

		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: 0050427

Facility Name: Manor Court of Maryville

Address: 6955 State Route 162 Maryville 62062
Number City Zip Code

County: Madison

Telephone Number: (618) 288-3800 Fax # (618) 288-1106

HFS ID Number:

Date of Initial License for Current Owners: 10/01/2006

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)
(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 Maryville # 0050427 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	<u>132</u>	Skilled (SNF)	<u>132</u>	<u>48,180</u>	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	<u>132</u>	TOTALS	<u>132</u>	<u>48,180</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	3,641	13,839	675		8,592	7,517	7,751	42,015	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	3,641	13,839	675		8,592	7,517	7,751	42,015	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 87.20%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒ Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 1/25/11

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 1/1/11 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 132

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ 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 Maryville

0050427

Report Period Beginning:

10/1/2024

Ending:

9/30/2025

Page 3

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	597,396	44,127	29,242	670,765		670,765		670,765			1
2	Food Purchase		431,256		431,256		431,256		431,256			2
3	Housekeeping	355,024	54,870		409,894		409,894		409,894			3
4	Laundry	68,912	38,327		107,239		107,239		107,239			4
5	Heat and Other Utilities			280,494	280,494		280,494		280,494			5
6	Maintenance	111,516	30,000	189,051	330,567		330,567	(37,940)	292,627			6
7	Other (specify):*											7
8	TOTAL General Services	1,132,848	598,580	498,787	2,230,215		2,230,215	(37,940)	2,192,275			8
	B. Health Care and Programs											
9	Medical Director			44,500	44,500		44,500		44,500			9
10	Nursing and Medical Records	6,102,163	372,516	17,984	6,492,663		6,492,663		6,492,663			10
10a	Therapy											10a
11	Activities	220,300	11,956		232,256		232,256		232,256			11
12	Social Services	112,370			112,370		112,370		112,370			12
13	CNA Training			1,148	1,148		1,148		1,148			13
14	Program Transportation			9,572	9,572		9,572		9,572			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	6,434,833	384,472	73,204	6,892,509		6,892,509		6,892,509			16
	C. General Administration											
17	Administrative	128,923			128,923		128,923		128,923			17
18	Directors Fees							1,890	1,890			18
19	Professional Services			411,870	411,870		411,870	939	412,809			19
20	Dues, Fees, Subscriptions & Promotions			38,379	38,379		38,379	(4,067)	34,312			20
21	Clerical & General Office Expenses	246,738	40,867	75,657	363,262		363,262	1,833	365,095			21
22	Employee Benefits & Payroll Taxes			1,008,116	1,008,116		1,008,116		1,008,116			22
23	Inservice Training & Education			1,526	1,526		1,526		1,526			23
24	Travel and Seminar			314	314		314		314			24
25	Other Admin. Staff Transportation			9,574	9,574		9,574		9,574			25
26	Insurance-Prop.Liab.Malpractice			450,456	450,456		450,456	1,495	451,951			26
27	Other (specify):*											27
28	TOTAL General Administration	375,661	40,867	1,995,892	2,412,420		2,412,420	2,090	2,414,510			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,943,342	1,023,919	2,567,883	11,535,144		11,535,144	(35,850)	11,499,294			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			107,291	107,291		107,291	32,181	139,472			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			122,400	122,400		122,400	(83)	122,317			33
34	Rent-Facility & Grounds			1,135,572	1,135,572		1,135,572		1,135,572			34
35	Rent-Equipment & Vehicles			15,313	15,313		15,313		15,313			35
36	Other (specify):*											36
37	TOTAL Ownership			1,380,576	1,380,576		1,380,576	32,098	1,412,674			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			471	471		471		471			38
39	Ancillary Service Centers		502,959	1,397,433	1,900,392		1,900,392		1,900,392			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			496	496		496	(496)				41
42	Provider Participation Fee			648,233	648,233		648,233		648,233			42
43	Other (specify):* Disallowed Costs	95,958		320,648	416,606		416,606	(416,606)				43
44	TOTAL Special Cost Centers	95,958	502,959	2,367,281	2,966,198		2,966,198	(417,102)	2,549,096			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,039,300	1,526,878	6,315,740	15,881,918		15,881,918	(420,854)	15,461,064			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				4
5	Telephone, TV & Radio in Resident Rooms	(44,337)	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	32,181	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				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	(125)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(127,395)	43		24
25	Fund Raising, Advertising and Promotional	(26,949)	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	(260,939)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (427,564)		\$	30

BHF USE ONLY							
48		49		50		51	
						52	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	6,710		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 6,710		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (420,854)		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	\$ (4,137)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Disallow Marketing Wages	(95,958)	43	3
4	Capitalized Repairs over \$2,500	(37,940)	6	4
5	Offset Vending Income	(496)	41	5
6	Disallow Lab Expense	(77,953)	43	6
7	Disallow X-Ray Expense	(40,242)	43	7
8	Disallow Loss on Disposal	(3,772)	43	8
9	Disallow Duplicate Accounting Invoice	(358)	19	9
10	Nonallowable Real Estate Taxes	(83)	33	10
11				11
12				12
13				13
14				14
15				15
16				16
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(260,939)		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%	\$ 1,890	\$ 1,890	1
2	V	19	Professional Fees		Unlimited Development, Inc.	100.00%	1,422	1,422	2
3	V	20	Dues, Licenses and Subs		Unlimited Development, Inc.	100.00%	70	70	3
4	V	21	General Admin Expense		Unlimited Development, Inc.	100.00%	1,833	1,833	4
5	V	26	Property Insurance		Unlimited Development, Inc.	100.00%	1,495	1,495	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			\$			\$ 6,710	\$ * 6,710	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 Maryville

0050427

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 Maryville

0050427

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
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26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See Attached Schedule 7A								\$ 1,890	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	\$ 1,890		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

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

FACILITY NAME	Manor Court of Maryville	COUNTY	Madison
---------------	--------------------------	--------	---------

CONTACT PERSON REGARDING THIS REPORT Brian Burger

A. Summary of Real Estate Tax Cost

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

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

X. BUILDING AND GENERAL INFORMATION:

- A.

Square Feet:

72,233

B. General Construction Type:

Exterior

Brick

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 Maryville

#

0050427

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	Sign		2010		44,512		10			44,512
10	Water Filtration System		2012		8,588		10			8,588
11	Water Softener		2014		7,902		10			7,902
12	Workstation-Counters/Cabinets/Chair		2014		3,834	319	12	319		3,461
13	Compressr/Inverter Assembly		2016		7,384	492	15	492		4,528
14	Carpet-Nurse Station, Office, Garden Court Sitting Area		2016		5,452		5			5,452
15	A/C Units/Condenser		2016		8,253	250	5-15 Yrs	250		6,771
16	Furnace Repair		2016		2,913		10	291	291	2,474
17	Furnace Repairs		2017		8,359		10	836	836	7,106
18	AC Repair		2017		4,328		10	433	433	3,680
19	Compressor Repairs		2017		16,629	1,109	15	1,109		9,603
20	Lighted Floating Lake Fountain		2017		6,047	605	10	605		5,090
21	Compressor Repairs		2017		8,286	703	10-15 ys	703		5,547
22	Water Heater - Mechanical Room in Service Hallway		2018		5,726	572	10	572		4,437
23	Compressor Repair - 100 Hall		2018		8,965	598	15	598		4,582
24	Condenser Coil		2018		4,294	286	15	286		2,169
25	Inverter Compressor - Master Unit		2018		5,849	584	10	584		4,435
26	Water Heater - Mechanical Room in Service Hallway		2018		11,404	1,140	10	1,140		8,361
27	Water Heater - Mechanical Room next to Kitchen		2018		9,672	967	10	967		6,850
28	Replace Compressors on System 3		2018		7,767		15	518	518	3,885
29	Replace Compressors on System 7		2018		9,554		15	637	637	4,777
30	Water Heater - Mechanical Room		2018		6,440	644	10	644		4,508
31	Compressor		2018		3,591	239	15	239		1,655
32	Sprinkler Pipe		2019		10,094	1,009	10	1,009		6,812
33	Compressors/Cap Tube/Inverter Assy - Sys 3-1, 5-2		2019		41,760	2,783	15	2,783		18,462
34	Asphalt - Parking Lot		2019		22,000	2,750	8	2,750		17,188
35	Replace 2 Modules on VRV System - Outdoor Units		2019		5,795	579	10	579		3,622
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 Manor Court of Maryville

0050427

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	AC Unit 5-2-Replace Inverter Compressor/Outdoor Fan Motor	2019	\$ 3,696	\$	10	\$ 370	\$ 370	\$ 2,405	37
38	Install Air Filter Grills in Ducts and Clean AC Coils	2019	4,800		10	480	480	3,120	38
39	Replace Compressor in Master Unit CU 1-3 and Install Coil	2019	7,713		10	771	771	5,012	39
40	Repair AAON Make Up Air Units 3,4,6,7	2019	3,249		10	325	325	2,112	40
41	Compressor/Inverter Board-Garden Ct Area (8 Patient Rms/Cent	2019	16,896	1,127	15	1,127		6,572	41
42	Clean/Repair Indoor Fan Coils	2019	3,120		10	312	312	1,716	42
43	Replace Inverter Bd/ Master Compressor / Suction Pipe Termistor	2020	13,159		10	1,316	1,316	7,238	43
44	Replace Compressor/repair leak unit 5-2	2020	5,611		10	561	561	3,086	44
45	Replace Compressor and Inverter on Unit 1-1	2020	9,711		10	971	971	5,341	45
46	Replace Compressors on 2 Outdoor Units	2020	6,907		10	691	691	3,800	46
47	Repair AC Unit 3-1	2020	4,252		10	425	425	2,338	47
48	Inspect 7 Roof Top AC Units	2020	4,652		10	465	465	2,558	48
49	Replace Inverter Compressor on System 6-1	2021	8,000	533	15	533		2,532	49
50	New Compressor Unit 5-1/Coil Assy Unit 2-1	2021	8,847	590	15	590		2,557	50
51	New Compressor Unit 3-1	2021	13,377	892	15	892		3,865	51
52	Reapir HVAC System Units 2-1 and 6-3	2020	3,847		10	385	385	1,732	52
53	Replace Compressor/Inverter Board - Unit 6-1	2020	6,079		10	608	608	2,736	53
54	Repair 4 PTAC Units in 500 Wing	2021	4,270		10	427	427	1,922	54
55	Replaced EEV Operators on HVAC Unit 7-1	2021	2,878		10	288	288	1,296	55
56	Replace Compressor Heat Pump 6-3	2021	6,296		10	630	630	2,835	56
57	Replaced Compressor on Unit 2-2	2021	9,905		10	991	991	4,459	57
58	Replaced 2 Compressors in Garden Court Unit 6-3	2021	12,020		10	1,202	1,202	5,409	58
59	New Compressor Unit M#REYQ72PTJU	2021	7,850	523	15	523		2,092	59
60	Replace Compressor CU-01	2021	8,270	551	15	551		2,204	60
61	New Master Module Compressor on Unit 6-3	2022	7,300	487	15	487		1,623	61
62	New Outdoor Condensing Unit for System 4-2	2022	18,948	1,895	10	1,895		6,317	62
63	New Vinyl Plank Flooring - Garden Court	2022	4,842	484	10	484		1,573	63
64	New Inverter Compressor for HRU 2-1	2021	8,907	891	10	891		3,415	64
65	Repair Sprinkler Heads-Attic/200 & 400 Wings/Dining Areas/Jani	2021	20,747		10	2,075	2,075	7,262	65
66	VRV Compressor Changout on HRU 4-2	2021	8,600		10	860	860	3,010	66
67	Replace Inverter Compressor on CU 7-1	2021	7,576		10	758	758	2,653	67
68	Repair/Evaluate Roof Top AC Units	2022	2,880		10	288	288	1,008	68
69	Repair/Evaluate All VRV Systems	2022	6,720		10	672	672	2,352	69
70	TOTAL (lines 4 thru 69)		\$ 547,323	\$ 23,602		\$ 42,188	\$ 18,586	\$ 314,607	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Manor Court of Maryville

0050427

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	
1	Totals from Page 12A, Carried Forward		\$ 547,323	\$ 23,602		\$ 42,188	\$ 18,586	\$ 314,607	1
2	Repair Compressor Unit CU 1-3	2022	5,608		10	561	561	1,963	2
3	Repair HVAC Unit 6-3	2022	5,525		10	553	553	1,935	3
4	Replace EEV and Thermistors on CU 6-1	2022	5,629		10	563	563	1,970	4
5	Replace Electronic Coil for EEV and Motorized Valve on CU 6-2	2022	5,583		10	558	558	1,953	5
6	Replace EEV Coil and Motor, Thermistor ASSY on Unit	2022	7,650		10	765	765	2,678	6
7	Clean All Coils for all Units and Made Repairs as Needed	2022	8,700		10	870	870	3,045	7
8	Replace Compressor on Unit 6-3 Sub Side	2022	9,825		10	983	983	3,440	8
9	Replace Compressor and Inverter Board on Unit 1-3 Sub Module	2022	10,984		10	1,098	1,098	3,843	9
10	New Actuator/Modgas II Board/Combustion Speed Board on ERV	2022	4,310		10	431	431	1,509	10
11	Replace MODGAS II Control Board on ERV-200 Wing	2022	3,080		10	308	308	1,078	11
12	Replace Outdoor Condensing Unit	2023	29,870	2,987	10	2,987		8,214	12
13	New Compressor-Front Office Area	2023	10,950	730	15	730		1,825	13
14	New EEV Unit-Computer Server Area/Conference Rooms	2023	8,425	562	15	562		1,405	14
15	Replace AC Coil - Front Office/Computer Server Room	2023	10,930	729	15	729		1,822	15
16	Replace Outdoor Condensing Unit	2023	18,948	1,263	15	1,263		3,158	16
17	New Inverter Compressors	2023	15,746	1,050	15	1,050		2,537	17
18	New Air Conditioner	2023	5,552	1,110	5	1,110		2,683	18
19	Replace Control Boards on AC Unit	2022	3,462		10	346	346	865	19
20	Replace Sensor Bundle and Leak Check on Unit CU-2-1	2022	7,400		10	740	740	1,850	20
21	Replace 5 Thermistor Pack on Unit 2-2	2022	4,500		10	450	450	1,125	21
22	Repair AC Unit 0-1-IT Room	2022	2,650		10	265	265	663	22
23	Repair Leak on Two Outdoor Master Hot Gas Valves	2023	8,575		10	858	858	2,145	23
24	Replaced Gas Heat Exchanger - 100 Hall	2023	2,750		10	275	275	688	24
25	Replaced Fuses to Unit U-0	2023	4,375		10	438	438	1,095	25
26	Repair AC Unit in Server Room	2023	3,525		10	353	353	882	26
27	Replace Heat Exchanger Thermistor on Unit 7-1	2023	2,784		10	278	278	695	27
28	Repair AC Unit - Control Board/Coils	2023	12,239	816	15	816		1,972	28
29	Repair AC Unit in IT Room - Coil/Thermostat	2023	6,501	433	15	433		1,047	29
30	New Transducer- AC Unit	2023	2,841	284	10	284		615	30
31	New Furnace - Sitting Room/Corp Office	2023	9,110	607	15	607		1,315	31
32	New Double Module Condensing Units	2023	68,200	4,547	15	4,547		9,473	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 853,550	\$ 38,720		\$ 67,999	\$ 29,279	\$ 384,095	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Manor Court of Maryville

0050427

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	
1	Totals from Page 12B, Carried Forward		\$ 853,550	\$ 38,720		\$ 67,999	\$ 29,279	\$ 384,095	1
2	New Pressure Sensor for AC Unit	2023	2,740	274	10	274		548	2
3	New AC Unit/Compressor - 100 Hall	2024	19,829	1,983	10	1,983		3,470	3
4	New Fan Coil - Front of Bldg/Offices	2024	9,559	956	10	956		1,660	4
5	New Inverter/Compressor/Board-Back of Hall 100	2024	12,550	1,255	10	1,255		2,196	5
6	2 Large Condensing Units-300 Hall Nurse Station & Svc Areas	2024	78,413	5,227	15	5,227		9,148	6
7	Fan Coil Units	2024	10,680	1,068	10	1,068		1,780	7
8	New Furnace	2024	10,680	712	15	712		1,068	8
9	New Compressor/Inverter/Pumps	2024	15,200	1,013	15	1,013		1,435	9
10	New HVAC nits/Condensing Unit	2024	54,399	5,440	10	5,440		6,800	10
11	New Floor Walk in Cooler-4x8 Aluminum Diamond Plate	2024	4,000	400	10	400		667	11
12	New Compressors/Boards/Cap Tubes	2024	32,540	2,169	15	2,169		2,350	12
13	Repair to High Pressure Transducer - Unit CU 2-2	2023	4,464		10	446	446	669	13
14	Install New 72 HD Channel Com System	2024	32,576	6,515	5	6,515		6,515	14
15	New Mixing Valve for Water Heater	2024	6,045	504	10	504		504	15
16	2 FCU HVAC Replacements with Ductwork Modifications in								16
17	Lounge Dining & Dining Rm Hall	2025	30,739	1,367	15	1,367		1,367	17
18	New Fire Doors - Mechanical Room	2025	9,817	573	10	573		573	18
19	Repairs to HVAC Systems 1-3 and 0-3	2025	13,898		10	695	695	695	19
20	Repair to HVAC System 1-3	2025	7,363		10	368	368	368	20
21	Repair to HVAC System 2-1	2025	5,260		10	263	263	263	21
22	New Evaporator Coil - NE Main Room	2025	6,564	274	10	274		274	22
23	New Flooring - Offices/Conference Rm/Activity/Common Area	2025	30,987	1,277	5	1,277		1,277	23
24	Physical Therapy Rm - Countertops/Kitchenette/Sink	2025	20,240	675	10	675		675	24
25	AC Unit Evaporator Coil	2025	7,650	128	15	128		128	25
26	New Coil/Compressor - MDS Office	2025	10,050	56	15	56		56	26
27	Install New Plumbing Line to Laundry Room	2025	8,600	72	10	72		72	27
28	Install New AC Outdoor Module - Rms 501-509	2025	56,113	468	10	468		468	28
29	Repair to HVAC System 5-1	2025	2,719		10	136	136	136	29
30	Repair to HVAC System 2-1	2025	4,325		10	216	216	216	30
31	Replace Motor and Fan Wheel on Rm 107 Wall Unit	2025	4,375		10	219	219	219	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,365,925	\$ 71,126		\$ 102,748	\$ 31,622	\$ 429,692	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 177,601	\$ 21,252	\$ 21,811	\$ 559	5-15 yrs	\$ 109,844	71
72	Current Year Purchases	143,204	10,586	10,586		5-12 yrs	10,586	72
73	Fully Depreciated Assets	74,220					74,220	73
74								74
75	TOTALS	\$ 395,025	\$ 31,838	\$ 32,397	\$ 559		\$ 194,650	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	2005 Ford E350 Universal	2006	\$ 47,110	\$	\$	\$	4	\$ 47,110
77	Patient Care	2018 Ford E350	2018	59,242				4	59,242
78	Facility	2020 Toyota Corolla	2024	17,306	4,327	4,327		4	4,688
79									79
80	TOTALS			\$ 123,658	\$ 4,327	\$ 4,327	\$		\$ 111,040

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)			\$	1,884,608
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	107,291
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	139,472
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	32,181
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	735,382

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		\$	\$	\$
87	N/A			
88				
89				
90				
91	TOTALS	\$	\$	\$

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: LB Properties, Inc.
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:	2010	120	1/1/2011	\$ 1,135,572	15	10	3
4	Additions		12					4
5								5
6								6
7	TOTAL		132		\$ 1,135,572			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: \$ 15,313
- Description: Medical Equipment \$11,169; Ice Machine \$4,144
- (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	\$	\$ 1,148	\$	\$ 1,148
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	\$	\$ 1,148	\$	\$ 1,148
10	SUM OF line 9, col. 1 and 2 (e)	\$ 1,148			

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	\$	9,917
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,958	236,548		2,958	236,548	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		9,789	584,691		9,789	584,691	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				502,959		502,959	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$	22,664	\$ 1,397,433	\$ 502,959	22,664	\$ 1,900,392	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	\$1,333,792	\$1,333,792	1
2	Cash-Patient Deposits	4,814	4,814	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance140,000)	1,620,746	1,620,746	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	180,709	180,709	6
7	Other Prepaid Expenses	6,370	6,370	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$3,146,431	\$3,146,431	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	1,030,456	1,365,925	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	507,643	518,683	16
17	Accumulated Depreciation (book methods)	(600,116)	(735,382)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	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)	\$937,983	\$1,149,226	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$4,084,414	\$4,295,657	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$758,631	\$758,631	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,814	4,814	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	188,158	188,158	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	102,556	102,556	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Interdivision Payable	12,944,087	12,944,087	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$13,998,246	\$13,998,246	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	Security Deposits	12,000	12,000	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$12,000	\$12,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$14,010,246	\$14,010,246	46
47	TOTAL EQUITY(page 18, line 24)	\$(9,925,832)	\$(9,714,589)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$4,084,414	\$4,295,657	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (8,926,912)	1
2	Restatements (describe):		2
3	Prior Period Adjustments - Liability Settlement Adj	3,274	3
4	Prior Period Adjustments - Employee Benefits Adj	(2,107)	4
5	Prior Period Adjustments - Miscellaneous	(633)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (8,926,378)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(999,454)	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)	\$ (999,454)	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)	\$ (9,925,832)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Maryville

0050427

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	\$ 14,616,400	1
2	Discounts and Allowances for all Levels	(104,117)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,512,283	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	365,904	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 365,904	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	815	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,231	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	98	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,144	23
	D. Non-Operating Revenue		
24	Contributions	323	24
25	Interest and Other Investment Income***	97	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 420	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Late Fees	713	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 713	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,882,464	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,230,215	31
32	Health Care	6,892,509	32
33	General Administration	2,412,420	33
	B. Capital Expense		
34	Ownership	1,380,576	34
	C. Ancillary Expense		
35	Special Cost Centers	2,317,965	35
36	Provider Participation Fee	648,233	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,881,918	40
41	Income before Income Taxes (line 30 minus line 40)**	(999,454)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (999,454)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 937,493.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	3,563,297.00	45
46	MMAI-Medicaid is the Primary Payer	173,800.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	2,630,027.00	48
49	Medicare Part A	4,580,068.00	49
50	Other-(specify) Medicare Replacement/Managed Care MCA	1,990,260.00	50
51	Other-(specify) Hospice	637,338.00	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)	\$ 14,512,283	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	2,205	2,205	\$ 128,978	\$ 58.49	1
2	Assistant Director of Nursing	1,926	1,966	95,028	48.34	2
3	Registered Nurses	20,417	21,416	1,058,753	49.44	3
4	Licensed Practical Nurses	32,812	34,984	1,349,095	38.56	4
5	CNAs & Orderlies	123,075	130,084	3,395,741	26.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,215	2,337	53,031	22.69	9
10	Activity Assistants	8,569	9,214	167,269	18.15	10
11	Social Service Workers	4,310	4,568	112,370	24.60	11
12	Dietician					12
13	Food Service Supervisor	2,074	2,200	52,683	23.95	13
14	Head Cook	2,006	2,221	43,397	19.54	14
15	Cook Helpers/Assistants	27,972	30,459	501,316	16.46	15
16	Dishwashers					16
17	Maintenance Workers	4,504	4,718	111,516	23.64	17
18	Housekeepers	20,252	22,122	355,024	16.05	18
19	Laundry	3,760	4,269	68,912	16.14	19
20	Administrator	1,871	2,037	128,923	63.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,373	11,137	246,738	22.15	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	3,902	4,113	74,568	18.13	31
32	Other Health Care(specify)					32
33	Other(specify)Marketing	2,092	2,203	95,958	43.56	33
34	TOTAL (lines 1 - 33)	274,335	292,253	\$ 8,039,300 *	\$ 27.51	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	\$ 29,242	L1, C3	35
36	Medical Director	Monthly	44,500	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	17,719	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)		\$ 91,461		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.

STATE OF ILLINOIS

Facility Name & ID NumberManor Court of Maryville# 0050427Report Period Beginning:10/1/2024Ending:9/30/2025Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Johnny Law

Administrator

None

\$ 128,923

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 128,923

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

21,291

Templin Healthcare Accounting

Accounting Services

5,139

Guided Care

MCO Guide

1,000

Polsinelli

Legal Services

2,952

Jack P. Cranley

Legal Services

125

Davis & Campbell LLC

Legal Services

27,735

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 411,870

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 91,065

Unemployment Compensation Insurance

30,982

FICA Taxes

603,945

Employee Health Insurance

236,606

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

401k

27,547

Other Employee Benefits

17,971

TOTAL (agree to Schedule V, line 22, col.8)

\$ 1,008,116

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

\$ 1,990

Advertising: Employee Recruitment

14,587

Health Care Worker Background Check

(Indicate # of checks performed 32)

1,184

Patient Background Checks

230

Association Dues (total from pg 22, #4)

11,663

Subscriptions

2,055

Other Licenses & Fees

1,130

Indirect costs

70

Less: Public Relations Expense

(

PAC and Lobbying payments

(4,137)

All non-allowable advertising

(

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 34,312

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

314

Seminar Expense

Entertainment Expense

(

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 314

* Attach copy of IMRF notifications

SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

XX. GENERAL INFORMATION:

- (1)

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

No
- (2)

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

Association Name

IL HEALTHCARE ASSOCIATION (IHCA)

Amount

7,526

7,526 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)

4,137

4,137 Total
- (4)

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

IL HEALTHCARE ASSOCIATION (IHCA)

11,663

11,663 Total
- (5)

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

\$ 71,472 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.

\$ 648,233

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?

N/A

Indicate the amount.

\$ N/A
- (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?
Indicate the amount of income earned from providing such
transportation during this reporting period.

\$ N/A

No
- (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
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.