

		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>0047233</u></p> <p>Facility Name: <u>Seminary Manor</u></p> <p>Address: <u>2345 N Seminary St</u> <u>Galesburg</u> <u>61401</u> Number City Zip Code</p> <p>County: <u>Knox</u></p> <p>Telephone Number: <u>(309) 344-1300</u> Fax # <u>(309) 344-2473</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>7/28/05</u></p> <p>Type of Ownership:</p> <table border="0"> <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>10/1/2019</u> to <u>9/30/2020</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 border="1"> <tr> <td rowspan="3" style="width: 15%; text-align: center;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Sherri Miller</u></td> </tr> <tr> <td>(Title) <u>LTC CEO</u></td> </tr> </table> <table border="1"> <tr> <td rowspan="4" style="width: 15%; text-align: center;">Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Larry Templin Partner</u></td> </tr> <tr> <td>(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 326, Plainfield, IL 60544-0326</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(630) 361-2868</u> Fax # ()</td> </tr> </table> <p align="right">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>Sherri Miller</u>	(Title) <u>LTC CEO</u>	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	(Date) _____	(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 Seminary Manor

0047233 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	121	Skilled (SNF)	121	44,286	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	121	TOTALS	121	44,286	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	10,891	9,603	13,223	33,717	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,891	9,603	13,223	33,717	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.13%

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 8/01/05

J. Was the facility purchased or leased after January 1, 1978?
YES Date 7/28/05 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 121 and days of care provided 8,267

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 Seminary Manor # 0047233 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	370,496	37,459	16,498	424,453		424,453		424,453		1
2	Food Purchase		379,691		379,691		379,691	(2,228)	377,463		2
3	Housekeeping	193,223	64,275		257,498		257,498		257,498		3
4	Laundry	62,892	12,711		75,603		75,603		75,603		4
5	Heat and Other Utilities			114,943	114,943		114,943		114,943		5
6	Maintenance	58,281	33,787	71,583	163,651		163,651		163,651		6
7	Other (specify):*										7
8	TOTAL General Services	684,892	527,923	203,024	1,415,839		1,415,839	(2,228)	1,413,611		8
	B. Health Care and Programs										
9	Medical Director			26,000	26,000		26,000		26,000		9
10	Nursing and Medical Records	2,870,368	278,455	11,158	3,159,981		3,159,981		3,159,981		10
10a	Therapy										10a
11	Activities	98,166	1,583		99,749		99,749		99,749		11
12	Social Services	115,639			115,639		115,639		115,639		12
13	CNA Training		288		288		288		288		13
14	Program Transportation			1,463	1,463		1,463		1,463		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,084,173	280,326	38,621	3,403,120		3,403,120		3,403,120		16
	C. General Administration										
17	Administrative	126,573			126,573		126,573		126,573		17
18	Directors Fees							1,295	1,295		18
19	Professional Services			389,216	389,216		389,216	(1,181)	388,035		19
20	Dues, Fees, Subscriptions & Promotions			37,307	37,307		37,307	(2,459)	34,848		20
21	Clerical & General Office Expenses	147,438	44,649	68,436	260,523		260,523	33	260,556		21
22	Employee Benefits & Payroll Taxes			569,410	569,410		569,410	14	569,424		22
23	Inservice Training & Education			343	343		343		343		23
24	Travel and Seminar			750	750		750		750		24
25	Other Admin. Staff Transportation			1,464	1,464		1,464		1,464		25
26	Insurance-Prop.Liab.Malpractice			72,621	72,621		72,621	22,403	95,024		26
27	Other (specify):*										27
28	TOTAL General Administration	274,011	44,649	1,139,547	1,458,207		1,458,207	20,105	1,478,312		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,043,076	852,898	1,381,192	6,277,166		6,277,166	17,877	6,295,043		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

Seminary Manor

#0047233

Report Period Beginning:

10/1/2019

Ending:

9/30/2020

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			195,392	195,392		195,392	307,829	503,221			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							306,582	306,582			32
33	Real Estate Taxes							174,685	174,685			33
34	Rent-Facility & Grounds			844,620	844,620		844,620	(844,620)				34
35	Rent-Equipment & Vehicles			11,661	11,661		11,661	27	11,688			35
36	Other (specify):* MIP Insurance							39,120	39,120			36
37	TOTAL Ownership			1,051,673	1,051,673		1,051,673	(16,377)	1,035,296			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			11,518	11,518		11,518		11,518			38
39	Ancillary Service Centers		404,288	1,028,053	1,432,341		1,432,341		1,432,341			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			1,774	1,774		1,774	(1,774)				41
42	Provider Participation Fee			209,761	209,761		209,761		209,761			42
43	Other (specify):* Disallowed Costs	52,569		501,085	553,654		553,654	(432,343)	121,311			43
44	TOTAL Special Cost Centers	52,569	404,288	1,752,191	2,209,048		2,209,048	(434,117)	1,774,931			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,095,645	1,257,186	4,185,056	9,537,887		9,537,887	(432,617)	9,105,270			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

Seminary Manor

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			40,318	40,318	40,318		40,318			
	Radiology Expenses			80,993	80,993	80,993		80,993			
	Non-Allowable Expenses	52,569		379,774	432,343	432,343	(432,343)	0			
					0	0		0			
					0	0		0			
	TOTAL Other Special Cost Centers	52,569	0	501,085	553,654	553,654	(432,343)	121,311			

Facility Name & ID Number Seminary Manor

0047233

Report Period Beginning:

10/1/2019

Ending:

9/30/2020

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	(2,228)	2		4
5	Telephone, TV & Radio in Resident Rooms	(22,157)	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	1,049	30		9
10	Interest and Other Investment Income	(1,299)	32		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	(2,559)	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	(3,748)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(325,632)	43		24
25	Fund Raising, Advertising and Promotional	(31,985)	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	(81,253)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (469,812)		\$	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)	37,195		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 37,195		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (432,617)		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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' PREPARATION REPORT

Seminary Manor

ID# 0047233

Report Period Beginning: 10/1/2019

Ending: 9/30/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Vending Expenses Against Income	\$ (1,774)	41	1
2	Disallow Marketing Wages	(52,569)	43	2
3	Disallow R/E Entity HUD Audit	(26,910)	19	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(81,253)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
None	N/A	Unlimited Development, Inc (UDI)		See Page 6 Supplemental		
		Community Living Options, Inc. (CLO)				
		See Page 6 Supplemental for specific homes				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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%	\$ 1,295	\$ 1,295	1	
2	V	19 Professional Fees		Unlimited Development, Inc.	100.00%	2,567	2,567	2	
3	V	20 Dues, Licenses and Subs		Unlimited Development, Inc.	100.00%	25	25	3	
4	V	21 General Admin Expense		Unlimited Development, Inc.	100.00%	33	33	4	
5	V	22 Employee Benefits		Unlimited Development, Inc.	100.00%	14	14	5	
6	V	26 Property Insurance		Unlimited Development, Inc.	100.00%	1,827	1,827	6	
7	V	35 Equipment Rental		Unlimited Development, Inc.	100.00%	27	27	7	
8	V							8	
9	V							9	
10	V							10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$			\$ 5,788	\$ *	5,788	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	19 Professional Fees		Galesburg North Seminary, LLC	N/A	\$ 26,910	\$	26,910	15
16	V	20 Dues, Fees, Subs & Prom		Galesburg North Seminary, LLC	N/A	75		75	16
17	V	26 Property Insurance		Galesburg North Seminary, LLC	N/A	20,576		20,576	17
18	V	30 Depreciation		Galesburg North Seminary, LLC	N/A	306,780		306,780	18
19	V	32 Interest Expense	173	Galesburg North Seminary, LLC	N/A	287,190		287,017	19
20	V	32 Loan Fee Amortization		Galesburg North Seminary, LLC	N/A	20,864		20,864	20
21	V	33 Property Taxes		Galesburg North Seminary, LLC	N/A	174,685		174,685	21
22	V	34 Facility Rent	844,620	Galesburg North Seminary, LLC	N/A			(844,620)	22
23	V	36 Mortgage Insurance		Galesburg North Seminary, LLC	N/A	39,120		39,120	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 844,793			\$ 876,200	\$ *	31,407	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Seminary Manor

0047233

Report Period Beginning:

10/1/2019

Ending:

9/30/2020

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

Facility Name & ID Number

Seminary Manor

0047233

Report Period Beginning:

10/1/2019

Ending:

9/30/2020

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Seminary Manor

0047233

Report Period Beginning:

10/1/2019

Ending:

9/30/2020

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Seminary Manor

0047233

Report Period Beginning:

10/1/2019

Ending:

9/30/2020

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								\$ 1,295	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	\$ 1,295		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 Seminary Manor

0047233

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	\$ 44,286	\$ 1,295	1
2	19	Professional Fees	Weighted Avg BDA	462,258	19	26,790	44,286	2,567	2
3	20	Dues, Licenses and Subs	Weighted Avg BDA	462,258	19	256	44,286	25	3
4	21	General Admin Expense	Weighted Avg BDA	462,258	19	342	44,286	33	4
5	22	Employee Benefits	Weighted Avg BDA	462,258	19	147	44,286	14	5
6	26	Property Insurance	Weighted Avg BDA	462,258	19	19,075	44,286	1,827	6
7	35	Equipment Rental	Weighted Avg BDA	462,258	19	287	44,286	27	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	\$	\$ 5,788	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Seminary Manor

0047233

Report Period Beginning:

10/1/2019

Ending:

9/30/2020

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Cambridge Realty Capital						\$	\$			\$	1						
2	LTD. of Illinois		X	Facility purchase	\$40,951.77	7/1/2011	9,063,800	7,758,218	8/1/2046	4.1500	287,190	2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related				\$40,951.77		\$ 9,063,800	\$ 7,758,218			\$ 287,190	9						
B. Non-Facility Related*																		
10										Amortization Exp	20,864	10						
11										Int Income Offset	(1,472)	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 19,392	14						
15	TOTALS (line 9+line14)						\$ 9,063,800	\$ 7,758,218			\$ 306,582	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 39,120 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

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.		\$	130,942	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.)	2019	\$	175,256	2
3. Under or (over) accrual (line 2 minus line 1).		\$	44,314	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	130,371	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.		\$	174,685	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	165,456	8
	2016	173,486	9
	2017	170,998	10
	2018	169,569	11
	2019	175,256	12

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

This facility was purchased from an unrelated for-profit entity during 2005. A tax exemption has not yet been obtained.

Amount accrued includes the taxes for 9 months based on fiscal year end. Estimate is based on prior year tax bill.

Taxes paid during year represents the entire 2019 bill.

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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 Seminary Manor COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0047233

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>99-02-101-045</u>	<u>HAWTHORNE CENTRE SUB</u>	\$ <u>175,255.78</u>	\$ <u>175,255.78</u>
2. _____	<u>LOT 1 (EX E50 FT) BLK 1 &</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><u>175,255.78</u></u>	\$ <u><u>175,255.78</u></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 Seminary Manor

0047233 Report Period Beginning:

10/1/2019 Ending:

9/30/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,680 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: N/A 2. Number of Years Over Which it is Being Amortized: N/A
 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.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>4.33 Acres</u>	<u>2005</u>	<u>\$ 287,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	#VALUE!		\$ 287,000	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Seminary Manor

0047233

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	121	2005		\$ 9,633,067	\$	40	\$ 240,824	\$ 240,824	\$ 3,652,538	4
5		2014	2014	501,672		40	12,541	12,541	76,296	5
6										6
7										7
8										8
Improvement Type**										
9	Fire Door Closers		2005	3,059	204	15	204		3,025	9
10	A/C, Sign, Concrete, Asphalt, Door, Dining rm addn, Alarm		2006	74,961	971	8-15 yrs	971		74,247	10
11	AC, Vinyl, Cabinetry, Sidewalk, Roof/deck repair, Window treatments		2007	123,842	439	5-15 yrs	439		123,344	11
12	Roof,Fire dampers,Condensor, Sidewalks, Sprinklers		2008	61,632	535	10-25 yrs	535		59,082	12
13	Prime Walls/Paint, Condensing Units/Refridgeration piping, A/C		2008	14,320	426	5-15 yrs	426		13,403	13
14	Handrail, Double door w/ side lights, Roof repair, Roof repair - Garage		2008	44,415	185	10-15 yrs	185		44,013	14
15	Lighting ple, Rplc wall/ceil, Roof Repl, Rbbr Flr, Lgt post concrete		2009	73,343	3,497	10-15 yrs	3,497		71,792	15
16	Prking lot poles, Prking lot (asphalt), Tile, Wtrheater, Shwr rm.		2009	89,588	2,715	8-20 yrs	2,715		79,243	16
17	PT addtn, Garden crt addtn, Concrete prking lot & sidewalk		2009	296,914	12,221	15-25 yrs	12,221		144,171	17
18	Waterheater, Waterheater		2010	7,500	719	10	719		7,500	18
19	Carpet - Bounce Back		2011	25,627		5			25,627	19
20	Seminary Manor Public BR - Floor/Wallpaper/Vanity/Faucets/Mirrors		2011	15,530	1,294	12	1,294		11,754	20
21	New Fan for kitchen exhaust hood		2012	2,650	265	10	265		2,230	21
22	Bedroom - Drywall/Tile/Covebase/Countertop/Cabinets/Paint		2012	7,925	661	12	661		5,446	22
23	Water heater		2012	4,888	488	10	488		3,829	23
24	Walk in cooler remodel- Drywall/paint/prime/tile/insulation		2012	23,065	1,922	12	1,922		15,376	24
25	Furnace		2013	2,600	173	15	173		1,283	25
26	AC Condensor		2013	2,850	190	15	190		1,409	26
27	Water Heater		2013	4,600	460	10	460		3,258	27
28	Roof		2013	12,447	1,242	10	1,242		8,712	28
29	Training Cntr Remodel-Kawneer Dr, 2 ADA Rmps, Deck Rmvl		2013	23,582	1,965	12	1,965		13,428	29
30	Water Heater		2014	3,794	379	10	379		2,400	30
31	Fence-Metal		2014	7,193		5			7,193	31
32	Foyer Remodel-Drywll/Pnt/Rmv/Rnstll Fire Alarms/Handrails/Wllprpr/F		2014	16,400	1,365	12	1,365		8,428	32
33	Generator Transfer Switches		2014	10,872	1,087	10	1,087		6,613	33
34	PT Completion-Equipment/Supplies/Cabinets		2014	83,319	6,943	12	6,943		42,237	34
35	Parking Lot addition		2014	29,100		8	3,637	3,637	22,128	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 Seminary Manor

0047233

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Wall Sconces	2014	5,278	754	7	754		4,461	37
38	Landscaping	2014	\$ 5,797	\$ 579	10	\$ 579		3,527	38
39	Landscaping	2014	3,448	344	10	344		2,011	39
40	Cabinets-Conference Room/Kitchen	2015	2,596	173	15	173		995	40
41	Decorative Fencing	2015	7,678	307	25	307		1,689	41
42	Water Softener	2015	6,993	701	10	701		3,788	42
43	Interior Doors/Automatic Doors	2015	8,700	870	10	870		4,495	43
44	Fiber Optic Cables-Phone and Internet	2015	3,710	618	5	618		3,710	44
45	Fencing	2015	6,173	414	5	414		6,173	45
46	PTAC Units	2015	3,678	736	5	736		3,126	46
47	Water Heater	2016	3,516	351	10	351		1,524	47
48	Gazebo-Garden Court	2016	3,988	398	10	398		1,728	48
49	Nurse Station Remodel-Tile/Cabinets	2016	84,138	7,012	12	7,012		28,632	49
50	Shower Room A Remodel-Tub/Plumbing/Tile/Electrical	2016	124,926	10,411	12	10,411		42,512	50
51	Replaced Burglar Alarm System-Back Service Entrance Door	2016	5,490	549	10	549		2,150	51
52	LSI Vinyl Flooring-Nurse Station	2016	8,666	867	10	867		3,468	52
53	Condenser/Air Handler-Front Office/Lobby A/C	2016	5,725	382	15	382		1,210	53
54	Installed New Heating Element for Furnace	2017	2,870		10	287	287	1,005	54
55	PTAC Units	2017	3,600	720	5	720		2,460	55
56	Training Center Roof	2018	13,876		10	1,388	1,388	2,776	56
57	Blinds/Window Treatments-Dining Room/Front Lounge	2018	16,265	3,252	5	3,252		8,945	57
58	PTAC Units	2018	3,811		5	762	762	1,905	58
59	Convert Sprinkler System to Wet System-Entire Facility	2018	350,355		15	23,357	23,357	46,714	59
60	New Flooring-Common areas/Living Rms/Dining Rms/Entry/Garage	2018	98,664		10	9,866	9,866	19,732	60
61	Painting/New Lighting/Move Water Lines to Above- Living Room/								61
62	Dining Room/Hallway	2018	117,729		12	9,811	9,811	19,622	62
63	New Flooring - Memory Care Unit	2019	5,362	536	10	536		893	63
64	Compressor - Bounce Back Entrance	2019	2,691	179	15	179		254	64
65	New Flooring/Lighting - Garden Wing	2019	23,772	1,981	12	1,981		2,806	65
66	Convert Sprinkler System to Wet System-Entire Facility	2019	178,519	11,901	15	11,901		20,827	66
67	South Shower Room-Tile/Water Lines/Fixtures	2019	45,814	3,818	12	3,818		5,727	67
68	Roof Top AC Unit	2019	8,575	858	10	858		1,072	68
69	Kickplates for Resident Room Doors	2019	12,138	1,214	10	1,214		1,416	69
70	TOTAL (lines 4 thru 69)		\$ 12,375,296	\$ 90,271		\$ 392,744	\$ 302,473	\$ 4,781,358	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 12,375,296	\$ 90,271		\$ 392,744	\$ 302,473	\$ 4,781,358	1
2	Condenser - Laundry Back Hallway	2019	2,541	169	15	169		197	2
3	Door Guards - Wings 100,200,400,500,600	2019	15,809	1,581	10	1,581		1,713	3
4	Door Guards - Wing 300	2019	4,854	485	10	485		606	4
5	PTAC Units - 6	2019	4,099	820	5	820		1,367	5
6	PTAC Units - 4	2019	2,710	542	5	542		723	6
7	PTAC Units - 4	2019	4,670	934	5	934		1,168	7
8	PTAC Units - 6	2020	4,313	791	5	791		791	8
9	PTAC Units - 4	2020	2,742	137	5	137		137	9
10	Water Heater	2019	7,726	773	10	773		773	10
11	Living Room Ceiling Repair	2019	3,628	333	10	333		333	11
12	Vinyl-Garden Court	2019	2,626	219	10	219		219	12
13	Roof-Shop and Garage	2020	13,000	758	10	758		758	13
14	Water Heater	2020	7,279	425	10	425		425	14
15	Parking Lot-Asphalt Entire Lot/Lines	2020	99,746	1,039	8	1,039		1,039	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,551,039	\$ 99,277		\$ 401,750	\$ 302,473	\$ 4,791,607	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,221,310	\$ 73,703	\$ 79,059	\$ 5,356	3-15 yrs	\$ 1,017,000	71
72	Current Year Purchases	38,908	4,920	4,920		5-10 yrs	4,920	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,260,218	\$ 78,623	\$ 83,979	\$ 5,356		\$ 1,021,920	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	Facility	2011 Ford F250	2018	21,386	\$ 5,347	\$ 5,347	\$	4	\$ 11,585	76
77	Facility	2020 E 350 Bus	2019	58,294	12,145	12,145		4	12,145	77
78										78
79										79
80	TOTALS			\$ 79,680	\$ 17,492	\$ 17,492	\$		\$ 23,730	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)	\$ 14,177,937	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 195,392	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 503,221	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 307,829	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,837,257	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	2006 Toyota Corolla - 2006	\$ 14,900	\$	\$ 14,900	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 14,900	\$	\$ 14,900	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 Seminary Manor

0047233

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: 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: \$ 11,688 Description: Medical Equipment \$11,661; Home Office Allocation \$27

(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

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	\$	\$	\$	\$
2	Books and Supplies		288		288
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	\$	\$ 288	\$	\$ 288
10	SUM OF line 9, col. 1 and 2 (e)	\$	288		

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		\$	5,631	\$ 394,799	\$	5,631	\$	394,799					1
2	Licensed Speech and Language Development Therapist	39(3)	hrs			1,326	66,711		1,326		66,711					2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39(3)	hrs			7,759	566,543		7,759		566,543					4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39(2)	# of prescrpts							404,288					404,288	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				\$	14,716	\$ 1,028,053	\$	14,716	\$	404,288	\$	14,716	\$	1,432,341	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 Seminary Manor

0047233

Report Period Beginning: 10/1/2019

Ending:

9/30/2020

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	\$ (13,090)	\$ 155,814	1
2	Cash-Patient Deposits	24,791	24,791	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 420,000)	1,257,538	1,257,538	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	105,825	137,804	6
7	Other Prepaid Expenses	1,490	18,121	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interdivision Receivable	9,279,316	7,731,161	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 10,655,870	\$ 9,325,229	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		287,000	13
14	Buildings, at Historical Cost	1,723,835	12,551,039	14
15	Leasehold Improvements, at Historical Cost	5,797		15
16	Equipment, at Historical Cost	990,269	1,339,898	16
17	Accumulated Depreciation (book methods)	(1,611,823)	(5,837,257)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Att Sch 17A		880,331	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,108,078	\$ 9,221,011	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,763,948	\$ 18,546,240	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 131,541	\$ 377,130	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,791	24,791	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	92,841	92,841	30
31	Accrued Taxes Payable (excluding real estate taxes)	44,026	44,026	31
32	Accrued Real Estate Taxes(Sch.IX-B)		130,371	32
33	Accrued Interest Payable		23,727	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)	\$ 293,199	\$ 692,886	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,758,218	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Security Deposits	33,087	33,087	43
44	Medicare Advance COVID	1,059,258	1,059,258	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,092,345	\$ 8,850,563	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,385,544	\$ 9,543,449	46
47	TOTAL EQUITY(page 18, line 24)	\$ 10,378,404	\$ 9,002,791	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,763,948	\$ 18,546,240	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Seminary Manor

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

Schedule 17A

XV. Balance Sheet

Line 23 Long Term Assets Other (specify):

Description	Operating	After Consolidation
Real Estate Tax Escrow		49,744
Insurance Escrow		2,000
MIP Insurance Escrow		4,788
Reserve for Replacement		432,739
Capitalized Loan Fee		619,342
Amortization Loan Fee		(228,282)
Total - Line 36	-	880,331

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,182,330	1
2	Restatements (describe):		2
3	Prior Period Adjustment	11,000	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,193,330	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,185,074	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)	\$ 1,185,074	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)	\$ 10,378,404	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Seminary Manor

0047233

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.

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,653,273	1
2	Discounts and Allowances for all Levels	(53,420)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,599,853	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	136,078	6
7	Oxygen	(183)	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 135,895	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	951,668	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,656	12
13	Barber and Beauty Care	4,612	13
14	Non-Patient Meals	2,228	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,978	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,745	19
20	Radiology and X-Ray		20
21	Other Medical Services	5,855	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 983,742	23
D. Non-Operating Revenue			
24	Contributions	1,344	24
25	Interest and Other Investment Income***	1,299	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,643	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule 19A	828	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 828	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,722,961	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,415,839	31
32	Health Care	3,403,120	32
33	General Administration	1,458,207	33
B. Capital Expense			
34	Ownership	1,051,673	34
C. Ancillary Expense			
35	Special Cost Centers	1,999,287	35
36	Provider Participation Fee	209,761	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,537,887	40
41	Income before Income Taxes (line 30 minus line 40)**	1,185,074	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,185,074	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,809,176	44
45	Private Pay - Net Inpatient Revenue	2,133,007	45
46	Medicare - Net Inpatient Revenue	4,266,074	46
47	Other-(specify) Medicare Replacement/Managed Care	976,662	47
48	Other-(specify) Hospice	414,934	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,599,853	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

Seminary Manor

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

Schedule 19A

XVII. Income Statement
Line 28a Other Income

<u>Rental Description</u>	<u>Amount</u>
Late Fees	778
Transportation	50
Total - Line 16	828

Facility Name & ID Number **Seminary Manor**

0047233

Report Period Beginning: **10/1/2019**

Ending:

9/30/2020

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	2,368	2,536	\$ 80,107	\$ 31.59	1
2	Assistant Director of Nursing	1,992	2,104	61,847	29.39	2
3	Registered Nurses	27,734	29,230	719,418	24.61	3
4	Licensed Practical Nurses	28,655	30,340	617,329	20.35	4
5	CNAs & Orderlies	111,008	115,158	1,347,731	11.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,896	8,403	98,166	11.68	10
11	Social Service Workers	8,001	8,664	115,639	13.35	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	31,423	33,898	370,496	10.93	15
16	Dishwashers					16
17	Maintenance Workers	4,356	4,632	58,281	12.58	17
18	Housekeepers	18,152	18,326	193,223	10.54	18
19	Laundry	5,829	6,160	62,892	10.21	19
20	Administrator	2,228	2,488	126,573	50.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,696	13,378	147,438	11.02	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	3,790	4,117	43,936	10.67	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	2,440	2,536	52,569	20.73	33
34	TOTAL (lines 1 - 33)	268,568	281,969	\$ 4,095,645 *	\$ 14.53	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	\$ 16,498	L1, C3	35
36	Medical Director	Monthly	26,000	L9, C3	36
37	Medical Records Consultant	Monthly	1,500	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,597	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)		\$ 53,595		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

Facility Name & ID Number

Seminary Manor

0047233

Report Period Beginning:

10/1/2019

Ending:

9/30/2020

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				
Tracy Owens	Administrator	None	\$ 126,573	Workers' Compensation Insurance	\$ 40,318	IDPH License Fee	\$ 1,992				
				Unemployment Compensation Insurance	8,837	Advertising: Employee Recruitment	18,630				
				FICA Taxes	305,489	Health Care Worker Background Check (Indicate # of checks performed <u>60</u>)	597				
				Employee Health Insurance	175,869	Patient Background Checks	364				
				Employee Meals							
				Illinois Municipal Retirement Fund (IMRF)*							
				401k	22,656	Subscriptions	2,325				
				Other Employee Benefits	16,241	IHCA Dues	9,312				
						Other Licenses & Fees	814				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 126,573			Indirect costs	100				
B. Administrative - Other				Indirect costs	14	Less: Public Relations Expense	(2,559)				
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 Sch. V, line 20, col. 8)	\$ 34,848				
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		\$ 184,092	N/A			Out-of-State Travel	\$			
RFMS, Inc.	Administrative Services		171,600								
Templin Healthcare Accounting	Accounting Services		3,804				In-State Travel				
RSM US LLP	Accounting Services		23,500								
Healthlink	Computer Services		7				Seminar Expense	750			
Barnhart, Tinsman & Associated, Ltc	Legal Services		3,748								
Fudge Broadwater	Legal Services		159				Entertainment Expense	()			
Polsinelli	Legal Services		2,306				TOTAL (agree to Sch. V, line 24, col. 8)	\$ 750			
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$ 389,216	TOTAL	\$					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name & ID Number Seminary Manor

0047233

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. 9,312 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? 5-10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 35,002 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. \$ 209,761
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. \$ 2,228
- (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