

		FOR BHF USE					

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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: 0047597

Facility Name: Jerseyville Manor

Address: 1251 North State St Jerseyville 62052

County: Jersey

Telephone Number: (618) 498-6441 Fax # (618) 498-9025

HFS ID Number:

Date of Initial License for Current Owners: 09/28/05

Type of Ownership:

X

VOLUNTARY,NON-PROFIT

X

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)

(Type or Print Name) Brian Burger

(Title) Chief Financial Officer

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT

(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 Jerseyville Manor # 0047597 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	154	Skilled (SNF)	154	56,210	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	154	TOTALS	154	56,210	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	7,205	15,948			18,618	9,458	2,486	53,715	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	7,205	15,948			18,618	9,458	2,486	53,715	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 95.56%

SEE ACCOUNTANTS' PREPARATION REPORT

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 10/01/05

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 9/28/05 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter certified beds.
number of certified beds 154

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS
ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐
Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 9/30/2025 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	625,453	47,543	18,312	691,308		691,308		691,308			1
2	Food Purchase		640,940		640,940		640,940	(1,165)	639,775			2
3	Housekeeping	349,049	57,246		406,295		406,295		406,295			3
4	Laundry	156,218	31,235	98	187,551		187,551		187,551			4
5	Heat and Other Utilities			281,678	281,678		281,678		281,678			5
6	Maintenance	169,705	35,604	171,275	376,584		376,584	(12,085)	364,499			6
7	Other (specify):*											7
8	TOTAL General Services	1,300,425	812,568	471,363	2,584,356		2,584,356	(13,250)	2,571,106			8
	B. Health Care and Programs											
9	Medical Director			56,250	56,250		56,250		56,250			9
10	Nursing and Medical Records	6,174,736	342,274	18,844	6,535,854		6,535,854		6,535,854			10
10a	Therapy											10a
11	Activities	186,463	2,964		189,427		189,427		189,427			11
12	Social Services	85,560			85,560		85,560		85,560			12
13	CNA Training		2,429		2,429		2,429		2,429			13
14	Program Transportation			8,772	8,772		8,772		8,772			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	6,446,759	347,667	83,866	6,878,292		6,878,292		6,878,292			16
	C. General Administration											
17	Administrative	129,253			129,253		129,253		129,253			17
18	Directors Fees							2,205	2,205			18
19	Professional Services			430,595	430,595		430,595	1,659	432,254			19
20	Dues, Fees, Subscriptions & Promotions			24,428	24,428		24,428	(5,821)	18,607			20
21	Clerical & General Office Expenses	142,079	35,306	88,180	265,565		265,565	2,139	267,704			21
22	Employee Benefits & Payroll Taxes			1,220,561	1,220,561		1,220,561		1,220,561			22
23	Inservice Training & Education			1,610	1,610		1,610		1,610			23
24	Travel and Seminar			344	344		344		344			24
25	Other Admin. Staff Transportation			8,774	8,774		8,774		8,774			25
26	Insurance-Prop.Liab.Malpractice			345,253	345,253		345,253	26,806	372,059			26
27	Other (specify):*											27
28	TOTAL General Administration	271,332	35,306	2,119,745	2,426,383		2,426,383	26,988	2,453,371			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,018,516	1,195,541	2,674,974	11,889,031		11,889,031	13,738	11,902,769			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.

SEE ACCOUNTANTS' PREPARATION REPORT

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			251,480	251,480		251,480	359,820	611,300			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							71,368	71,368			32
33	Real Estate Taxes			4,648	4,648		4,648	179,090	183,738			33
34	Rent-Facility & Grounds			835,200	835,200		835,200	(835,200)				34
35	Rent-Equipment & Vehicles			16,652	16,652		16,652		16,652			35
36	Other (specify):* Mortgage Ins							15,355	15,355			36
37	TOTAL Ownership			1,107,980	1,107,980		1,107,980	(209,567)	898,413			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			3,368	3,368		3,368		3,368			38
39	Ancillary Service Centers		399,847	1,333,587	1,733,434		1,733,434		1,733,434			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			936,162	936,162		936,162		936,162			42
43	Other (specify):* Disallowed Costs	40,012		211,397	251,409		251,409	(251,409)				43
44	TOTAL Special Cost Centers	40,012	399,847	2,484,514	2,924,373		2,924,373	(251,409)	2,672,964			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,058,528	1,595,388	6,267,468	15,921,384		15,921,384	(447,238)	15,474,146			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	(1,165)	2		4
5	Telephone, TV & Radio in Resident Rooms	(15,551)	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	(9,240)	30		9
10	Interest and Other Investment Income	(2,243)	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	(1,152)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(114,047)	43		24
25	Fund Raising, Advertising and Promotional	(56,156)	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	(458,377)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (657,931)		\$	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)	210,693		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 210,693		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (447,238)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (4,826)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Disallow Marketing Wages	(40,012)	43	3
4	Disallow R/E Entity HUD Audit	(30,585)	19	4
5	Disallow Related Party Interest Expense	(344,316)	32	5
6	Disallow Lab Expense	(11,979)	43	6
7	Disallow X-Ray Expense	(10,678)	43	7
8	Offset Maint Fee Income	(12,085)	6	8
9	Disallow Loss on Disposal	(2,986)	43	9
10	Disallow AL Allocated RE Taxes & Late Fees	(910)	33	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
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(458,377)		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%	\$ 2,205	\$ 2,205	1
2	V	19	Professional Fees		Unlimited Development, Inc.	100.00%	1,659	1,659	2
3	V	20	Dues, Licenses and Subs		Unlimited Development, Inc.	100.00%	82	82	3
4	V	21	General Admin Expense		Unlimited Development, Inc.	100.00%	2,139	2,139	4
5	V	26	Property Insurance		Unlimited Development, Inc.	100.00%	1,744	1,744	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			\$			\$ 7,829	\$ * 7,829	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	\$	Jerseyville North State, LLC	N/A	\$ 30,585	\$ 30,585	15
16	V	20	Dues, Fees, Subs & Prom		Jerseyville North State, LLC	N/A	75	75	16
17	V	26	Property Insurance		Jerseyville North State, LLC	N/A	25,062	25,062	17
18	V	30	Depreciation		Jerseyville North State, LLC	N/A	369,060	369,060	18
19	V	32	Interest Expense	25	Jerseyville North State, LLC	N/A	417,952	417,927	19
20	V	33	Property Taxes		Jerseyville North State, LLC	N/A	180,000	180,000	20
21	V	34	Facility Rent	835,200	Jerseyville North State, LLC	N/A		(835,200)	21
22	V	36	Mortgage Insurance		Jerseyville North State, LLC	N/A	15,355	15,355	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			\$ 835,225			\$ 1,038,089	\$ * 202,864	39

Facility Name & ID Number

Jerseyville Manor

0047597

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

Jerseyville Manor

0047597

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								\$ 2,205	L18, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,205		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 Jerseyville Manor # 0047597 Report Period Beginning: 10/1/2024 Ending: 1/30/2025

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	18	Director Fees	Weighted Avg BDA	458,805	17	18,000	\$	56,210	\$ 2,205	1
2	19	Professional Fees	Weighted Avg BDA	458,805	17	13,539		56,210	1,659	2
3	20	Dues, Licenses and Subs	Weighted Avg BDA	458,805	17	668		56,210	82	3
4	21	General Admin Expense	Weighted Avg BDA	458,805	17	17,456		56,210	2,139	4
5	26	Property Insurance	Weighted Avg BDA	458,805	17	14,235		56,210	1,744	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					\$ 63,898	\$		\$ 7,829	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	Cambridge Realty Capital						\$		\$			\$	1		
2	LTD. of Illinois		X	Facility purchase	\$17,694.29	5/1/12		4,173,100	3,028,923	3/1/2046	3.5500	73,636	2		
3													3		
4	Community Living												4		
5	Options, Inc.	X		Wing addition		8/1/2009		5,738,601	5,738,601	7/1/2039	6.0000	344,316	5		
	Working Capital														
6													6		
7													7		
8													8		
9	TOTAL Facility Related				\$17,694.29		\$	9,911,701	\$	8,767,524			\$	417,952	9
	B. Non-Facility Related*														
10													10		
11									Int Income Offset			(2,268)	11		
12									Disallow Related Party Int Exp			(344,316)	12		
13													13		
14	TOTAL Non-Facility Related						\$		\$			\$	(346,584)	14	
15	TOTALS (line 9+line14)						\$	9,911,701	\$	8,767,524			\$	71,368	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 15,355 Line # 36

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Jerseyville Manor COUNTY Jersey

FACILITY IDPH LICENSE NUMBER 0047597

CONTACT PERSON REGARDING THIS REPORT Brian Burger

TELEPHONE (309) 343-1550 FAX #: (309) 343-2857

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2024.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 04-127-014-00	PARCELS PT SE 1/4 (TRACT	\$ 250,878.80	\$ 175,615.16
2.	1 & PT TRACT 2 - SURVEY	\$	\$
3.	IN PC1/54B)	\$	\$
4.		\$	\$
5. 04-127-015-00	PT SE1/4 SE1/4 (PT TRACT 2	\$ 1,536.30	\$ 768.15
6.	PC1/54B)	\$	\$
7.		\$	\$
8. 04-127-016-00	TRACT IN MID PT SE1/4	\$	\$
9.	E OF RD	\$ 2,969.26	\$ 2,969.26
10.		\$	\$
TOTALS		\$ 255,384.36	\$ 179,352.57

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,306 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:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	3.5 Acres	2005	\$ 160,000	1
2	Facility Addition	.88 Acres	2008	14,025	2
3	TOTALS	#VALUE!		\$ 174,025	3

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	86		2005		\$ 4,578,867	\$	40	\$ 114,472	\$ 114,472	\$ 2,298,973	4
5	68		2008		4,926,175		25	197,047	197,047	3,349,800	5
6											6
7											7
8											8
	Improvement Type**										
9	Attic Insulation			2005	5,952		15			5,952	9
10	Parking Lot Lighting			2006	5,355		15			5,355	10
11	Furnace, Wall Paper/Paint Dining/Kitchen/Beauty Shop			2008	13,072		5-15 yrs			13,072	11
12	Floor Scrubber, Elec Sign, Prking Lot, Renten Pnd, Sidwlks			2008	398,166		5-20 yrs	1,851	1,851	392,610	12
13	Landscaping, Fence			2008	47,677		10-15 yrs			47,677	13
14	Electric Install, Recliner Wheelchairs, Baskets			2008	37,076		13			37,076	14
15	Dish Truck, Steamable, Convect. Steamer, Wiring Convec Over			2008	15,149		10			15,149	15
16	Roof			2008	116,316		10			116,316	16
17	Paint & Wallpaper, Paint & Wallpaper, Fence			2008	16,441		5-8 yrs			16,441	17
18	Wndw Decs, Duct work, Veranda, outside lights, Jrsvyle Parking Lot			2009	265,075		5-15 yrs			265,075	18
19	Generator, lobby remodel (Contracted Total)			2011	35,315		5-12 yrs.			35,315	19
20	Bathroom #1- Fixtures/Plumbing/Toilet/Drywall/Cabinets/Tile Floor/Pain			2012	68,090	474	12	474		68,090	20
21	Bathroom #2- Drywall/Plumbing/Fixtures/Cabinets/Tile Floor/Toilet/ Gra			2012	59,732	415	12	415		59,732	21
22	Bathroom #3- Fixtures/Plumbing/Toilet/Cabinets/Paint/ Drywall			2012	29,696	206	12	206		29,696	22
23	Bathroom #4- Fixtures/Drywall/Paint/Cabinets/Toilet/Tile Floor/ Grab Ba			2012	30,269	210	12	210		30,269	23
24	Water heater			2014	10,185		10			10,185	24
25	Water heater			2014	5,204		10			5,204	25
26	Exterior Double Doors			2014	5,641		10			5,641	26
27	Courtyard Doors			2014	2,615	174	15	174		1,990	27
28	Hollow Metal Doors			2014	4,937	247	20	247		2,818	28
29	Water Softener			2014	3,539		10			3,539	29
30	Concrete-Parking Lot			2014	52,000	3,466	15	3,466		38,422	30
31	Concrete Driveway			2015	25,040	1,669	15	1,669		17,249	31
32	Furnace/AC			2015	6,800	510	10	510		6,800	32
33	Carpet Therapy Room			2015	2,791		5			2,791	33
34	Therapy Room Addition			2015	582,659		40	14,566	14,566	143,236	34
35											35
36											36

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

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

Facility Name & ID Number Jerseyville Manor

0047597

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	Quarry Tile-Kitchen/VCT-Hall/Breakroom/Office/3 Bathrooms	2015	\$ 9,804	\$ 490	20	\$ 490	\$	\$ 4,861	37
38	Seal Parking Lot	2016	5,058		8			5,058	38
39	Kitchen Remodel-Tile/Cabinets/Counter Tops/Fixtures/Plumbing	2016	152,555	12,713	12	12,713		119,713	39
40	A/C Unit; Coil	2016	10,100		5			10,100	40
41	A/C Unit; Coil, Furnace, Condenser-Roof Top Unit	2016	10,250	683	15	683		6,206	41
42	Repair Boiler Fill Valve	2016	2,836	284	10	284		2,529	42
43	Furnace/AC Units/Coil	2017	10,950	730	15	730		6,144	43
44	100 Wing-Demo Electrical, Install TV Receptacles, Jacks/Light Fix	2017	16,985	1,699	10	1,699		14,013	44
45	300 Wing-Demo Electrical, Install TV Receptacles, Jacks/Light Fix	2017	14,536	1,453	10	1,453		11,992	45
46	200 Wing-Demo Electrical, Install TV Receptacles, Jacks/Light Fix	2017	20,217	2,022	10	2,022		16,679	46
47	100-300 Wing Remodel-VCT Tile/Lighting/Cove Base/Nurse Call/I	2017	949,403	65,996	12	79,117	13,121	639,529	47
48	Life Safety/Ceiling Mural								48
49	Furnace/AC Units/Coil	2018	8,601	573	15	573		4,109	49
50	Compressor	2018	3,301	220	15	220		1,558	50
51	Replace Roof - Wings 400 and 500	2018	121,475		10	12,146	12,146	85,034	51
52	Nutrition Rm & O2 Room- New Cabinets/Counters/Exhaust Fan	2018	10,600		12	885	885	6,110	52
53	Water Heater - 400 Hall	2018	8,100	810	10	810		5,603	53
54	2 Water Heaters	2019	19,635	1,963	10	1,963		13,088	54
55	New Motor/Exhaust Fan-Dishwasher Rooftop Unit	2019	5,703	380	15	380		2,407	55
56	Garden Court Remodel-Flooring-Carpet/Vinyl	2020	5,337	444	12	444		2,557	56
57	New Lighted Outdoor Sign	2021	6,321	421	15	421		1,931	57
58	New Split System Air Conditioner	2021	6,430	429	15	429		1,822	58
59	New Direct TV System	2021	23,400	2,340	10	2,340		9,555	59
60	New Flooring/Lighting/Ceiling Track Installed in PT Room	2021	91,270	6,084	15	6,084		24,846	60
61	PT Room Addition - Gen Contractor/Engineering/Architect/Permi	2021	846,759	33,870	25	33,870		138,303	61
62	Landscaping - PT Addition - Sod/Bushes/Trees/Edging/Rock	2021	88,619	8,862	10	8,862		36,186	62
63	New Water Heater	2022	15,632	1,563	10	1,563		5,340	63
64	New Water Softener	2022	3,839	383	10	383		1,343	64
65	Repace Compressors in 2 AC Units	2022	7,222		5	1,444	1,444	5,054	65
66	3 New PTAC Units	2022	2,514		5	503	503	1,760	66
67	New AC Unit/Coil	2023	9,052	1,810	5	1,810		4,525	67
68	New Water Heater	2023	8,585	858	10	858		1,860	68
69	Replace Leaking Drainage Pipe/Concrete in Front Bathrooms	2023	17,500	1,167	15	1,167		2,528	69
70	TOTAL (lines 4 thru 69)		\$ 13,862,423	\$ 155,618		\$ 511,653	\$ 356,035	\$ 8,216,816	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

****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	\$ 1,347,557	\$ 51,919	\$ 68,075	\$ 16,156	5-15 yrs	\$ 1,104,685	71
72	Current Year Purchases	84,561	8,259	8,259		5-7 yrs	8,259	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,432,118	\$ 60,178	\$ 76,334	\$ 16,156		\$ 1,112,944	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	2014 Braun Entervan	2014	\$ 41,928	\$	\$	\$	4	\$ 41,928	76
77	Patient Care	2018 Turtle Top Bus	2018	57,517				4	57,517	77
78	Patient Care	2016 Toyota Corola	2021	9,000	559	559		4	9,000	78
79										79
80	TOTALS			\$ 108,445	\$ 559	\$ 559	\$		\$ 108,445	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)	\$ 15,810,582	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 251,444	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 611,300	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 359,856	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 9,462,309	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 GMC G3500 Van - 2006	\$ 29,848	\$	\$ 29,848	86
87					87
88	Leasehold Improvements - AL	4,326	36	36	88
89					89
90					90
91	TOTALS	\$ 34,174	\$ 36	\$ 29,884	91

G. Construction-in-Progress

	Description	Cost	
92	Sprinkler System	\$ 270,000	92
93			93
94			94
95		\$ 270,000	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 .
N/A
N/A
9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 16,652 Description: Medical Equipment
(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	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	\$	\$ 2,180	\$	\$ 2,180
2	Books and Supplies		249		249
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	\$	\$ 2,429	\$	\$ 2,429
10	SUM OF line 9, col. 1 and 2 (e)	\$ 2,429			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	14,805	\$ 624,207	\$	14,805	\$ 624,207	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		3,951	211,785		3,951	211,785	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		11,174	497,595		11,174	497,595	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				399,847		399,847	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	29,930	\$ 1,333,587	\$ 399,847	29,930	\$ 1,733,434	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' PREPARATION REPORT

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (239,132)	\$ 126,982	1
2	Cash-Patient Deposits	40,011	40,011	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 89,000)	2,066,225	2,168,565	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		700,000	5
6	Prepaid Insurance	213,929	240,604	6
7	Other Prepaid Expenses	1,015	1,015	7
8	Accounts Receivable (owners or related parties)	25,784,830	25,077,758	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 27,866,878	\$ 28,354,935	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		174,025	13
14	Buildings, at Historical Cost	3,358,761	13,607,316	14
15	Leasehold Improvements, at Historical Cost	95,644	488,678	15
16	Equipment, at Historical Cost	746,902	1,540,563	16
17	Accumulated Depreciation (book methods)	(2,430,643)	(9,462,309)	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 (see Schedule 17A)	270,000	274,290	22
23	Other(specify): See Schedule 17A		293,505	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,040,664	\$ 6,916,068	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 29,907,542	\$ 35,271,003	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 856,410	\$ 1,077,593	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	40,011	40,011	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	230,351	230,351	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		149,084	32
33	Accrued Interest Payable		522,507	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)	\$ 1,126,772	\$ 2,019,546	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,767,524	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Security Deposits	76,500	76,500	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 76,500	\$ 8,844,024	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,203,272	\$ 10,863,570	46
47	TOTAL EQUITY(page 18, line 24)	\$ 28,704,270	\$ 24,407,433	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 29,907,542	\$ 35,271,003	48

Facility Name:Jerseyville Manor

IDPH License ID Number:0047597

Fiscal Year End:9/30/2025

Schedule 17A

Line 22 Other Long Term Assets (specify):

Description	Operating	After Consolidation
Non Care Assets		34,174
Reserve for Depr - Non Care Assets		(29,884)
Construction in Progress	270,000	270,000
Total - Line 22	270,000	274,290

XV. Balance Sheet

Line 23 Long Term Assets Other (specify):

Description	Operating	After Consolidation
Real Estate Tax Escrow		48,000
Insurance Escrow		2,000
MIP Insurance Escrow		2,680
Reserve for Replacement		240,825
Total - Line 23	-	293,505

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$26,214,848	1
2	Restatements (describe):		2
3	Prior Period Adjustments - Liability Settlement	(42,500)	3
4	Prior Period Adjustments - Intercompany Adj	3,857	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$26,176,205	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,528,065	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)	\$2,528,065	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)	\$28,704,270	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Jerseyville Manor

0047597

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	\$ 17,951,747	1
2	Discounts and Allowances for all Levels	(118,103)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 17,833,644	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	595,559	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 595,559	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,165	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,957	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,122	23
	D. Non-Operating Revenue		
24	Contributions	2,796	24
25	Interest and Other Investment Income***	2,243	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,039	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Maintenance Fee Income	12,085	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,085	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 18,449,449	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,584,356	31
32	Health Care	6,878,292	32
33	General Administration	2,426,383	33
	B. Capital Expense		
34	Ownership	1,107,980	34
	C. Ancillary Expense		
35	Special Cost Centers	1,988,211	35
36	Provider Participation Fee	936,162	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,921,384	40
41	Income before Income Taxes (line 30 minus line 40)**	2,528,065	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,528,065	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 2,064,239.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	3,811,256.00	45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	4,603,701.00	48
49	Medicare Part A	6,341,841.00	49
50	Other-(specify) Medicare Replacement/Managed Care MCA	1,012,607.00	50
51	Other-(specify)		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)	\$ 17,833,644	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	1,869	2,077	\$ 130,377	\$ 62.77	1
2	Assistant Director of Nursing	1,132	1,206	46,133	38.25	2
3	Registered Nurses	20,673	22,434	915,076	40.79	3
4	Licensed Practical Nurses	33,266	36,175	1,259,977	34.83	4
5	CNAs & Orderlies	132,774	144,744	3,715,216	25.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,193	2,278	53,877	23.65	9
10	Activity Assistants	8,383	8,942	132,586	14.83	10
11	Social Service Workers	3,538	3,743	85,560	22.86	11
12	Dietician					12
13	Food Service Supervisor	111	118	3,365	28.52	13
14	Head Cook					14
15	Cook Helpers/Assistants	36,392	39,714	622,088	15.66	15
16	Dishwashers					16
17	Maintenance Workers	6,558	7,257	169,705	23.39	17
18	Housekeepers	19,470	21,212	349,049	16.46	18
19	Laundry	9,360	10,184	156,218	15.34	19
20	Administrator	1,841	2,076	129,253	62.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,461	5,930	142,079	23.96	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	2,083	2,153	43,485	20.20	31
32	Other Health Care: Dir Memory Care	1,931	2,100	64,472	30.70	32
33	Other(specify) Marketing	999	1,222	40,012	32.74	33
34	TOTAL (lines 1 - 33)	288,034	313,565	\$ 8,058,528 *	\$ 25.70	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	\$ 18,312	L1, C3	35
36	Medical Director	Monthly	56,250	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	18,844	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)		\$ 93,406		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				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	%	Amount	Description		Amount	Description		Amount	
Dana Bainter	Administrator	None	\$ 129,253	Workers' Compensation Insurance		\$ 90,274	IDPH License Fee		\$ 2,014	
				Unemployment Compensation Insurance		(10,055)	Advertising: Employee Recruitment			
				FICA Taxes		587,764	Health Care Worker Background Check			
				Employee Health Insurance		511,950	(Indicate # of checks performed 32)		1,168	
				Employee Meals			Patient Background Checks 234		5,856	
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)		13,606	
				401k		30,704	Subscriptions		1,152	
TOTAL (agree to Schedule V, line 17, col. 1)				Other Employee Benefits		5,849	Other Licenses & Fees		632	
(List each licensed administrator separately.)			\$ 129,253	Tuition Reimb - LPN/Student Loan Assist		4,075				
B. Administrative - Other							Indirect costs		157	
Description			Amount				Less: Public Relations Expense		(1,152)	
N/A			\$				PAC and Lobbying payments		(4,826)	
							All non-allowable advertising		()	
							TOTAL (agree to Sch. V, line 20, col. 8)		\$ 18,607	
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,220,561				
TOTAL (agree to Schedule V, line 17, col. 3)							G. Schedule of Travel and Seminar**			
(Attach a copy of any management service agreement)										
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees						
Vendor/Payee	Type		Amount	Description	Line #	Amount				
RFMS, Inc.	Administrative Services		\$ 180,180			\$	Out-of-State Travel			\$
LTC Support Services, LLC	Support Services		206,424							
RSM US LLP	Accounting Services		21,292							
Templin Healthcare Accounting	Accounting Services		4,428				In-State Travel			
Guided Care	MCO Guide		4,990							
Polsinelli	Legal Services		5,674							
HealthCap, RRG	Legal Services		7,607							
							Seminar Expense			344
							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)			\$ 430,595				TOTAL			\$ 344

*** 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	Amount
IL HEALTHCARE ASSOCIATION (IHCA)	8,780
	8,780 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)	4,826
	4,826 Total
- (4)

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

IL HEALTHCARE ASSOCIATION (IHCA)	13,606
	13,606 Total
- (5)

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

\$ 99,172 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.

\$ 936,162

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.

\$ 1,165
- (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.