

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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.

<p>I. IDPH License ID Number: <u>0035774</u></p> <p>Facility Name: <u>Douglas Terrace</u></p> <p>Address: <u>324 East Douglas Ave</u> <u>Jacksonville</u> <u>62650</u> Number City Zip Code</p> <p>County: <u>Morgan</u></p> <p>Telephone Number: <u>(217)245-5100</u> Fax # <u>(217)245-8022</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>12/06/89</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501 (c) 3</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Ron Wilson</u> Telephone Number: <u>(309) 343-1550</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501 (c) 3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust			<input type="checkbox"/> Other	_____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/19</u> to <u>9/30/20</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%; border: 1px solid black; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>Lisa Winnette</u> (Title) <u>Director of Operations</u></td> </tr> <tr> <td style="border: 1px solid black; vertical-align: top;">Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 326, Plainfield, IL 60544-0326</u> (Telephone) <u>(630) 361-2868</u> Fax # () _____</td> </tr> </table> <p align="center">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Lisa Winnette</u> (Title) <u>Director of Operations</u>	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 326, Plainfield, IL 60544-0326</u> (Telephone) <u>(630) 361-2868</u> Fax # () _____
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SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Douglas Terrace

0035774 Report Period Beginning: 10/1/19 Ending: 9/30/20

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,963	31		4,994	13
14	TOTALS	4,963	31		4,994	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.28%

D. How many bed reserve days during this year were paid by the Department?
682 (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 12/6/89

J. Was the facility purchased or leased after January 1, 1978?
YES Date 3/27/90 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 9/30/2020 Fiscal Year: 9/30/2020

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Douglas Terrace # 0035774 Report Period Beginning: 10/1/19 Ending: 9/30/20

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassification 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	37,842	2,400	228	40,470		40,470		40,470		1
2	Food Purchase		50,853		50,853		50,853		50,853		2
3	Housekeeping	20,930	3,844		24,774		24,774		24,774		3
4	Laundry		2,398		2,398		2,398		2,398		4
5	Heat and Other Utilities			14,395	14,395		14,395	72	14,467		5
6	Maintenance	10,947	15,813	16,710	43,470		43,470	10	43,480		6
7	Other (specify):*										7
8	TOTAL General Services	69,719	75,308	31,333	176,360		176,360	82	176,442		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	259,493	25,198	1,505	286,196		286,196	8	286,204		10
10a	Therapy			120	120		120		120		10a
11	Activities		968	379	1,347		1,347		1,347		11
12	Social Services										12
13	CNA Training	9,119			9,119		9,119		9,119		13
14	Program Transportation			8,272	8,272		8,272		8,272		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	268,612	26,166	10,276	305,054		305,054	8	305,062		16
	C. General Administration										
17	Administrative	12,318			12,318		12,318		12,318		17
18	Directors Fees							452	452		18
19	Professional Services			64,804	64,804		64,804	452	65,256		19
20	Dues, Fees, Subscriptions & Promotions			4,778	4,778		4,778	(233)	4,545		20
21	Clerical & General Office Expenses	10,543	4,177	7,457	22,177		22,177	7	22,184		21
22	Employee Benefits & Payroll Taxes			50,851	50,851		50,851		50,851		22
23	Inservice Training & Education			4,335	4,335		4,335		4,335		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			3,483	3,483		3,483		3,483		25
26	Insurance-Prop.Liab.Malpractice			5,492	5,492		5,492	1,242	6,734		26
27	Other (specify):*										27
28	TOTAL General Administration	22,861	4,177	141,200	168,238		168,238	1,920	170,158		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	361,192	105,651	182,809	649,652		649,652	2,010	651,662		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.

Facility Name & ID Number

Douglas Terrace

#0035774

Report Period Beginning:

10/1/19

Ending:

9/30/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			25,506	25,506		25,506	(208)	25,298			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles							12	12			35
36	Other (specify):*											36
37	TOTAL Ownership			25,506	25,506		25,506	(196)	25,310			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,340	40,340		40,340		40,340			42
43	Other (specify):* Disallowed Costs			77,077	77,077		77,077	(77,077)				43
44	TOTAL Special Cost Centers			117,417	117,417		117,417	(77,077)	40,340			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	361,192	105,651	325,732	792,575		792,575	(75,263)	717,312			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

Facility Name & ID Number Douglas Terrace

0035774

Report Period Beginning:

10/1/19

Ending:

9/30/20

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(208)	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	(267)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(77,077)	43		24
25	Fund Raising, Advertising and Promotional				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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (77,552)		\$	30

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	2	
		Amount	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)	2,289		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 2,289		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (75,263)		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	

Douglas Terrace

ID# 0035774

Report Period Beginning: 10/1/19

Ending: 9/30/20

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			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
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31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Facility Name & ID Number

Douglas Terrace

0035774

Report Period Beginning:

10/1/19

Ending:

9/30/20

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	Community Living Options, Inc. (CLO)		See Page 6 Supplemental		
		Unlimited Development, Inc. (CLO is sole member)				
		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: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	5 Utilities	\$	Community Living Options, Inc.	100.00%	\$ 72	\$ 72	1	
2	V	6 Maintenance		Community Living Options, Inc.	100.00%	10	10	2	
3	V	10 Nursing Supplies-PPE		Community Living Options, Inc.	100.00%	8	8	3	
4	V	18 Director Fees		Community Living Options, Inc.	100.00%	452	452	4	
5	V	19 Professional Fees		Community Living Options, Inc.	100.00%	452	452	5	
6	V	20 Dues, Licenses and Subs		Community Living Options, Inc.	100.00%	34	34	6	
7	V	21 Clerical & General Office		Community Living Options, Inc.	100.00%	7	7	7	
8	V	26 Property/ Liability Insurance		Community Living Options, Inc.	100.00%	1,242	1,242	8	
9	V	35 Equipment Rental		Community Living Options, Inc.	100.00%	12	12	9	
10	V							10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$			\$ 2,289	\$ *	2,289	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Douglas Terrace

0035774

Report Period Beginning:

10/1/19

Ending:

9/30/20

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	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

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0035774

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VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	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%	Vahle 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-CILA	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%	Leroy Manor	Leroy				18
19	Unlimited Development, Inc. (UDI)	100%	Manor Court of Carbondale	Carbondale				19
20	Unlimited Development, Inc. (UDI)	100%			Liberty Estates of Car	Carbondale	Retirement living ce	20
21	Unlimited Development, Inc. (UDI)	100%	Seminary Manor	Galesburg				21
22	Unlimited Development, Inc. (UDI)	100%			Seminary Estates	Galesburg	Retirement living ce	22
23	Unlimited Development, Inc. (UDI)	100%			Hawthorne Inn of Gal	Galesburg	Assisted Living Faci	23
24	Unlimited Development, Inc. (UDI)	100%	Centralia Manor	Centralia				24
25	Unlimited Development, Inc. (UDI)	100%			Centralia Estates	Centralia Estates	Retirement living ce	25
26	Unlimited Development, Inc. (UDI)	100%	Pittsfield Manor	Pittsfield				26
27	Unlimited Development, Inc. (UDI)	100%	Pekin Manor	Pekin				27
28	Unlimited Development, Inc. (UDI)	100%			Pekin Estates	Pekin	Retirement living ce	28
29	Unlimited Development, Inc. (UDI)	100%	Jerseyville Manor	Jerseyville				29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Douglas Terrace

0035774

Report Period Beginning:

10/1/19

Ending:

9/30/20

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	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 McCorn	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%			Leroy South Buck, LL	Galesburg	Lessor	9
10	Unlimited Development, Inc. (UDI)	100%			2245 Seminary Street,	Galesburg	Lessor	10
11	Unlimited Development, Inc. (UDI)	100%			Pittsfield Lowry, LLC	Galesburg	Lessor	11
12	Unlimited Development, Inc. (UDI)	100%			Pekin El Camino, LLC	Galesburg	Lessor	12
13	Unlimited Development, Inc. (UDI)	100%			Keokuk Village Circle	Galesburg	Lessor	13
14	Unlimited Development, Inc. (UDI)	100%			The Kensington	Galesburg	Supportive Living	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

SEE ACCOUNTANTS' PREPARATION REPORT

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Douglas Terrace

0035774

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VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See Attached Schedule 7A								\$ 452	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	\$ 452		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 Douglas Terrace

0035774

Report Period Beginning:

10/1/19

Ending: 9/30/20

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Community Living Options, Inc.

Street Address 285 S Farnham

City / State / Zip Code Galesburg, IL 61401

Phone Number (309) 343-1550

Fax Number (309) 343-2857

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.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Bed Days Available	193,248	35	\$ 2,372	\$ 5,856	\$ 72	1
2	6	Maintenance	Bed Days Available	193,248	35	315	5,856	10	2
3	10	Nursing Supplies-PPE	Bed Days Available	193,248	35	267	5,856	8	3
4	18	Director Fees	Bed Days Available	193,248	35	14,922	5,856	452	4
5	19	Professional Fees	Bed Days Available	193,248	35	14,910	5,856	452	5
6	20	Dues, Licenses and Subs	Bed Days Available	193,248	35	1,133	5,856	34	6
7	21	Clerical & General Office	Bed Days Available	193,248	35	235	5,856	7	7
8	26	Property/ Liability Insurance	Bed Days Available	193,248	35	40,983	5,856	1,242	8
9	35	Equipment Rental	Bed Days Available	193,248	35	397	5,856	12	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					\$ 75,534	\$	\$ 2,289	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Douglas Terrace

0035774

Report Period Beginning:

10/1/19

Ending:

9/30/20

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

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ 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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2019 report.		\$	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.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	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. 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.		\$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	N/A	8
	2016	N/A	9
	2017	N/A	10
	2018	N/A	11
	2019	N/A	12

The facility is owned by a non-profit organization. Real estate taxes are not assessed due to the tax exempt status of the facility. Therefore, no accrual for real estate tax is required.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2019	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

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.

SEE ACCOUNTANTS' PREPARATION REPORT

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Douglas Terrace COUNTY Morgan

FACILITY IDPH LICENSE NUMBER 0035774

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

Facility Name & ID Number Douglas Terrace

0035774 Report Period Beginning:

10/1/19 Ending:

9/30/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,200 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (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. 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:

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for counts. Row 1: Facility, 23,760, 1990, \$ 22,692, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 23,760, (blank), \$ 22,692, 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	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	16	1990	1989	\$ 412,308	\$ 5,901	30	\$ 5,693	\$ (208)	\$ 412,308	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Garage, Parking Lot, Sidewalks, Landscaping		1989	30,000		15			30,000	9
10	Paving		1996	1,680		8			1,680	10
11	Carpet		2001	7,590		5			7,590	11
12	Kitchen Cabinets		2002	2,544		15			2,544	12
13	Roof, Furnace		2005	16,500	745	10-15yrs	745		16,500	13
14	New Roof		2007	9,060		10			9,060	14
15	Furnace/AC Unit		2008	6,581	438	15	438		5,411	15
16	Shower (Tile)		2009	3,336	167	20	167		1,946	16
17	Shower/Marble Surround		2009	4,210	210	20	210		2,421	17
18	Carpeting - Living Room & Hallway		2014	3,637	61	5	61		3,637	18
19	Bathroom 3 - New Floor/Tile/Toilet/Fixtures/Drain/Cabinets		2016	11,480	956	12	956		4,305	19
20	Bathroom 4 - New Tile/Walls/Toilet/Mirrors/Cabinets/Fixtures		2016	15,250	1,271	12	1,271		5,613	20
21	Bathroom 1 - New Tile/Walls/Toilet/Mirrors/Cabinets/Fixtures		2016	15,250	1,271	12	1,271		5,719	21
22	Kitchen - New Cabinets/Countertops/Tile/Backsplash		2016	21,150	1,762	12	1,762		7,638	22
23	Bathroom 2 - New Tile/Cabinets/Toilet/Fixtures		2016	10,980	915	12	915		4,118	23
24	Install Vinyl Tile in the Common Area		2019	3,713	371	10	371		464	24
25	New LVT Plank Tile - Halls/Staff Bathroom		2019	7,566	757	10	757		883	25
26	New LVT Plank Tile - 8 Bedrooms and Closets		2019	12,588	1,258	10	1,258		1,468	26
27	Patching and Painting Resident Rooms		2019	21,300	4,260	5	4,260		4,970	27
28	Replace Sprinkler System with a Wet System		2020	14,500	503	12	503		503	28
29	Install Cable TV Receptacles and Outlets		2020	6,200	362	10	362		362	29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Douglas Terrace

0035774

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Ending:

9/30/20

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 637,423	\$ 21,208		\$ 21,000	\$ (208)	\$ 529,140	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

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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	\$ 96,440	\$ 4,298	\$ 4,298	\$	3-15 yrs	\$ 60,201	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 96,440	\$ 4,298	\$ 4,298	\$		\$ 60,201	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	2008 Ford E350/Vanterra	2008	\$ 46,465	\$	\$	\$	4	\$ 46,465	76
77										77
78										78
79										79
80	TOTALS			\$ 46,465	\$	\$	\$		\$ 46,465	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)	\$ 803,020	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 25,506	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 25,298	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (208)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 635,806	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	2001 Ford Econ Van - 2002	\$ 19,847	\$	\$ 19,847	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 19,847	\$	\$ 19,847	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	_____ /2021	\$ _____
13.	_____ /2022	\$ _____
14.	_____ /2023	\$ _____

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: \$ 12 Description: Home Office Allocation

(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	<u>N/A</u>		\$	\$	17
18					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.

SEE ACCOUNTANTS' PREPARATION REPORT

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>138</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		9,119		9,119
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 9,119	\$	\$ 9,119
10	SUM OF line 9, col. 1 and 2 (e)	\$	9,119		

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	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	4

- (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.)

	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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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			\$		\$	\$		\$	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

Facility Name & ID Number Douglas Terrace

0035774

Report Period Beginning: 10/1/19

Ending:

9/30/20

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/20

(last day of reporting year)

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
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>6,266</u>)	87,409	87,409	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interdivision Receivable</u>	2,047,854	2,047,854	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,135,263	\$ 2,135,263	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	10,000	22,692	13
14	Buildings, at Historical Cost	643,915	637,423	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	168,952	142,905	16
17	Accumulated Depreciation (book methods)	(668,345)	(635,806)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 154,522	\$ 167,214	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,289,785	\$ 2,302,477	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 408	\$ 408	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	4,321	4,321	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,729	\$ 4,729	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				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,729	\$ 4,729	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,285,056	\$ 2,297,748	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,289,785	\$ 2,302,477	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,259,754	1
2	Restatements (describe):		2
3	Prior Period Adjustments	3,095	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,262,849	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	22,207	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)	\$ 22,207	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)	\$ 2,285,056	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

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	\$ 782,266	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 782,266	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	23,397	10
11	CNA Training Reimbursements	9,119	11
12	Gift and Coffee Shop		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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 32,516	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	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)	\$ 814,782	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	176,360	31
32	Health Care	305,054	32
33	General Administration	168,238	33
B. Capital Expense			
34	Ownership	25,506	34
C. Ancillary Expense			
35	Special Cost Centers	77,077	35
36	Provider Participation Fee	40,340	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 792,575	40
41	Income before Income Taxes (line 30 minus line 40)**	22,207	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 22,207	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 679,748	44
45	Private Pay - Net Inpatient Revenue	102,518	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 782,266	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

SEE ACCOUNTANTS' PREPARATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
James Graham	Administrator	None	\$ 12,318	Workers' Compensation Insurance	\$ 5,325	IDPH License Fee	\$	
				Unemployment Compensation Insurance	2,908	Advertising: Employee Recruitment	2,464	
				FICA Taxes	27,276	Health Care Worker Background Check (Indicate # of checks performed <u>38</u>)	380	
				Employee Health Insurance	11,472	Patient Background Checks		
				Employee Meals	1,452			
				Illinois Municipal Retirement Fund (IMRF)*				
				401k	585	Subscriptions	961	
				Other Employee Benefits	1,833	IHCA Dues	973	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 12,318			Indirect costs	34	
B. Administrative - Other						Less: Public Relations Expense	(267)	
Description			Amount			Non-allowable advertising	()	
N/A			\$			Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 50,851	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 4,545	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
LTC Support Services, LLC	Support Services		\$ 26,844			\$	Out-of-State Travel	\$
RFMS, Inc.	Administrative Services		34,062					
RSM US LLP	Accounting Services		2,213	N/A				
Templin Healthcare Accounting	Accounting Services		1,351				In-State Travel	
Polsinelli	Legal Services		334					
							Seminar Expense	0
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 64,804	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name & ID Number Douglas Terrace

0035774

Report Period Beginning:

10/1/19

Ending:

9/30/20

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
2	Assistant Director of Nursing				2
3	Registered Nurses				3
4	Licensed Practical Nurses	2,660	62,318	23.11	4
5	CNAs & Orderlies	10,280	151,726	13.64	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants				10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	3,536	37,842	10.31	15
16	Dishwashers				16
17	Maintenance Workers	647	10,947	15.25	17
18	Housekeepers	2,000	20,930	10.26	18
19	Laundry				19
20	Administrator	584	12,318	19.25	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	722	10,543	13.16	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	2,310	54,568	23.00	28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	22,739	361,192 *	15.01	34

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

** See instructions.

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	\$ 228	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	58	L10, C3	38
39	Pharmacist Consultant	Monthly	952	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	Psychological Consultant	Monthly	495	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 1,733		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

Facility Name & ID Number Douglas Terrace# 0035774

Report Period Beginning:

10/1/19Ending: 9/30/20**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 973 IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,768 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) 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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 40,340
This amount is to be recorded on line 42 of Schedule V.
- (12) 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.
- (13) 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
- (14) 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.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 1,452 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) 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
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: RSM US LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) 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.

SEE ACCOUNTANTS' PREPARATION REPORT