

		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: 0052894

Facility Name: Manor Court of Carbondale

Address: 2940 W Westridge Pl Carbondale 62901
Number City Zip Code

County: Jackson

Telephone Number: (618) 457-1010 Fax # (618) 457-9226

HFS ID Number:

Date of Initial License for Current Owners: 08/25/14

Type of Ownership:

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

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/2024 to 9/30/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)

(Type or Print Name) Brian Burger

(Title) Chief Financial Officer

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)

(Print Name and Title) Larry Templin Partner

(Firm Name & Address) Templin Healthcare Accounting Services, LLP
P.O. Box 326, Plainfield, IL 60544-0326

(Telephone) (630) 361-2868 Fax # ()

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Carbondale # 0052894 Report Period Beginning: 10/1/2024 Ending: 9/30/2025

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.										
	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	3,328	7,521	3,841		10,808	6,873	3,886	36,257	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	3,328	7,521	3,841		10,808	6,873	3,886	36,257	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 82.78%

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 08/26/14

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 06/18/14 NO ☐

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

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS
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.

STATE OF ILLINOIS

Facility Name & ID Number

Manor Court of Carbondale

0052894

Report Period Beginning: 10/1/2024

Ending: 9/30/2025

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	654,927	41,931	20,559	717,417		717,417		717,417			1
2	Food Purchase		485,551		485,551		485,551	(3,368)	482,183			2
3	Housekeeping	303,830	53,695		357,525		357,525		357,525			3
4	Laundry	122,440	22,897		145,337		145,337		145,337			4
5	Heat and Other Utilities			182,259	182,259		182,259		182,259			5
6	Maintenance	142,055	38,002	117,165	297,222		297,222		297,222			6
7	Other (specify):*											7
8	TOTAL General Services	1,223,252	642,076	319,983	2,185,311		2,185,311	(3,368)	2,181,943			8
	B. Health Care and Programs											
9	Medical Director			8,475	8,475		8,475		8,475			9
10	Nursing and Medical Records	4,545,267	340,003	15,036	4,900,306		4,900,306		4,900,306			10
10a	Therapy											10a
11	Activities	148,433	13,505		161,938		161,938		161,938			11
12	Social Services	94,407			94,407		94,407		94,407			12
13	CNA Training											13
14	Program Transportation			6,149	6,149		6,149		6,149			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,788,107	353,508	29,660	5,171,275		5,171,275		5,171,275			16
	C. General Administration											
17	Administrative	109,117			109,117		109,117		109,117			17
18	Directors Fees							1,718	1,718			18
19	Professional Services			390,978	390,978		390,978	1,293	392,271			19
20	Dues, Fees, Subscriptions & Promotions			37,354	37,354		37,354	(4,317)	33,037			20
21	Clerical & General Office Expenses	164,796	24,322	74,739	263,857		263,857	1,666	265,523			21
22	Employee Benefits & Payroll Taxes			909,827	909,827		909,827		909,827			22
23	Inservice Training & Education			6,869	6,869		6,869		6,869			23
24	Travel and Seminar			457	457		457		457			24
25	Other Admin. Staff Transportation			6,150	6,150		6,150		6,150			25
26	Insurance-Prop.Liab.Malpractice			218,410	218,410		218,410	1,359	219,769			26
27	Other (specify):*											27
28	TOTAL General Administration	273,913	24,322	1,644,784	1,943,019		1,943,019	1,719	1,944,738			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,285,272	1,019,906	1,994,427	9,299,605		9,299,605	(1,649)	9,297,956			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' PREPARATION REPORT
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			41,560	41,560		41,560	731	42,291			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			389,400	389,400		389,400		389,400			33
34	Rent-Facility & Grounds			870,000	870,000		870,000		870,000			34
35	Rent-Equipment & Vehicles			4,520	4,520		4,520		4,520			35
36	Other (specify):*											36
37	TOTAL Ownership			1,305,480	1,305,480		1,305,480	731	1,306,211			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			5,611	5,611		5,611		5,611			38
39	Ancillary Service Centers		390,996	1,157,058	1,548,054		1,548,054		1,548,054			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			29	29		29	(29)				41
42	Provider Participation Fee			523,914	523,914		523,914		523,914			42
43	Other (specify):* Disallowed Costs	60,492		325,366	385,858		385,858	(385,858)				43
44	TOTAL Special Cost Centers	60,492	390,996	2,011,978	2,463,466		2,463,466	(385,887)	2,077,579			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,345,764	1,410,902	5,311,885	13,068,551		13,068,551	(386,805)	12,681,746			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	(395)	2		4
5	Telephone, TV & Radio in Resident Rooms	(40,464)	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	731	30		9
10	Interest and Other Investment Income				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	(620)	20		17
18	Fines and Penalties	(21,674)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(173,569)	43		24
25	Fund Raising, Advertising and Promotional	(35,647)	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	(121,267)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (392,905)		\$	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)	6,100		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 6,100		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (386,805)		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	\$ (3,761)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Disallow Marketing Wages	(60,492)	43	3
4	Disallow Lab Expense	(39,632)	43	4
5	Disallow X-Ray Expense	(11,583)	43	5
6	Offset Vending Income	(29)	41	6
7	Offset Vending Income	(2,973)	2	7
8	Disallow Loss on Disposal	(2,797)	43	8
9				9
10				10
11				11
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44				44
45				45
46				46
47				47
48				48
49	Total	(121,267)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
None	N/A	Unlimited Development, Inc (UDI)		See Page 6 Supplemental		
		Community Living Options, Inc. (CLO)				
		See Page 6 Supplemental for specific homes				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	18	Director Fees	\$	Unlimited Development, Inc.	100.00%	\$ 1,718	\$ 1,718	1
2	V	19	Professional Fees		Unlimited Development, Inc.	100.00%	1,293	1,293	2
3	V	20	Dues, Licenses and Subs		Unlimited Development, Inc.	100.00%	64	64	3
4	V	21	General Admin Expense		Unlimited Development, Inc.	100.00%	1,666	1,666	4
5	V	26	Property Insurance		Unlimited Development, Inc.	100.00%	1,359	1,359	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 6,100	\$ * 6,100	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Manor Court of Carbondale

0052894

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

Manor Court of Carbondale

0052894

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 McCord	Galesburg	Lessor	4
5	Unlimited Development, Inc. (UDI)	100%			Galesburg North Semi	Galesburg	Lessor	5
6	Unlimited Development, Inc. (UDI)	100%			Jerseyville North State	Galesburg	Lessor	6
7	Unlimited Development, Inc. (UDI)	100%			Shelbyville Route 128,	Galesburg	Lessor	7
8	Unlimited Development, Inc. (UDI)	100%			Marion Willimason Co	Galesburg	Lessor	8
9	Unlimited Development, Inc. (UDI)	100%			2245 Seminary Street,	Galesburg	Lessor	9
10	Unlimited Development, Inc. (UDI)	100%			Pittsfield Lowry, LLC	Galesburg	Lessor	10
11	Unlimited Development, Inc. (UDI)	100%			Pekin El Camino, LLC	Galesburg	Lessor	11
12	Unlimited Development, Inc. (UDI)	100%			Keokuk Village Circle	Galesburg	Lessor	12
13	Unlimited Development, Inc. (UDI)	100%			The Kensington	Galesburg	Supportive Living	13
14								14
15								15
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VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See Attached Schedule 7A								\$ 1,718	L18, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,718		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' PREPARATION REPORT

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							\$					\$	1
2	N/A												2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$				\$		9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$		14
15	TOTALS (line 9+line14)						\$				\$		15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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.) 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 Manor Court of Carbondale COUNTY Jackson

FACILITY IDPH LICENSE NUMBER 0052894

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. 15-18-376-074	LOT 19 LIBERTY VILLAGE	\$ 370,846.46	\$ 370,846.46
2.	SECTION 1-A 3.42 AC 18-9-1	\$	\$
3.	PC 3 SL 063	\$	\$
4. 15-18-376-075	OUTLOT F-PARK AREA	\$ 475.28	\$ 475.28
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 371,321.74	\$ 371,321.74

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? YES X 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:

61,679

B. General Construction Type:

Exterior

Brick/Vinyl Siding

Frame

Wood

Number of Stories

1
- C.

Does the Operating Entity?

☐

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☒

(c) Rent from Completely Unrelated Organization.

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

Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

- F.

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

☒

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:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Carbondale

0052894

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	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Double Faced Lighted Sign			2014	5,980		10			5,980	9
10	Workstations-Cubicle/Desk/Storage Cabinets			2014	55,904		10			55,904	10
11	Water Heater - Mechanical Room			2018	10,848	1,084	10	1,084		7,683	11
12	New PTAC Units - 4			2019	2,780		5			2,780	12
13	New PTAC Units - 4			2019	2,765	47	5	47		2,765	13
14	New PTAC Units - 4			2020	2,763	139	5	139		2,763	14
15	Asphalt Parking Repairs			2020	3,997	500	8	500		2,623	15
16	New Water Heater			2022	3,253	325	10	325		1,219	16
17	New PTAC Units - 4			2022	3,654		5	731	731	2,558	17
18	New 3 Ton Cooling Unit - Electrical Room			2023	6,986	1,397	5	1,397		3,376	18
19	Dry Pipe Replacement in Sprinkler System-100 Hall			2023	3,189	213	15	213		514	19
20	8 New PTAC Units with Thermostats			2024	6,618	1,324	5	1,324		1,545	20
21	8 New PTAC Units with Thermostats			2024	6,750	1,350	5	1,350		1,463	21
22	Install 2 New Fire Doors-Main Entrance/Employee Area			2025	23,374	1,558	10	1,558		1,558	22
23	Countertop Repairs - Nurses Station			2025	5,868	391	10	391		391	23
24	New Pole Light Fixtures - Parking Lot			2025	5,067	225	15	225		225	24
25	New HVAC Unit			2025	15,790	790	10	790		790	25
26	Install New 72 HD Channel Com System			2025	32,576	3,256	10	3,256		3,256	26
27	Install 3 Delay Egress Maglocks			2025	2,785	93	10	93		93	27
28	New Countertops - 2 Nurse Station Desk Areas			2025	3,045	102	10	102		102	28
29											29
30											30
31											31
32											32
33											33
34											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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 203,992	\$ 12,794		\$ 13,525	\$ 731	\$ 97,588	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 194,828	\$ 21,256	\$ 21,256	\$	5-15 yrs	\$ 110,020	71
72	Current Year Purchases	69,401	7,510	7,510		5-7 yrs	7,510	72
73	Fully Depreciated Assets	405,235					405,235	73
74								74
75	TOTALS	\$ 669,464	\$ 28,766	\$ 28,766	\$		\$ 522,765	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 Starcraft Allstar 8929	2014	\$ 51,133	\$	\$	\$	4	\$ 51,133
77									
78									
79									
80	TOTALS			\$ 51,133	\$	\$	\$		\$ 51,133

E. Summary of Care-Related Assets					1	2
		Reference				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)				\$ 924,589
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)				\$ 41,560
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)				\$ 42,291
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)				\$ 731
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)				\$ 671,486

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	2014 Toyota Corolla-5939 - 2014	\$ 18,621	\$	\$ 18,621
87				
88				
89				
90				
91	TOTALS	\$ 18,621	\$	\$ 18,621

G. Construction-in-Progress		
	Description	Cost
92		\$
93	N/A	
94		
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: Edwin Enterprises, LLC
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:	2014	120	6/8/14	\$ 870,000	15	10	3
4	Additions							4
5								5
6								6
7	TOTAL		120		\$ 870,000			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: \$ 4,520
- 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.

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.

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	\$	9,391	\$ 515,320	\$	9,391	\$ 515,320	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,513	166,791		2,513	166,791	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		7,027	473,427		7,027	473,427	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				390,996		390,996	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	39(3)				1,520			1,520	12
13	Other (specify): <u> </u>									13
14	TOTAL			\$	18,931	\$ 1,157,058	\$ 390,996	18,931	\$ 1,548,054	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	\$ (362,706)	\$ (362,706)	1
2	Cash-Patient Deposits	13,869	13,869	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 204,000)	3,169,812	3,169,812	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	138,241	138,241	6
7	Other Prepaid Expenses	1,988	1,988	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,961,204	\$ 2,961,204	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	172,682	203,992	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	764,094	720,597	16
17	Accumulated Depreciation (book methods)	(684,769)	(671,486)	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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 252,007	\$ 253,103	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,213,211	\$ 3,214,307	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,217,783	\$ 1,217,783	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,869	13,869	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	109,010	109,010	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	278,759	278,759	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Interdivision Payable</u>	7,748,945	7,748,945	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 9,368,366	\$ 9,368,366	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Security Deposits</u>	22,500	22,500	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 22,500	\$ 22,500	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,390,866	\$ 9,390,866	46
47	TOTAL EQUITY(page 18, line 24)	\$ (6,177,655)	\$ (6,176,559)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,213,211	\$ 3,214,307	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (6,021,588)	1
2	Restatements (describe):		2
3	Prior Period Adjustments - Liability Settlement Adj	70,820	3
4	Prior Period Adjustments - Bad Debt Exp Adj	(10,179)	4
5	Prior Period Adjustments -Intercompany Adj	454	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (5,960,493)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(217,162)	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)	\$ (217,162)	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)	\$ (6,177,655)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Carbondale

0052894

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	\$ 12,584,023	1
2	Discounts and Allowances for all Levels	(88,609)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,495,414	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	320,749	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 320,749	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	11,950	11
12	Gift and Coffee Shop	3,002	12
13	Barber and Beauty Care	1,604	13
14	Non-Patient Meals	395	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	15,051	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 32,002	23
	D. Non-Operating Revenue		
24	Contributions	3,144	24
25	Interest and Other Investment Income***	60	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,204	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>AJ's Fitness Center</u>	20	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 20	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,851,389	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,185,311	31
32	Health Care	5,171,275	32
33	General Administration	1,943,019	33
	B. Capital Expense		
34	Ownership	1,305,480	34
	C. Ancillary Expense		
35	Special Cost Centers	1,939,552	35
36	Provider Participation Fee	523,914	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,068,551	40
41	Income before Income Taxes (line 30 minus line 40)**	(217,162)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (217,162)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 915,623.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,807,700.00	45
46	MMAI-Medicaid is the Primary Payer	1,056,764.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	2,897,200.00	48
49	Medicare Part A	4,443,082.00	49
50	Other-(specify) <u>Medicare Replacement/Managed Care MCA</u>	1,003,417.00	50
51	Other-(specify) <u>Hospice</u>	371,628.00	51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,495,414	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	1,909	2,084	\$ 107,169	\$ 51.42	1
2	Assistant Director of Nursing	1,961	2,090	96,281	46.07	2
3	Registered Nurses	19,380	21,184	829,141	39.14	3
4	Licensed Practical Nurses	27,912	30,309	924,958	30.52	4
5	CNAs & Orderlies	110,438	120,209	2,549,072	21.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,987	2,106	40,811	19.38	9
10	Activity Assistants	6,607	7,082	107,622	15.20	10
11	Social Service Workers	3,948	4,224	94,407	22.35	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	55,429	26.65	13
14	Head Cook	2,184	2,532	48,851	19.29	14
15	Cook Helpers/Assistants	32,010	34,433	550,647	15.99	15
16	Dishwashers					16
17	Maintenance Workers	5,883	6,365	142,055	22.32	17
18	Housekeepers	17,382	18,710	303,830	16.24	18
19	Laundry	7,240	7,691	122,440	15.92	19
20	Administrator	1,914	2,106	109,117	51.81	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,312	7,932	164,796	20.78	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	1,855	1,971	38,646	19.61	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	1,968	2,194	60,492	27.57	33
34	TOTAL (lines 1 - 33)	253,890	275,302	\$ 6,345,764 *	\$ 23.05	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	\$ 20,559	L1, C3	35
36	Medical Director	Monthly	8,475	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	13,092	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)		\$ 42,126		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Melissa Neitzel	Administrator	None	\$ 109,117
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 109,117
B. Administrative - Other			
Description			Amount
N/A			\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
RFMS, Inc.	Administrative Services		\$ 180,180
LTC Support Services, LLC	Support Services		173,448
RSM US LLP	Accounting Services		21,292
Templin Healthcare Accounting	Accounting Services		4,428
Cooper Valuation Group	Appraisal Service		3,750
Guided Care	MCO Guide		1,000
Polsinelli	Legal Services		6,880
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 390,978
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 73,448
Unemployment Compensation Insurance			34,825
FICA Taxes			473,309
Employee Health Insurance			262,896
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
401k			42,678
Other Employee Benefits			22,671
TOTAL (agree to Schedule V, line 22, col.8)			\$ 909,827
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$ 1,992
Advertising: Employee Recruitment			18,065
Health Care Worker Background Check (Indicate # of checks performed 14)			546
Patient Background Checks			
Association Dues (total from pg 22, #4)			10,602
Subscriptions			1,895
Other Licenses & Fees			923
Managed Care Provider Fees			3,331
Indirect costs			64
Less: Public Relations Expense			(620)
PAC and Lobbying payments			(3,761)
All non-allowable advertising			()
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 33,037
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			457
Entertainment Expense			()
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 457

*** 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)	6,841
	6,841 Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

IL HEALTHCARE ASSOCIATION (IHCA)	3,761
	3,761 Total
- (4)

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

IL HEALTHCARE ASSOCIATION (IHCA)	10,602
	10,602 Total
- (5)

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

\$	81,853	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.

\$	523,914
----	---------

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.	\$	395
----	-----	--	-----	----------------------	----	-----
- (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.