

		FOR BHF USE					

LL1

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0047969

Facility Name: Pekin Manor

Address: 1520 El Camino Drive Pekin 61554

County: Tazewell

Telephone Number: (309) 353-1099 Fax #: (309) 353-1363

HFS ID Number:

Date of Initial License for Current Owners: 4/26/06

Type of Ownership:

X

VOLUNTARY,NON-PROFIT

X

Charitable Corp.

Trust

IRS Exemption Code 501 (c) (3)

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:

Name: Brian Burger Telephone Number: (309) 343-1550

Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider

(Signed)

(Type or Print Name) Brian Burger

(Title) Chief Financial Officer

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT

(Print Name and Title) Larry Templin Partner

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pekin Manor # 0047969 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>130</u>	Skilled (SNF)	<u>130</u>	<u>47,450</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>130</u>	TOTALS	<u>130</u>	<u>47,450</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	2,368	4,248	5,278		13,109	4,009	5,773	34,785	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	2,368	4,248	5,278		13,109	4,009	5,773	34,785	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 73.31%

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 4/26/06

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 4/1/06 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 130

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

Pekin Manor

#0047969

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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	485,486	46,278	15,194	546,958		546,958		546,958			1
2	Food Purchase		446,807		446,807		446,807	(518)	446,289			2
3	Housekeeping	231,235	39,734		270,969		270,969		270,969			3
4	Laundry	88,964	21,502		110,466		110,466		110,466			4
5	Heat and Other Utilities			235,676	235,676		235,676		235,676			5
6	Maintenance	127,350	30,269	130,178	287,797		287,797		287,797			6
7	Other (specify):*											7
8	TOTAL General Services	933,035	584,590	381,048	1,898,673		1,898,673	(518)	1,898,155			8
	B. Health Care and Programs											
9	Medical Director			15,000	15,000		15,000		15,000			9
10	Nursing and Medical Records	4,496,342	230,213	232,631	4,959,186		4,959,186		4,959,186			10
10a	Therapy											10a
11	Activities	160,721	4,401		165,122		165,122		165,122			11
12	Social Services	99,013			99,013		99,013		99,013			12
13	CNA Training											13
14	Program Transportation			7,717	7,717		7,717		7,717			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,756,076	234,614	255,348	5,246,038		5,246,038		5,246,038			16
	C. General Administration											
17	Administrative	137,119			137,119		137,119		137,119			17
18	Directors Fees							1,862	1,862			18
19	Professional Services			384,817	384,817		384,817	1,400	386,217			19
20	Dues, Fees, Subscriptions & Promotions			49,349	49,349		49,349	(3,928)	45,421			20
21	Clerical & General Office Expenses	207,726	32,392	77,557	317,675		317,675	1,805	319,480			21
22	Employee Benefits & Payroll Taxes			859,138	859,138		859,138		859,138			22
23	Inservice Training & Education			2,054	2,054		2,054		2,054			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			7,718	7,718		7,718		7,718			25
26	Insurance-Prop.Liab.Malpractice			282,682	282,682		282,682	23,976	306,658			26
27	Other (specify):*											27
28	TOTAL General Administration	344,845	32,392	1,663,315	2,040,552		2,040,552	25,115	2,065,667			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,033,956	851,596	2,299,711	9,185,263		9,185,263	24,597	9,209,860			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			158,106	158,106		158,106	180,290	338,396			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							100,785	100,785			32
33	Real Estate Taxes							133,197	133,197			33
34	Rent-Facility & Grounds			540,000	540,000		540,000	(540,000)				34
35	Rent-Equipment & Vehicles			20,108	20,108		20,108		20,108			35
36	Other (specify):* Mortgage Ins							21,102	21,102			36
37	TOTAL Ownership			718,214	718,214		718,214	(104,626)	613,588			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			16,277	16,277		16,277		16,277			38
39	Ancillary Service Centers		283,241	631,365	914,606		914,606		914,606			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			700	700		700	(700)				41
42	Provider Participation Fee			517,262	517,262		517,262		517,262			42
43	Other (specify):* Disallowed Costs	71,109		124,178	195,287		195,287	(195,287)				43
44	TOTAL Special Cost Centers	71,109	283,241	1,289,782	1,644,132		1,644,132	(195,987)	1,448,145			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,105,065	1,134,837	4,307,707	11,547,609		11,547,609	(276,016)	11,271,593			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	(518)	2		4
5	Telephone, TV & Radio in Resident Rooms	(11,701)	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	938	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	(5,272)	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	(36,332)	43		24
25	Fund Raising, Advertising and Promotional	(15,036)	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	(162,306)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (230,227)		\$	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)	(45,789)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (45,789)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (276,016)		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			Sch. V Line	
		Amount	Reference	
1	Political Action Committee Payments	\$ (4,075)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Offset Vending Expenses Against Income	(700)	41	3
4	Disallow R/E Entity HUD Audit	(30,585)	19	4
5	Disallow Marketing Wages	(71,109)	43	5
6	Disallow Lab Expense	(43,264)	43	6
7	Disallow X-ray Expense	(9,399)	43	7
8	Disallow Loss on Disposal	(3,174)	43	8
9				9
10				10
11				11
12				12
13				13
14				14
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37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(162,306)		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%	\$ 1,862	\$ 1,862	1
2	V	19	Professional Fees		Unlimited Development, Inc.	100.00%	1,400	1,400	2
3	V	20	Dues, Licenses and Subs		Unlimited Development, Inc.	100.00%	69	69	3
4	V	21	General Admin Expense		Unlimited Development, Inc.	100.00%	1,805	1,805	4
5	V	26	Property Insurance		Unlimited Development, Inc.	100.00%	1,472	1,472	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			\$			\$ 6,608	\$ * 6,608	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

☒ X

 YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees	\$	Pekin El Camino, LLC	N/A	\$ 30,585	\$ 30,585	15
16	V	20	Dues, Fees, Subs & Prom		Pekin El Camino, LLC	N/A	78	78	16
17	V	26	Property Insurance		Pekin El Camino, LLC	N/A	22,504	22,504	17
18	V	30	Depreciation		Pekin El Camino, LLC	N/A	179,352	179,352	18
19	V	32	Interest Expense	93	Pekin El Camino, LLC	N/A	100,878	100,785	19
20	V	33	Property Taxes		Pekin El Camino, LLC	N/A	133,197	133,197	20
21	V	34	Facility Rent	540,000	Pekin El Camino, LLC	N/A		(540,000)	21
22	V	36	Mortgage Insurance		Pekin El Camino, LLC	N/A	21,102	21,102	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 540,093			\$ 487,696	\$ * (52,397)	39

Facility Name & ID Number

Pekin Manor

0047969

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

Pekin Manor

0047969

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
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See Attached Schedule 7A								\$ 1,862	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	\$ 1,862		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

Facility Name & ID Number Pekin Manor # 0047969 Report Period Beginning: 10/1/2024 Ending: 1/30/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	18	Director Fees	Weighted Avg BDA	458,805	17	18,000	\$	47,450	\$ 1,862	1
2	19	Professional Fees	Weighted Avg BDA	458,805	17	13,539		47,450	1,400	2
3	20	Dues, Licenses and Subs	Weighted Avg BDA	458,805	17	668		47,450	69	3
4	21	General Admin Expense	Weighted Avg BDA	458,805	17	17,456		47,450	1,805	4
5	26	Property Insurance	Weighted Avg BDA	458,805	17	14,235		47,450	1,472	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 63,898	\$		\$ 6,608	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10				
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense					
		YES	NO				Original	Balance								
	A. Directly Facility Related															
	Long-Term															
1	Cambridge Realty Capital						\$		\$			\$	1			
2	LTD. of Illinois		X	Facility purchase	\$28,646.12	6/1/12		6,249,800	4,125,145	10/1/2041	3.5500	100,878	2			
3													3			
4													4			
5													5			
	Working Capital															
6													6			
7													7			
8													8			
9	TOTAL Facility Related				\$28,646.12		\$	6,249,800	\$	4,125,145			\$	100,878	9	
	B. Non-Facility Related*															
10														10		
11									Interest Inc Offset			(93)		11		
12														12		
13														13		
14	TOTAL Non-Facility Related						\$		\$				\$	(93)	14	
15	TOTALS (line 9+line14)						\$	6,249,800	\$	4,125,145				\$	100,785	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 21,102 Line # 36

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	88,126	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2024		\$	126,232	2
3. Under or (over) accrual (line 2 minus line 1).				\$	38,106	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	95,091	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.				\$		6
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	133,197	7
Assessed Value from Real Estate Tax Bill:	2024	1,381,400	8			
Real Estate Tax Bill for Calendar Year:	2020	121,876	9			
	2021	122,952	10			
	2022	122,949	11			
	2023	120,288	12			
	2024	126,232	13			
This facility was purchased from an unrelated for-profit entity during 2006. A tax exemption has not yet been obtained.						
Amount accrued includes the taxes for 9 months based on fiscal year end. Estimate is based on prior year tax bill.						
Taxes paid during year represent the entire 2024 bill.						

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

NOTES:

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

FACILITY NAME	<u>Pekin Manor</u>	COUNTY	<u>Tazewell</u>
---------------	--------------------	--------	-----------------

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

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.)

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.

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,948B. General Construction Type: Exterior BrickFrame WoodNumber of Stories 1

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

F. List the bed capacity for the building if it differs from the licensed total. N/A
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
I. Are you presently operating under a sublease agreement? No
J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO X If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES X NO
If so, please complete the following:
1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

1		2		3		4	
A. Land.		Use	Square Feet	Year Acquired	Cost		
1	Facility		6.24 Acres	2006	\$ 450,000	1	
2						2	
3	TOTALS		#VALUE!		\$ 450,000	3	

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	130		2006	1988	\$ 7,174,313	\$	40	\$ 179,352	\$ 179,352	\$ 3,497,471	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Light Sign - Double Faced, Fire Alarm Panel			2006	43,700		10			43,700	9
10	Replace Defective Pipe for Dry System, Roof			2007	139,058	586	10-25 yrs	586		134,909	10
11	Roof Repair, Furnace Duct Repair, Sprinkler System			2008	179,648	4,936	10-25 yrs	4,936		140,161	11
12	A/C, Shower Room, Firewall, Wall/Ceiling, Kitchen Repairs			2009	78,867		5-15 yrs			78,867	12
13	Shower, Shower, Tile, AC, Carpet, Sprinkler, Sidewalks			2009	50,035	565	5-25 yrs	565		46,530	13
14	Landscaping/Lights			2009	7,280		10			7,280	14
15	Single Face Lighted Sign			2010	2,734		10			2,734	15
16	Physical Therapy Completion, Water Heater			2010	397,172		10-12 yrs			397,172	16
17	Apollo Tub Room - Sink/Mirror/Shower/Tile/Drywall/Drains/Faucets			2011	56,049		12			56,049	17
18	Water Heater, Condensor, Bathroom remodel			2011	47,199	167	10-15 yrs	167		47,074	18
19	PT Remodel, Dining Room, Sprinkler			2011	458,041	5,102	12-25 yrs	5,102		401,071	19
20	Sprinkler-New Tamper Switch/Relocate FDC Check Valve			2012	5,867	235	25	235		3,227	20
21	Kitchenette Rmdl-Sink/Vnyl Tile/Cabinet/Counter/Crnr Grds			2012	53,384		12			53,384	21
22	Nurse Station/Lounge Remodel-Paint/Vinyl/Counter/Cabinet			2012	150,956		12			150,956	22
23	Remodel-Paint/drywall/corner Plates			2012	4,570		5			4,570	23
24	Smoke Detectors-48/Pull Stations-6.5/Heat Detectors-10			2012	9,831		10			9,831	24
25	Water Heater			2012	3,717		10			3,717	25
26	Excavation of Lake			2012	13,885		10			13,885	26
27	Overbed Lights - 25			2012	6,266		10			6,266	27
28	Air Conditioners			2012	9,440		5			9,440	28
29	New Well for Lake			2012	7,760		8.4			7,760	29
30	Sidewalk/Landscaping			2012	3,050	203	15	203		2,643	30
31	Nurse Call System			2013	17,031		10			17,031	31
32	Double Egress Doors			2013	4,730		10			4,730	32
33	Water Heater			2013	5,147		10			5,147	33
34	Phone System			2013	2,637		10			2,637	34
35	Water Heater			2013	4,014		10			4,014	35
36											36

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

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

Facility Name & ID Number Pekin Manor

0047969

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	Storage Shed	2014	\$ 18,870	\$ 943	20	\$ 943	\$	\$ 11,085	37
38	Condensor/Furnance	2014	5,800	387	15	387		4,318	38
39	Water Heater	2014	5,104		10			5,104	39
40	Pekin Manor Shower Remodel-Tile/Fixtures/Electrical/Drains	2014	66,251	5,520	12	5,520		61,189	40
41	Roof	2014	2,900		5			2,900	41
42	Landscaping	2014	22,225		10			22,225	42
43	Water Heater	2015	3,550	149	10	149		3,550	43
44	Water Heater	2015	6,420	319	10	319		6,420	44
45	Ceramic Tile-Service Cooridor	2015	3,242	162	20	162		1,702	45
46	Concrete-Parking Lot	2015	3,300	220	15	220		2,218	46
47	Relocate Water Lines from Floor to Overhead	2015	62,335	2,493	25	2,493		25,141	47
48	Soffits - West Corridor	2015	43,300	3,969	10	3,969		43,300	48
49	Parking Lot Lights	2015	11,850	1,087	10	1,087		11,850	49
50	100 Hall Remodel-Tile/Fire Alarm/Carpet/Fixtures/Cabinets	2015	54,280	4,523	12	4,523		45,609	50
51	Carpet/VCT Tile 100 Hall	2016	11,368	1,137	10	1,137		11,084	51
52	Soffits over water lines	2016	4,400	440	10	440		4,143	52
53	Pond Excavation-Filled in with Dirt	2016	71,996	4,800	15	4,800		43,598	53
54	Breaker/Electrical Panel	2016	6,120	612	10	612		5,406	54
55	Water Heater	2017	3,927	392	10	392		3,370	55
56	Nurse Call System	2017	15,623	1,562	10	1,562		13,019	56
57	Shower Remodel-Garden Court-Tile, Grab Bars, Lighting, Drywa	2017	34,868	2,905	12	2,905		23,971	57
58	Water Heater - Hallway Mechanical Room	2018	6,575	658	10	658		5,096	58
59	Install Wireless Annunciator	2019	2,862	286	10	286		1,908	59
60	Water Heater - Mechanical Rm off Service Hallway	2019	4,338	434	10	434		2,784	60
61	Carpet/VCT/Vinyl - Living Rm/Dining Rm/Activity Rm/Nurses St	2019	84,907	7,076	12	7,076		43,043	61
62	Remodel - Painting - All Common Areas/Living Rm/Dining Rm/Halls								62
63	-Flooring Installation/Soffits to Cover Water Lines/Lighting	2019	408,430	34,036	12	34,036		207,051	63
64	Relocate Water Lines From in Floor to Above-Entire Facility	2019	174,690	14,556	12	14,556		88,558	64
65	Walk In Cooler/Condensor	2019	6,088	608	10	608		3,703	65
66	Window Treatments - Entire Facility	2019	13,698	1,141	12	1,141		6,941	66
67	Power To 3 Ground Flood Lights-East End/ & 5 Light Poles-West	2019	8,643	576	15	576		3,409	67
68	Parking Lot/Sidewalks-Concrete	2020	8,152	543	15	543		3,124	68
69	AC Unit 5 Ton	2020	3,185	478	5	478		3,185	69
70	TOTAL (lines 4 thru 69)		\$ 10,115,678	\$ 103,806		\$ 283,158	\$ 179,352	\$ 5,872,260	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Pekin Manor

0047969

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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 10,115,678	\$ 103,806		\$ 283,158	\$ 179,352	\$ 5,872,260	1
2	Paint/Stain - Hallways/Doors/Door Jambs/Bumpers/Chair Rail/								2
3	Shower Rms/Garden Ct Dining Rm/Mechanical Rm/								3
4	Small Dining Rm/Entry Way	2020	44,480	3,707	12	3,707		21,315	4
5	Repair Leaks on 4 HVAC Split Systems	2020	2,703		10	270	270	1,485	5
6	Replace 30 x 40 ft Section of Concrete Parking Lot	2020	7,535	754	10	754		3,642	6
7	New Water Heater	2021	9,516	951	10	951		3,885	7
8	New Water Heater - Service Hallway	2022	7,783	778	10	778		2,918	8
9	New Asphalt Parking Lot	2022	14,247	1,781	8	1,781		6,678	9
10	New Water Heater - 200 Hall Mechanical Rm	2022	8,154	815	10	815		2,785	10
11	New Water Heater - 600 Hall Mechanical Rm	2022	8,157	816	10	816		2,787	11
12	New Water Heater - Service Hallway Mechanical Room	2023	6,513	651	10	651		1,791	12
13	New Roof - Entire Building	2023	69,428	6,943	10	6,943		17,357	13
14	Kitchen AC Repair	2023	3,340		5	668	668	1,670	14
15	New Water Heater	2024	6,986	699	10	699		815	15
16	Asphalt Overlay - Side of Building/Walking Trail	2024	11,668	1,458	8	1,458		1,701	16
17	Install Condensation Pump/Mini Splits	2024	8,308	554	15	554		554	17
18	Install 4 Expansion Tanks	2024	4,368	400	10	400		400	18
19	Install New Water Heater - Mechanical Room	2025	9,768	570	10	570		570	19
20	Install New Condensing Unit/Evaporator - Freezer	2025	13,850	808	10	808		808	20
21	Install AC Condensor/Handler/Mounting Pad-300 Hall	2025	17,873	596	10	596		596	21
22	Install 2 Water Heaters - Off Service Hallway/Laundry/Kitchen	2025	7,141	60	10	60		60	22
23	Install LVT Flooring - Connecting Hallway	2025	3,324	28	10	28		28	23
24	Install New Water Heater - Laundry/Kitchen Area	2025	6,788	170	10	170		170	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,387,608	\$ 126,345		\$ 306,635	\$ 180,290	\$ 5,944,275	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

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	\$ 218,946	\$ 23,863	\$ 23,863	\$	5-15 yrs	\$ 142,913	71
72	Current Year Purchases	72,249	7,898	7,898		5 yrs	7,898	72
73	Fully Depreciated Assets	528,011					528,011	73
74								74
75	TOTALS	\$ 819,206	\$ 31,761	\$ 31,761	\$		\$ 678,822	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	2012 Ford E350 Bus	2012	\$ 42,610	\$	\$	\$	4	\$ 42,610	76
77										77
78										78
79										79
80	TOTALS			\$ 42,610	\$	\$	\$		\$ 42,610	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 11,699,424	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 158,106	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 338,396	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 180,290	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,665,707	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	2003 Chevy G3500 - 2006	\$ 34,100	\$	\$ 34,100	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 34,100	\$	\$ 34,100	91

G. Construction-in-Progress

	Description	Cost	
92	Fire Alarm System Upgrade	\$ 63,866	92
93			93
94			94
95		\$ 63,866	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A- Facility Owned
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .
N/A
N/A
9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 20,108 Description: Medical Equipment \$19,239; Miscellaneous \$869
(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	\$	1,602	\$ 200,939	\$	1,602	\$ 200,939	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		762	85,810		762	85,810	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		3,268	344,616		3,268	344,616	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				283,241		283,241	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	5,632	\$ 631,365	\$ 283,241	5,632	\$ 914,606	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	\$ (199,084)	\$ (32,636)	1
2	Cash-Patient Deposits	20,063	20,063	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 56,000)	1,608,546	1,676,946	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	168,177	200,006	6
7	Other Prepaid Expenses	2,320	2,320	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,600,022	\$ 1,866,699	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		450,000	13
14	Buildings, at Historical Cost	2,849,141	10,279,502	14
15	Leasehold Improvements, at Historical Cost	108,106	108,106	15
16	Equipment, at Historical Cost	525,857	861,816	16
17	Accumulated Depreciation (book methods)	(2,579,114)	(6,665,707)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Schedule 17A	63,866	938,111	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 967,856	\$ 5,971,828	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,567,878	\$ 7,838,527	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 775,518	\$ 891,505	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,063	20,063	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	166,525	166,525	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		95,091	32
33	Accrued Interest Payable		8,216	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Interdivision Payable	7,397,091	9,287,187	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 8,359,197	\$ 10,468,587	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,125,145	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Security Deposits	25,031	25,031	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 25,031	\$ 4,150,176	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,384,228	\$ 14,618,763	46
47	TOTAL EQUITY(page 18, line 24)	\$ (5,816,350)	\$ (6,780,236)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,567,878	\$ 7,838,527	48

Facility Name:	Pekin Manor
IDPH License ID Number:	0047969
Fiscal Year End:	9/30/2025

Schedule 17A

XV. Balance Sheet

Line 23 Long Term Assets Other (specify):

Description	Operating	After Consolidation
Real Estate Tax Escrow		10,526
Insurance Escrow		2,000
MIP Insurance Escrow		4,400
Reserve for Replacement		857,319
Construction in Progress	63,866	63,866
Total - Line 23	63,866	938,111

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (5,438,000)	1
2	Restatements (describe):		2
3	Prior Period Adjustment - Liability Settlement Adj	(74,215)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (5,512,215)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(304,135)	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)	\$ (304,135)	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)	\$ (5,816,350)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pekin Manor

0047969

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	\$ 11,237,278	1
2	Discounts and Allowances for all Levels	(54,950)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,182,328	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	54,942	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 54,942	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	745	12
13	Barber and Beauty Care	1,345	13
14	Non-Patient Meals	518	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	6,637	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 9,245	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	(3,041)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (3,041)	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,243,474	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,898,673	31
32	Health Care	5,246,038	32
33	General Administration	2,040,552	33
	B. Capital Expense		
34	Ownership	718,214	34
	C. Ancillary Expense		
35	Special Cost Centers	1,126,870	35
36	Provider Participation Fee	517,262	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,547,609	40
41	Income before Income Taxes (line 30 minus line 40)**	(304,135)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (304,135)	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 726,854.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,152,388.00	45
46	MMAI-Medicaid is the Primary Payer	1,620,074.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	3,260,574.00	48
49	Medicare Part A	2,498,371.00	49
50	Other-(specify) Medicare Replacement/Managed Care MCA	1,079,470.00	50
51	Other-(specify) Hospice	844,597.00	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)	\$ 11,182,328	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	1,962	2,110	\$ 110,930	\$ 52.57	1
2	Assistant Director of Nursing	798	819	37,251	45.48	2
3	Registered Nurses	15,528	16,512	792,898	48.02	3
4	Licensed Practical Nurses	21,163	22,449	821,561	36.60	4
5	CNAs & Orderlies	99,362	105,673	2,637,469	24.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,520	1,594	34,804	21.83	9
10	Activity Assistants	6,750	7,257	125,917	17.35	10
11	Social Service Workers	4,139	4,325	99,013	22.89	11
12	Dietician					12
13	Food Service Supervisor	2,364	2,428	68,193	28.09	13
14	Head Cook	60	64	1,472	23.00	14
15	Cook Helpers/Assistants	22,440	24,415	415,821	17.03	15
16	Dishwashers					16
17	Maintenance Workers	5,128	5,605	127,350	22.72	17
18	Housekeepers	12,014	13,021	231,235	17.76	18
19	Laundry	4,974	5,323	88,964	16.71	19
20	Administrator	2,117	2,126	137,119	64.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,912	8,574	207,726	24.23	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	1,730	1,934	39,864	20.61	31
32	Other Health Care: Dir Memory Care	1,699	1,930	56,369	29.21	32
33	Other(specify) Marketing	1,962	2,041	71,109	34.84	33
34	TOTAL (lines 1 - 33)	213,622	228,200	\$ 6,105,065 *	\$ 26.75	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 15,194	L1, C3	35
36	Medical Director	Monthly	15,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	12,692	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)		\$ 42,886		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	449	\$ 33,676	L10, C3	50
51	Licensed Practical Nurses	216	14,476	L10, C3	51
52	Certified Nurse Assistants/Aides	4,582	169,551	L10, C3	52
53	TOTAL (lines 50 - 52)	5,247	\$ 217,703		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Debbie Snow	Administrator	None	\$ 137,119	Workers' Compensation Insurance		\$ 69,433	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance		27,419	Advertising: Employee Recruitment	22,411	
				FICA Taxes		454,711	Health Care Worker Background Check		
				Employee Health Insurance		256,376	(Indicate # of checks performed 10)	880	
				Employee Meals			Patient Background Checks	409 10,243	
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)	11,487	
				401k		39,081	Subscriptions	1,122	
				Other Employee Benefits		12,118	Other Licenses & Fees	1,216	
							Indirect costs	147	
							Less: Public Relations Expense	()	
							PAC and Lobbying payments	(4,075)	
							All non-allowable advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							TOTAL (agree to Sch. V, line 20, col. 8)	\$ 45,421	
				TOTAL (agree to Schedule V, line 22, col.8)					
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
N/A			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
							N/A		
							Seminar Expense		
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							(agree to Sch. V, line 24, col. 8)		
C. Professional Services				TOTAL			TOTAL	\$	
Vendor/Payee	Type		Amount						
RFMS, Inc.	Administrative Services		\$ 180,180						
LTC Support Services, LLC	Support Services		176,916						
RSM US LLP	Accounting Services		21,292						
Templin Healthcare Accounting	Accounting Services		4,428						
Guided Care	MCO Guide		1,000						
Polsinelli	Legal Services		1,001						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)									
			\$ 384,817						

*** 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 |
|---|--------------------|
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>7,412</u> |
| <u> </u> | <u> </u> |
| <u> </u> | <u> </u> |
| <u> </u> | <u>7,412 Total</u> |
- (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.
- | | |
|---|--------------------|
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>4,075</u> |
| <u> </u> | <u> </u> |
| <u> </u> | <u> </u> |
| <u> </u> | <u> </u> |
| <u> </u> | <u>4,075 Total</u> |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|---|---------------------|
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>11,487</u> |
| <u> </u> | <u> </u> |
| <u> </u> | <u> </u> |
| <u> </u> | <u> </u> |
| <u> </u> | <u>11,487 Total</u> |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 76,528 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. \$ 517,262
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. \$ 518
- (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? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.