMS	RDR	DAR	Gail Greer		WDM
\$ 24,413.76	\$ 13,812.50	\$ 14,625.00	\$ 14,625.00	\$ 1,200.00	1	\$ 9,875.00
\$ 24,413.76	\$ 13,812.50	\$ 14,625.00	\$ 14,625.00	\$ 1,200.00	2	\$ 9,155.17
\$ 24,413.76	\$ 13,812.50	\$ 14,625.00	\$ 14,625.00	\$ 1,200.00	3	\$ 3,140.00
\$ 24,413.76	\$ 13,812.50	\$ 14,625.00	\$ 14,625.00	\$ 1,200.00	4	\$ 4,000.00
\$ 24,413.76	\$ 13,812.50	\$ 14,625.00	\$ 14,625.00	\$ 1,200.00	5	\$ 3,160.00
\$ 24,413.76	\$ 13,812.50	\$ 14,625.00	\$ 14,625.00	\$ 1,200.00	6	\$ 3,200.00
	\$ 13,812.50	\$ 14,625.00	\$ 14,625.00	\$ 1,200.00	7	\$ 3,875.00
\$ 24,413.76				\$ 1,200.00	8	\$ 3,140.00
\$ 24,413.76	\$ 13,812.50	\$ 14,625.00	\$ 14,625.00	\$ 1,200.00	9	\$ 3,572.50
\$ 24,413.76	\$ 13,812.50	\$ 14,625.00	\$ 14,625.00	\$ 1,200.00	10	\$ 7,173.50
\$ 24,413.76	\$ 13,812.50	\$ 14,625.00	\$ 14,625.00	\$ 1,200.00	11	\$ 3,180.00
\$ 24,413.76	\$ 13,812.50	\$ 14,625.00	\$ 14,625.00	\$ 1,200.00	12	\$ 4,704.19
\$ 24,413.76	\$ 13,812.50	\$ 14,625.00	\$ 14,625.00			
\$292,965.12	\$165,750.00	\$175,500.00	\$175,500.00	\$14,400.00		\$58,175.36

Clinton Manor Living Center, Inc.
01/01/25 thru 12/31/25
0033159

The following is a breakdown of the reclassifications:

- 1. Reclass \$
- 2. Reclass \$
- 3. Reclass \$
- 4. Reclass \$
- 5. Reclass \$
- 6. Reclass \$
- 7. Reclass \$
- 8. Reclass \$
- 9.
- 10
- 11

Clinton Manor Living Center, Inc.
01/01/25 thru 12/31/25
0033159

Schedule VII Attachment

Name	Function	Nursing Home	Compensation		
			Ownership Interest	from other Nursing Homes	Interest Income
D.A. Reis LLC	Management	Southern Illinois Comm. Support Services.	0	\$26,700.35	\$0.00
Greer Management	Management	Southern Illinois Comm. Support Services.	0	\$26,700.35	\$0.00
Brave Inc	Management	Southern Illinois Comm. Support Services.	0	\$26,700.35	\$0.00
RDR Management	Management	Southern Illinois Comm. Support Services.	0	\$26,700.35	\$0.00
David Reis	Owner	Southern Illinois Living Center, Inc.	25		\$0.00
Gail Greer	Owner	Southern Illinois Living Center, Inc.	12.5		\$0.00
Mike Greer	Owner	Southern Illinois Living Center, Inc.	12.5		\$0.00
Michael Brave	Owner	Southern Illinois Living Center, Inc.	25		\$0.00
Blain Richard	Owner	Southern Illinois Living Center, Inc.	25		\$0.00

Clinton Manor Living Center, Inc.
01/01/25 thru 12/31/25
0033159

Name of Lender	Related**		Purpose of Loan	Payment Required	Date of Note	Amount of Note		Maturity Date	Rate (4 Digits)	Interest Expense	Acct #
	YES	NO				Original	Balance				
A. Directly Facility Related											
Long-Term											
First County Bank		X	2020 Dodge Ram	\$719.00	6/22/2021	\$40,519.83	\$4,284.40	6/22/2026	2.4900%	\$219.73	212100
First County Bank		X	2023 Chrysler Voyager	\$1,230.00		\$62,509.59	\$43,964.84	4/2/2029	6.7400%	\$3,383.32	215000
						<u>\$103,029.42</u>	<u>\$48,249.24</u>			<u>\$3,603.05</u>	
Working Capital											
						<u>\$0.00</u>	<u>\$0.00</u>			<u>\$0.00</u>	

Clinton Manor Living Center, Inc.
01/01/25 thru 12/31/25
0033159

Schedule XIV Attatchment

Service	Sched V	Outside Practitioner Units	Cost	Supplies	Total Units	Total Costs
Pediatrist	10-3				\$0.00	\$0.00
Radiology	10a-3		\$4,031.73		\$0.00	\$4,031.73
Labs	10a-3		\$6,941.57		\$0.00	\$6,941.57
Respatory Therapy	10a-3		\$91,151.43		\$0.00	\$91,151.43
Total		0	\$102,124.73	0	0	\$102,124.73

Clinton Manor Living Center, Inc.
01/01/25 thru 12/31/25
0033159

91720 2025

[illegible]

92400 Inservice Training 2025

Date	Training	Instructor	Purchased	Purchased By	Total
1/1/2025	Relias		Agreement	Michael Brave	1,668.45
1/8/2025	CPR	L.Norris	Cert. Cards/Manuals	Link Norris	193.45
1/22/2025	CPR	L.Norris	Cert. Cards/Manuals	Link Norris	306.95
1/23/2025	AAPACN		Training Manual	Darla Loomis	63.00
1/23/2025	MandtSystem		Workbooks	Marah Elliott	187.59
1/31/2025	CPR	L.Norris	Cert. Cards/Manuals	Link Norris	17.00
1/31/2025	IHCA Surveyor Guidance		Books	Darla Loomis	545.00
2/1/2025	Relias		Agreement	Michael Brave	1,668.45
2/3/2025	AHCA		Nurse Assistant Textboo	Marah Elliott	293.82
2/28/2025	CPR	L.Norris	Cert. Cards/Manuals	Link Norris	156.45
2/28/2025	Skill Path		OSHA Recordkeeping E	Marah Elliott	224.00
2/28/2025	Leadership Lunch & Learn		Books	Sara Gerstner	55.44
3/1/2025	Relias		Agreement	Michael Brave	1,668.45
3/4/2025	CPR	L.Norris	Cert. Cards/Manuals	Link Norris	148.50
3/14/2025	Leadership Team		Certifications	Michael Brave	3,314.15
3/27/2025	CPR	L.Norris	Cert. Cards/Manuals	Link Norris	653.45
4/1/2025	Relias		Agreement	Michael Brave	1,668.45
4/2/2025	CPR	L.Norris	Cert. Cards/Manuals	Link Norris	158.45
4/2/2025	World Point	L.Norris	CPR Training Supplies	Marah Elliott	52.71
4/11/2025	HCCI	Webinar	Food Safety Course	Marah Elliott	100.00
5/1/2025	Relias		Agreement	Michael Brave	1,668.45
5/6/2025	CPR	L.Norris	Cert. Cards/Manuals	Link Norris	109.95
5/9/2025	IHCA	Webinar	NHA Class	Darla Loomis	370.00
5/14/2025	CPR	L.Norris	Cert. Cards/Manuals	Link Norris	134.95
5/14/2025	AAA Food Handler		Food Handler Cert.	Marah Elliott	119.95
5/15/2025	CPR	L.Norris	Cert. Cards/Manuals	Link Norris	55.95
5/20/2025	CPR	L.Norris	Cert. Cards/Manuals	Link Norris	158.95
6/1/2025	Relias		Agreement	Michael Brave	1,668.45
6/5/2025	Trenton Sun		Annual Training Books		398.40
6/6/2025	MandtSystem		Training Supplies	Marah Elliott	187.91
6/13/2025	Eden Alternative	Webinar	Eden Alternative Classes	Darla Loomis	760.00
6/16/2025	AAA Food Handler		Food Safety Course	Marah Elliott	119.95
6/23/2025	World Point		CPR Training Supplies	Marah Elliott	34.40
6/24/2025	ID/DD Symposium	Virtual	DD & HFS Training	Marah Elliott	1,050.00
6/24/2025	CPR	L.Norris	Cert. Cards/Manuals	Link Norris	306.95
6/30/2025	Eden Alternative		Certifications	Sara Gerstner	1,440.00
7/1/2025	Relias		Agreement	Michael Brave	1,668.45
7/14/2025	MandtSystem		Training Supplies	Marah Elliott	430.50
7/30/2025	CPR	L.Norris	Cert. Cards/Manuals	Link Norris	39.00
7/31/2025	Trenton Sun		Annual Training Books		1,494.00
7/31/2025	Internal Investigation		Webinar	Samantha Lappe	120.00
8/1/2025	Relias		Agreement	Michael Brave	1,668.45
8/5/2025	CPR	L.Norris	Cert. Cards/Manuals	Link Norris	353.50
8/28/2025	CPR	L.Norris	Cert. Cards/Manuals	Link Norris	312.95
8/31/2025	Leadership Lunch & Learn		Books	Sara Gerstner	544.99
9/1/2025	Relias		Agreement	Michael Brave	1,668.45
9/11/2025	CPR	L.Norris	Cert. Cards/Manuals	Link Norris	437.95
9/30/2025	Leadership Lunch & Learn		Books	Sara Gerstner	41.52
10/14/2025	CPR	L.Norris	Cert. Cards/Manuals	Link Norris	116.95
10/1/2025	Relias		Agreement	Michael Brave	1,668.45
10/8/2025	Optum		SNF Guideline	Darla Loomis	204.96
10/16/2025	CPR	L.Norris	Cert. Cards/Manuals	Link Norris	223.95
10/25/2025	CPR	L.Norris	Cert. Cards/Manuals	Link Norris	29.00
10/30/2025	CPR	L.Norris	Cert. Cards/Manuals	Link Norris	61.95
10/31/2025	Leadership Lunch & Learn		Books	Sara Gerstner	16.93
11/1/2025	Relias		Agreement	Michael Brave	1,668.45
11/5/2025	cpr	L.Norris	Cert. Cards/Manuals	Link Norris	29.00
11/20/2025	CPR	L.Norris	Cert. Cards/Manuals	Link Norris	231.92
12/1/2025	Relias		Agreement	Michael Brave	1,668.45
12/2/2025	AAA Food Handler		Food Safety Course	Marah Elliott	119.95
12/4/2025	CPR	L.Norris	Cert. Cards/Manuals	Link Norris	60.45
12/29/2025	Amazon	C. Leonard	Orientation	C. Leonard	129.26
12/29/2025	CPR	L.Norris	Cert. Cards/Manuals	Link Norris	57.25
12/29/2025	CPR	L.Norris	Cert. Cards/Manuals	Link Norris	268.70
12/31/2025			ADJ TUITION		22,992.34
					60,055.74