

		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: 0047878

Facility Name: Shelbyville Manor

Address: 1111 W North 12th St Shelbyville 62565
Number City Zip Code

County: Shelby

Telephone Number: (217) 774-2111 Fax # (217) 774-2209

HFS ID Number:

Date of Initial License for Current Owners: 2/2/06

Type of Ownership:

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

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider

(Signed) (Date)

(Type or Print Name) Brian Burger

(Title) Chief Financial Officer

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)

(Print Name and Title) Larry Templin Partner

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Shelbyville Manor # 0047878 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	109	Skilled (SNF)	109	39,785	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	109	TOTALS	109	39,785	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	3,661	13,385	4		6,417	4,016	1,267	28,750	8	
9	SNF/PED									9	
10	ICF									10	
11	ICF/DD									11	
12	SC									12	
13	DD 16 OR LESS									13	
14	TOTALS	3,661	13,385	4		6,417	4,016	1,267	28,750	14	

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 72.26%

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 2/2/06

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 2/1/06 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter certified beds.
number of certified beds 109

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐

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

Tax Year: 9/30/2025 Fiscal Year: 9/30/2025

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

V. COST CENTER EXPENSES (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			96,476	96,476		96,476	125,441	221,917			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							80,436	80,436			32
33	Real Estate Taxes							74,120	74,120			33
34	Rent-Facility & Grounds			463,200	463,200		463,200	(463,200)				34
35	Rent-Equipment & Vehicles			25,419	25,419		25,419		25,419			35
36	Other (specify):* Mortgage Ins							13,978	13,978			36
37	TOTAL Ownership			585,095	585,095		585,095	(169,225)	415,870			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		206,198	441,991	648,189		648,189		648,189			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			546,112	546,112		546,112		546,112			42
43	Other (specify):* Disallowed Costs	56,994		140,176	197,170		197,170	(197,170)				43
44	TOTAL Special Cost Centers	56,994	206,198	1,128,279	1,391,471		1,391,471	(197,170)	1,194,301			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,216,058	998,870	4,505,546	10,720,474		10,720,474	(1,093,770)	9,626,704			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

