

Facility Name & ID Number Manor Court of Maryville

0050427 Report Period Beginning: 10/1/2019 Ending: 9/30/2020

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	132	Skilled (SNF)	132	48,312	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	132	TOTALS	132	48,312	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,708	8,670	10,652	38,030	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,708	8,670	10,652	38,030	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.72%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 132 and days of care provided 5,450

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Maryville # 0050427 Report Period Beginning: 10/1/2019 Ending: 9/30/2020

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	374,022	27,984	14,511	416,517		416,517		416,517		1
2	Food Purchase		316,344		316,344		316,344	(1,972)	314,372		2
3	Housekeeping	238,018	58,321		296,339		296,339		296,339		3
4	Laundry	65,543	18,915		84,458		84,458		84,458		4
5	Heat and Other Utilities			220,582	220,582		220,582		220,582		5
6	Maintenance	116,581	27,493	133,983	278,057		278,057	(47,412)	230,645		6
7	Other (specify):*										7
8	TOTAL General Services	794,164	449,057	369,076	1,612,297		1,612,297	(49,384)	1,562,913		8
	B. Health Care and Programs										
9	Medical Director			32,500	32,500		32,500		32,500		9
10	Nursing and Medical Records	3,537,294	298,697	14,363	3,850,354		3,850,354		3,850,354		10
10a	Therapy										10a
11	Activities	102,214	4,958		107,172		107,172		107,172		11
12	Social Services	78,922			78,922		78,922		78,922		12
13	CNA Training		306	811	1,117		1,117		1,117		13
14	Program Transportation			3,754	3,754		3,754		3,754		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,718,430	303,961	51,428	4,073,819		4,073,819		4,073,819		16
	C. General Administration										
17	Administrative	105,217			105,217		105,217		105,217		17
18	Directors Fees							1,413	1,413		18
19	Professional Services			390,298	390,298		390,298	2,800	393,098		19
20	Dues, Fees, Subscriptions & Promotions			43,258	43,258		43,258	(2,766)	40,492		20
21	Clerical & General Office Expenses	176,679	29,855	69,129	275,663		275,663	36	275,699		21
22	Employee Benefits & Payroll Taxes			634,782	634,782		634,782	15	634,797		22
23	Inservice Training & Education			2,884	2,884		2,884		2,884		23
24	Travel and Seminar			750	750		750		750		24
25	Other Admin. Staff Transportation			3,756	3,756		3,756		3,756		25
26	Insurance-Prop.Liab.Malpractice			159,502	159,502		159,502	1,994	161,496		26
27	Other (specify):*										27
28	TOTAL General Administration	281,896	29,855	1,304,359	1,616,110		1,616,110	3,492	1,619,602		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,794,490	782,873	1,724,863	7,302,226		7,302,226	(45,892)	7,256,334		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

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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			67,908	67,908		67,908	7,033	74,941			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			115,200	115,200		115,200		115,200			33
34	Rent-Facility & Grounds			1,018,392	1,018,392		1,018,392		1,018,392			34
35	Rent-Equipment & Vehicles			24,192	24,192		24,192	30	24,222			35
36	Other (specify):*											36
37	TOTAL Ownership			1,225,692	1,225,692		1,225,692	7,063	1,232,755			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,847	1,847		1,847		1,847			38
39	Ancillary Service Centers		329,450	1,385,080	1,714,530		1,714,530		1,714,530			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			258,465	258,465		258,465		258,465			42
43	Other (specify):* Disallowed Costs	88,012		429,448	517,460		517,460	(469,476)	47,984			43
44	TOTAL Special Cost Centers	88,012	329,450	2,074,840	2,492,302		2,492,302	(469,476)	2,022,826			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,882,502	1,112,323	5,025,395	11,020,220		11,020,220	(508,305)	10,511,915			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

Manor Court of Maryville

Period Beginning 10/1/2019

Period End 9/30/2020

Schedule 4A

V. Cost Center Expenses

		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
	Ancillary Expense										
	E. Special Cost Centers										
43	Other (specify):*				0		0		0		
	Laboratory/Expenses			13,675	13,675		13,675		13,675		
	Radiology Expenses			34,309	34,309		34,309		34,309		
	Non-Allowable Expenses	88,012		381,464	469,476		469,476	(469,476)	0		
					0		0		0		
					0		0		0		
	TOTAL Other Special Cost Centers	88,012	0	429,448	517,460	0	517,460	(469,476)	47,984		

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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	(1,972)	2		4
5	Telephone, TV & Radio in Resident Rooms	(11,837)	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	7,033	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	(2,793)	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	(345,670)	43		24
25	Fund Raising, Advertising and Promotional	(23,957)	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	(135,424)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (514,620)		\$	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)	6,315		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 6,315		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (508,305)		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	

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallow Marketing Wages	\$ (88,012)	43	1
2	Capitalized Repairs over \$2,500	(47,412)	6	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
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17				17
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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	(135,424)		49

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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: 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	18 Director Fees	\$	Unlimited Development, Inc.	100.00%	\$ 1,413	\$ 1,413	1	
2	V	19 Professional Fees		Unlimited Development, Inc.	100.00%	2,800	2,800	2	
3	V	20 Dues, Licenses and Subs		Unlimited Development, Inc.	100.00%	27	27	3	
4	V	21 General Admin Expense		Unlimited Development, Inc.	100.00%	36	36	4	
5	V	22 Employee Benefits		Unlimited Development, Inc.	100.00%	15	15	5	
6	V	26 Property Insurance		Unlimited Development, Inc.	100.00%	1,994	1,994	6	
7	V	35 Equipment Rental		Unlimited Development, Inc.	100.00%	30	30	7	
8	V							8	
9	V							9	
10	V							10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$			\$ 6,315	\$ *	6,315	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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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%			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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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	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 Gal	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

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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	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%			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

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VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See Attached Schedule 7A								\$ 1,413	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	\$ 1,413		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 Manor Court of Maryville

0050427 Report Period Beginning: 10/1/2019

Ending: 1/30/2020

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 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	18	Director Fees	Weighted Avg BDA	462,258	19	13,522	\$ 48,312	\$ 1,413	1
2	19	Professional Fees	Weighted Avg BDA	462,258	19	26,790	48,312	2,800	2
3	20	Dues, Licenses and Subs	Weighted Avg BDA	462,258	19	256	48,312	27	3
4	21	General Admin Expense	Weighted Avg BDA	462,258	19	342	48,312	36	4
5	22	Employee Benefits	Weighted Avg BDA	462,258	19	147	48,312	15	5
6	26	Property Insurance	Weighted Avg BDA	462,258	19	19,075	48,312	1,994	6
7	35	Equipment Rental	Weighted Avg BDA	462,258	19	287	48,312	30	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					\$ 60,419	\$	\$ 6,315	25

SEE ACCOUNTANTS' PREPARATION REPORT

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manor Court of Maryville COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0050427

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

TELEPHONE (309) 343-1550 FAX #: (309) 343-2857

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>13-2-21-01-00-000-025</u>	<u>LIBERTY VILLAGE LOT 1</u>	\$ <u>116,439.12</u>	\$ <u>116,439.12</u>
2. _____	<u>147.69 X 1456.39 IRREGULAR</u>	\$ _____	\$ _____
3. _____	<u>HAWTHORNE CENTRE RESUB</u>	\$ _____	\$ _____
4. _____	<u>NO - 5 PT LOT 6 - BEG NW</u>	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>116,439.12</u>	\$ <u>116,439.12</u>

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 Manor Court of Maryville

0050427

Report Period Beginning:

10/1/2019 Ending:

9/30/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 72,233 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column with values 1, 2, 3. Row 3 contains 'TOTALS'.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Maryville

0050427

Report Period Beginning:

10/1/2019

Ending:

9/30/2020

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Sign		2010	44,512	3,339	10	3,339		44,512	9
10	Water Filtration System		2012	8,588	859	10	859		7,515	10
11	Water Softener		2014	7,902	790	10	790		5,202	11
12	Workstation-Counters/Cabinets/Chair		2014	3,834	320	12	320		1,864	12
13	Compressr/Inverter Assembly		2016	7,384	492	15	492		2,066	13
14	Carpet-Nurse Station, Office, Garden Court Sitting Area		2016	5,452	1,090	5	1,090		4,543	14
15	A/C Units/Condenser		2016	8,253	1,149	5-15 Yrs	1,149		4,693	15
16	Furnace Repair		2016	2,913		10	291	291	1,019	16
17	Furnace Repairs		2017	8,359		10	836	836	2,926	17
18	AC Repair		2017	4,328		10	433	433	1,515	18
19	Compressor Repairs		2017	16,629	1,109	15	1,109		4,060	19
20	Lighted Floating Lake Fountain		2017	6,047	604	10	604		2,066	20
21	Compressor Repairs		2017	8,286	703	10-15 ys	703		2,030	21
22	Water Heater - Mechanical Room in Service Hallway		2018	5,726	573	10	573		1,575	22
23	Compressor Repair - 100 Hall		2018	8,965	598	15	598		1,594	23
24	Condenser Coil		2018	4,294	286	15	286		739	24
25	Inverter Compressor - Master Unit		2018	5,849	585	10	585		1,511	25
26	Water Heater - Mechanical Room in Service Hallway		2018	11,404	1,140	10	1,140		2,660	26
27	Water Heater - Mechanical Room next to Kitchen		2018	9,672	967	10	967		2,015	27
28	Replace Compressors on System 3		2018	7,767		15	518	518	1,295	28
29	Replace Compressors on System 7		2018	9,554		15	637	637	1,592	29
30	Water Heater - Mechanical Room		2018	6,440	644	10	644		1,288	30
31	Compressor		2018	3,591	239	15	239		458	31
32	Sprinkler Pipe		2019	10,094	1,009	10	1,009		1,766	32
33	Compressors/Cap Tube/Inverter Assy - Sys 3-1, 5-2		2019	41,760	2,785	15	2,785		4,543	33
34	Asphalt - Parking Lot		2019	22,000	2,750	8	2,750		3,438	34
35	Replace 2 Modules on VRV System - Outdoor Units		2019	5,795	580	10	580		725	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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	AC Unit 5-2-Replace Inverter Compressor/Outdoor Fan Motor	2019	\$ 3,696	\$	10	\$ 370	\$ 370	\$ 555	37
38	Install Air Filter Grills in Ducts and Clean AC Coils	2019	4,800		10	480	480	720	38
39	Replace Compressor in Master Unit CU 1-3 and Install Coil	2019	7,713		10	771	771	1,157	39
40	Repair AAON Make Up Air Units 3,4,6,7	2019	3,249		10	325	325	487	40
41	Compressor/Inverter Board-Garden Ct Area (8 Patient Rms/Cent	2019	16,897	939	15	939		939	41
42	Clean/Repair Indoor Fan Coils	2019	3,120		10	156	156	156	42
43	Replace Inverter Bd/ Master Compressor / Suction Pipe Termistor	2020	13,159		10	658	658	658	43
44	Replace Compressor/repair leak unit 5-2	2020	5,611		10	281	281	281	44
45	Replace Compressor and Inverter on Unit 1-1	2020	9,711		10	486	486	486	45
46	Replace Compressors on 2 Outdoor Units	2020	6,907		10	345	345	345	46
47	Repair AC Unit 3-1	2020	4,252		10	213	213	213	47
48	Inspect 7 Roof Top AC Units	2020	4,652		10	233	233	233	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)		\$ 369,165	\$ 23,550		\$ 30,583	\$ 7,033	\$ 115,440	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 510,039	\$ 28,955	\$ 28,955	\$	3-15 yrs	\$ 435,013	71
72	Current Year Purchases	9,745	595	595		12-15 yrs	595	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 519,784	\$ 29,550	\$ 29,550	\$		\$ 435,608	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2005 Ford E350 Universal	2006	\$ 47,110	\$	\$	\$	4	\$ 47,110	76
77	Patient Care	2018 Ford E350	2018	59,242	14,808	14,808		4	28,385	77
78										78
79										79
80	TOTALS			\$ 106,352	\$ 14,808	\$ 14,808	\$		\$ 75,495	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)	\$ 995,301	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 67,908	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 74,941	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,033	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 626,543	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	2013 Toyota Corolla - 2013	\$ 17,060	\$	\$ 17,060	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 17,060	\$	\$ 17,060	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

Facility Name & ID Number Manor Court of Maryville

0050427

Report Period Beginning: 10/1/2019

Ending: 9/30/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: LB Properties, Inc.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>2010</u>	<u>120</u>	<u>1/1/2011</u>	\$ <u>1,018,392</u>	<u>15</u>	<u>10</u>	3
4	Additions		<u>12</u>					4
5								5
6								6
7	TOTAL		132		\$ 1,018,392			7

10. Effective dates of current rental agreement:

Beginning 1/1/2011

Ending 12/31/2025

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

Fiscal Year Ending Annual Rent

12.	<u>9/30/2021</u>	\$ <u>940,000</u>
13.	<u>9/30/2022</u>	\$ <u>940,000</u>
14.	<u>9/30/2023</u>	\$ <u>940,000</u>

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: \$ 24,222 Description: See Attached Schedule 14A

(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			\$ _____	\$ _____	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

Manor Court of Maryville

Period Beginning 10/1/2019
Period End 9/30/2020

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

<u>Rental Description</u>	<u>Amount</u>
Medical Equipment Rental	24,044
Other Equipment Rental	148
Home Office Allocation	30
Total - Line 16	<u><u>24,222</u></u>

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 type="checkbox"/> YES <input checked="" 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 type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</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	\$	\$ 811	\$	\$ 811
2	Books and Supplies		306		306
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 1,117	\$	\$ 1,117
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,117		

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.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	39(3)	hrs	\$	4,113	\$ 563,815	\$	4,113	\$	563,815		4,113	\$	563,815		1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,401	1,819,476		2,401		1,819,476		2,401		1,819,476		2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39(3)	hrs		4,475	622,069		4,475		622,069		4,475		622,069		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 prescripts							329,450				329,450		9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): <u>Respiratory Therapy</u>	39(3)					43		17,250				43		17,250	12
13	Other (specify):															13
14	TOTAL			\$			11,032	\$	3,022,610	\$	329,450		11,032	\$	3,352,060	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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/2020

(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	\$ 152,013	\$ 152,013	1
2	Cash-Patient Deposits	17,711	17,711	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 465,000)	1,122,525	1,122,525	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	119,956	119,956	6
7	Other Prepaid Expenses	6,370	6,370	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interdivision Receivable</u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,418,575	\$ 1,418,575	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	269,374	369,165	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	643,196	626,136	16
17	Accumulated Depreciation (book methods)	(629,965)	(626,543)	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)	\$ 282,605	\$ 368,758	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,701,180	\$ 1,787,333	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 337,443	\$ 337,443	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,711	17,711	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	121,683	121,683	30
31	Accrued Taxes Payable (excluding real estate taxes)	54,193	54,193	31
32	Accrued Real Estate Taxes(Sch.IX-B)	85,350	85,350	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		4,265,707	4,265,707	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,882,087	\$ 4,882,087	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Security Deposits</u>	15,000	15,000	43
44	<u>Medicare Advance-COVID</u>	647,223	647,223	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 662,223	\$ 662,223	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,544,310	\$ 5,544,310	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,843,130)	\$ (3,756,977)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,701,180	\$ 1,787,333	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,905,604)	1
2	Restatements (describe):		2
3	Prior Period Adjustments	1,059	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,904,545)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	61,415	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)	\$ 61,415	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)	\$ (3,843,130)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Maryville

0050427

Report Period Beginning: 10/1/2019

Ending: 9/30/2020

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	\$ 9,513,968	1
2	Discounts and Allowances for all Levels	(42,728)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,471,240	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	682,195	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 682,195	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	922,233	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,902	12
13	Barber and Beauty Care	1,549	13
14	Non-Patient Meals	70	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	205	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	76	20
21	Other Medical Services	418	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 926,453	23
D. Non-Operating Revenue			
24	Contributions	795	24
25	Interest and Other Investment Income***	360	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,155	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Late Payment Fee</u>	592	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 592	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,081,635	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,612,297	31
32	Health Care	4,073,819	32
33	General Administration	1,616,110	33
B. Capital Expense			
34	Ownership	1,225,692	34
C. Ancillary Expense			
35	Special Cost Centers	2,233,837	35
36	Provider Participation Fee	258,465	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,020,220	40
41	Income before Income Taxes (line 30 minus line 40)**	61,415	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 61,415	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 2,993,797	44
45	Private Pay - Net Inpatient Revenue	2,285,513	45
46	Medicare - Net Inpatient Revenue	2,855,362	46
47	Other-(specify) <u>Medicare Replacement/Managed Care</u>	894,498	47
48	Other-(specify) <u>Hospice</u>	442,070	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,471,240	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

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,304	2,360	\$ 77,941	\$ 33.03	1
2	Assistant Director of Nursing	2,224	2,358	66,303	28.12	2
3	Registered Nurses	19,587	20,383	523,650	25.69	3
4	Licensed Practical Nurses	55,525	57,476	1,125,960	19.59	4
5	CNAs & Orderlies	149,372	152,064	1,710,415	11.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,127	8,524	102,214	11.99	10
11	Social Service Workers	4,896	5,359	78,922	14.73	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	34,287	35,755	374,022	10.46	15
16	Dishwashers					16
17	Maintenance Workers	9,211	9,777	116,581	11.92	17
18	Housekeepers	23,582	23,356	238,018	10.19	18
19	Laundry	6,243	6,441	65,543	10.18	19
20	Administrator	2,664	2,832	105,217	37.15	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,478	14,904	176,679	11.85	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,008	3,168	33,025	10.43	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	3,020	3,293	88,012	26.73	33
34	TOTAL (lines 1 - 33)	338,528	348,050	\$ 4,882,502 *	\$ 14.03	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	\$ 14,511	L1, C3	35
36	Medical Director	Monthly	32,500	L9, C3	36
37	Medical Records Consultant	Monthly	1,500	L10, C3	37
38	Nurse Consultant	Monthly	1,197	L10, C3	38
39	Pharmacist Consultant	Monthly	11,666	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)		\$ 61,374		49

C. CONTRACT NURSES

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

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	
Johnny Law	Administrator	None	\$ 105,217	Workers' Compensation Insurance	\$ 53,880	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	12,629	Advertising: Employee Recruitment	23,074	
				FICA Taxes	358,471	Health Care Worker Background Check (Indicate # of checks performed <u>127</u>)	1,270	
				Employee Health Insurance	182,550	Patient Background Checks	3,480	
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*				
				401k	16,440	Subscriptions	289	
				Other Employee Benefits	10,812	IHCA Dues	10,163	
						Other Licenses & Fees	2,992	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 105,217			Indirect costs	27	
B. Administrative - Other				Indirect costs	15	Less: Public Relations Expense	(2,793)	
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)	\$ 634,797	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 40,492	
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		\$ 182,580	N/A			Out-of-State Travel	\$
RFMS, Inc.	Administrative Services		171,600					
Templin Healthcare Accounting	Accounting Services		3,804					
RSM US LLP	Accounting Services		23,501				In-State Travel	
Davis & Campbell LLC	Legal Services		6,784					
Fudge Broadwater	Legal Services		158					
Jack P. Cranley	Legal Services		500					
Polsinelli	Legal Services		1,371				Seminar Expense	750
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 390,298	TOTAL		\$	Entertainment Expense (agree to Sch. V, line 24, col. 8)	()
							TOTAL	\$ 750

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name & ID Number Manor Court of Maryville

0050427

Report Period Beginning: 10/1/2019

Ending: 9/30/2020

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. 10,163 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? 12-15 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 55,304 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. \$ 258,465
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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,972
- (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