



Facility Name & ID Number Manor Court of Maryville

# 0050427 Report Period Beginning: 10/1/2017 Ending: 9/30/2018

**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** N/A

	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	48,180	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	48,180	7

**B. Census-For the entire report period.**

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	21,251	9,098	10,987	41,336	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,251	9,098	10,987	41,336	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 85.79%

**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 5,843

Medicare Intermediary National Government Services

**IV. ACCOUNTING BASIS**

ACCURAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 9/30/18 Fiscal Year: 9/30/18

\* 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: 10/1/2017 Ending: 9/30/2018

**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
	<b>A. General Services</b>										
1	Dietary	337,352	39,216	11,647	388,215		388,215		388,215		1
2	Food Purchase		338,478		338,478		338,478	(310)	338,168		2
3	Housekeeping	207,400	71,312	128	278,840		278,840		278,840		3
4	Laundry	77,100	17,691		94,791		94,791		94,791		4
5	Heat and Other Utilities			243,944	243,944		243,944		243,944		5
6	Maintenance	121,519	37,285	100,446	259,250		259,250	(17,298)	241,952		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	743,371	503,982	356,165	1,603,518		1,603,518	(17,608)	1,585,910		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			42,500	42,500		42,500		42,500		9
10	Nursing and Medical Records	2,728,723	273,177	14,113	3,016,013		3,016,013		3,016,013		10
10a	Therapy										10a
11	Activities	90,748	5,234		95,982		95,982		95,982		11
12	Social Services	94,670		100	94,770		94,770		94,770		12
13	CNA Training										13
14	Program Transportation			14,534	14,534		14,534		14,534		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,914,141	278,411	71,247	3,263,799		3,263,799		3,263,799		16
	<b>C. General Administration</b>										
17	Administrative	109,169			109,169		109,169		109,169		17
18	Directors Fees							2,859	2,859		18
19	Professional Services			422,160	422,160		422,160	(107)	422,053		19
20	Dues, Fees, Subscriptions & Promotions			34,948	34,948		34,948	(2,475)	32,473		20
21	Clerical & General Office Expenses	164,509	34,720	113,446	312,675		312,675	83	312,758		21
22	Employee Benefits & Payroll Taxes			630,508	630,508		630,508	29	630,537		22
23	Inservice Training & Education			11,546	11,546		11,546		11,546		23
24	Travel and Seminar			110	110		110		110		24
25	Other Admin. Staff Transportation			14,536	14,536		14,536		14,536		25
26	Insurance-Prop.Liab.Malpractice			197,910	197,910		197,910	54	197,964		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	273,678	34,720	1,425,164	1,733,562		1,733,562	443	1,734,005		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,931,190	817,113	1,852,576	6,600,879		6,600,879	(17,165)	6,583,714		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 Manor Court of Maryville

#0050427

Report Period Beginning:

10/1/2017

Ending:

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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	
	<b>D. Ownership</b>											
30	Depreciation			43,890	43,890		43,890	2,137	46,027			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			114,000	114,000		114,000		114,000			33
34	Rent-Facility & Grounds			1,018,392	1,018,392		1,018,392		1,018,392			34
35	Rent-Equipment & Vehicles			48,818	48,818		48,818		48,818			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,225,100	1,225,100		1,225,100	2,137	1,227,237			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	892,950	327,890	27,790	1,248,630		1,248,630		1,248,630			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			270,836	270,836		270,836		270,836			42
43	Other (specify):* See Att Sch 4A	135,812		647,467	783,279		783,279	(733,769)	49,510			43
44	<b>TOTAL Special Cost Centers</b>	1,028,762	327,890	946,093	2,302,745		2,302,745	(733,769)	1,568,976			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	4,959,952	1,145,003	4,023,769	10,128,724		10,128,724	(748,797)	9,379,927			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 10/1/2017

Period End 9/30/2018

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					5	6
		1	2	3	4						
	Ancillary Expense										
	<b>E. Special Cost Centers</b>										
43	Other (specify):*				0		0		0		
	Laboratory/Expenses			12,750	12,750		12,750		12,750		
	Radiology Expenses			36,760	36,760		36,760		36,760		
	Non-Allowable Expenses	135,812		597,957	733,769		733,769	(733,769)	0		
					0		0		0		
					0		0		0		
	<b>TOTAL Other Special C</b>	<b>135,812</b>	<b>0</b>	<b>647,467</b>	<b>783,279</b>	<b>0</b>	<b>783,279</b>	<b>(733,769)</b>	<b>49,510</b>		

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	(310)	2		4
5	Telephone, TV & Radio in Resident Rooms	(11,210)	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	2,137	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	(2,489)	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	(3,743)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(511,309)	43		24
25	Fund Raising, Advertising and Promotional	(75,438)	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	(153,133)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (755,495)		\$	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)	6,698		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 6,698		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (748,797)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' PREPARATION REPORT

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ID# 0050427

Report Period Beginning: 10/1/2017

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallow Marketing Wages	(135,812)	43	1
2	Capitalized Equipment Repairs	(17,321)	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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43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(153,133)		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	6 Maintenance	\$	Unlimited Development, Inc.	100.00%	\$ 23	\$ 23	1	
2	V	18 Director Fees		Unlimited Development, Inc.	100.00%	2,859	2,859	2	
3	V	19 Professional Fees		Unlimited Development, Inc.	100.00%	3,636	3,636	3	
4	V	20 Dues, Licenses and Subs		Unlimited Development, Inc.	100.00%	14	14	4	
5	V	21 General Admin Expense		Unlimited Development, Inc.	100.00%	83	83	5	
6	V	22 Employee Benefits		Unlimited Development, Inc.	100.00%	29	29	6	
7	V	26 Property Insurance		Unlimited Development, Inc.	100.00%	54	54	7	
8	V							8	
9	V							9	
10	V							10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$			\$ 6,698	\$ *	6,698	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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# 0050427

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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

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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%	Leroy Manor	Leroy				18
19	Unlimited Development, Inc. (UDI)	100%			Liberty Estates of Car	Carbondale	Retirement living ce	19
20	Unlimited Development, Inc. (UDI)	100%	Care Center of Abingdon	Abingdon				20
21	Unlimited Development, Inc. (UDI)	100%	Seminary Manor	Galesburg				21
22	Unlimited Development, Inc. (UDI)	100%			Seminary Estates	Galesburg	Retirement living ce	22
23	Unlimited Development, Inc. (UDI)	100%			Hawthorne Inn of Gal	Galesburg	Assisted Living Faci	23
24	Unlimited Development, Inc. (UDI)	100%	Centralia Manor	Centralia				24
25	Unlimited Development, Inc. (UDI)	100%			Centralia Estates	Centralia Estates	Retirement living ce	25
26	Unlimited Development, Inc. (UDI)	100%	Pittsfield Manor	Pittsfield				26
27	Unlimited Development, Inc. (UDI)	100%	Pekin Manor	Pekin				27
28	Unlimited Development, Inc. (UDI)	100%			Pekin Estates	Pekin	Retirement living ce	28
29	Unlimited Development, Inc. (UDI)	100%	Jerseyville Manor	Jerseyville				29
30								30

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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%			Leroy South Buck, LL	Galesburg	Lessor	9
10	Unlimited Development, Inc. (UDI)	100%			2245 Seminary Street,	Galesburg	Lessor	10
11	Unlimited Development, Inc. (UDI)	100%			Pittsfield Lowry, LLC	Galesburg	Lessor	11
12	Unlimited Development, Inc. (UDI)	100%			Pekin El Camino, LLC	Galesburg	Lessor	12
13	Unlimited Development, Inc. (UDI)	100%			Abingdon West Marti	Galesburg	Lessor	13
14	Unlimited Development, Inc. (UDI)	100%			Keokuk Village Circle	Galesburg	Lessor	14
15	Unlimited Development, Inc. (UDI)	100%			The Kensington	Galesburg	Supportive Living	15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

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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								\$ 2,859	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	\$ 2,859		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:

10/1/2017

Ending: 1/30/2018

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	6	Maintenance	Weighted Avail Bed Days	505,933	21	\$ 240	\$ 48,180	\$ 23	1
2	18	Director Fees	Weighted Avail Bed Days	505,933	21	\$ 30,020	48,180	2,859	2
3	19	Professional Fees	Weighted Avail Bed Days	505,933	21	38,188	48,180	3,636	3
4	20	Dues, Licenses and Subs	Weighted Avail Bed Days	505,933	21	144	48,180	14	4
5	21	General Admin Expense	Weighted Avail Bed Days	505,933	21	873	48,180	83	5
6	22	Employee Benefits	Weighted Avail Bed Days	505,933	21	300	48,180	29	6
7	26	Property Insurance	Weighted Avail Bed Days	505,933	21	568	48,180	54	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					\$ 70,333	\$	\$ 6,698	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Manor Court of Maryville

# 0050427

Report Period Beginning:

10/1/2017

Ending:

9/30/2018

**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			
	<b>A. Directly Facility Related</b>																	
	<b>Long-Term</b>																	
1												1						
2	N/A											2						
3												3						
4												4						
5												5						
	<b>Working Capital</b>																	
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>							\$	\$			\$	9					
	<b>B. Non-Facility Related*</b>																	
10												10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>							\$	\$			\$	14					
15	<b>TOTALS (line 9+line14)</b>							\$	\$			\$	15					

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

(See instructions.)



**2017 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 2017 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 2017.

(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>113,458.04</u>	\$ <u>113,458.04</u>
2. _____	<u>147.69 X 1456.39 IRREGULAR</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>113,458.04</u>	\$ <u>113,458.04</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 a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

**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:

10/1/2017 Ending:

9/30/2018

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: 4. Dates Incurred:

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:

10/1/2017

Ending:

9/30/2018

**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
<b>Improvement Type**</b>										
9	Sign		2010	44,512	4,452	10	4,452		36,722	9
10	Water Filtration System		2012	8,588	858	10	858		5,797	10
11	Water Softener		2014	7,902	792	10	792		3,622	11
12	Workstation-Counters/Cabinets/Chair		2014	3,834	319	12	319		1,225	12
13	Compressor/Inverter Assembly		2016	7,384	492	15	492		1,082	13
14	Carpet-Nurse Station, Office, Garden Court Sitting Area		2016	5,452	1,091	5	1,091		2,363	14
15	A/C Units/Condenser		2016	8,253	1,149	5-15 Yrs	1,149		2,395	15
16	Furnace Repair		2016	2,913		10	291	291	437	16
17	Furnace Repairs		2017	8,359		10	836	836	1,254	17
18	AC Repair		2017	4,328		10	433	433	649	18
19	Compressor Repairs		2017	16,629	1,109	15	1,109		1,843	19
20	Lighted Floating Lake Fountain		2017	6,047	605	10	605		857	20
21	Compressor Repairs		2017	8,286	624	10-15 ys	624		624	21
22	Water Heater - Mechanical Room in Service Hallway		2018	5,726	429	10	429		429	22
23	Compressor Repair - 100 Hall		2018	8,965	398	15	398		398	23
24	Condenser Coil		2018	4,294	167	15	167		167	24
25	Inverter Compressor - Master Unit		2018	5,849	341	10	341		341	25
26	Water Heater - Mechanical Room in Service Hallway		2018	11,404	380	10	380		380	26
27	Water Heater - Mechanical Room next to Kitchen		2018	9,672	81	10	81		81	27
28	Replace Compressors on System 3		2018	7,767		15	259	259	259	28
29	Replace Compressors on System 7		2018	9,554		15	318	318	318	29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37						\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 195,718	\$ 13,287		\$ 15,424	\$ 2,137	\$ 61,243	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	\$ 466,276	\$ 29,615	\$ 29,615	\$	3-15 yrs	\$ 376,874	71
72	Current Year Purchases	19,205	988	988		10 yrs	988	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 485,481	\$ 30,603	\$ 30,603	\$		\$ 377,862	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										77
78										78
79										79
80	TOTALS			\$ 47,110	\$	\$	\$		\$ 47,110	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)	\$ 728,309	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 43,890	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 46,027	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,137	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 486,215	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

**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	<b>TOTAL</b>		<b>132</b>		\$ <b>1,018,392</b>			<b>7</b>

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>9/30/2019</u>	\$ <u>940,000</u>
13.	<u>9/30/2020</u>	\$ <u>940,000</u>
14.	<u>9/30/2021</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: \$ 48,818 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	<u>N/A</u>		\$ _____	\$ _____	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ _____	\$ _____	<b>21</b>

\* 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

**Facility Name:** Manor Court of Maryville  
**IDPH License ID Number:** 0050427  
**Fiscal Year End:** 9/30/2018

**Schedule 14A**

**XIV. Rental Costs**

**Line 16 Rental Amount for Moveable Equipment**

<b>Rental Description</b>	<b>Amount</b>
Medical Equipment Rental	48,548
Office Equipment	
Other Equipment Rental	270
<b>Total - Line 16</b>	<b><u>48,818</u></b>

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

**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)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' PREPARATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(1)	9145 hrs	\$ 339,935		\$	\$	9,145	\$ 339,935	1
2	Licensed Speech and Language Development Therapist	39(1,3)	2729 hrs	112,541	7	1,290		2,736	113,831	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(1)	11393 hrs	336,053				11,393	336,053	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				327,890		327,890	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)			722	26,050		722	26,050	12
13	Other (specify): <u>Therapy Coordinator</u>	39(1)	2809	104,421				2,809	104,421	13
14	TOTAL			\$ 892,950	729	\$ 27,340	\$ 327,890	26,805	\$ 1,248,180	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 **9/30/2018**

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 23,531	\$ 23,531	1
2	Cash-Patient Deposits	9,707	9,707	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>57,848</u> )	2,195,039	2,195,039	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	144,135	144,135	6
7	Other Prepaid Expenses	6,370	6,370	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,378,782	\$ 2,378,782	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	162,797	195,718	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	549,651	532,591	16
17	Accumulated Depreciation (book methods)	(500,356)	(486,215)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 212,092	\$ 242,094	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,590,874	\$ 2,620,876	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 274,073	\$ 274,073	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,707	9,707	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	104,457	104,457	30
31	Accrued Taxes Payable (excluding real estate taxes)	82,373	82,373	31
32	Accrued Real Estate Taxes(Sch.IX-B)	89,908	89,908	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Interdivision Payable</u>	5,573,062	5,573,062	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 6,133,580	\$ 6,133,580	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Security Deposits</u>	28,520	28,520	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 28,520	\$ 28,520	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 6,162,100	\$ 6,162,100	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (3,571,226)	\$ (3,541,224)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,590,874	\$ 2,620,876	48

SEE ACCOUNTANTS' PREPARATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(3,156,439)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Year Post Closing Adjustment</b>	<b>(6,960)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(3,163,399)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(407,827)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(407,827)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(3,571,226)</b>	<b>24</b> *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

**classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1			
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,591,955	1
2	Discounts and Allowances for all Levels	(112,603)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 9,479,352	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	213,869	6
7	Oxygen	3,219	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 217,088	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	3,123	12
13	Barber and Beauty Care	4,750	13
14	Non-Patient Meals	310	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,159	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	529	20
21	Other Medical Services	4,654	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 15,525	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	186	24
25	Interest and Other Investment Income***	10,577	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 10,763	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Late Fee Reversal</u>	(1,831)	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ (1,831)	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,720,897	30

2			
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,603,518	31
32	Health Care	3,263,799	32
33	General Administration	1,733,562	33
<b>B. Capital Expense</b>			
34	Ownership	1,225,100	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	2,031,909	35
36	Provider Participation Fee	270,836	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 10,128,724	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(407,827)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (407,827)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,083,198	44
45	Private Pay - Net Inpatient Revenue	2,026,558	45
46	Medicare - Net Inpatient Revenue	2,810,959	46
47	Other-(specify) <u>Medicare Replacement/Managed Care</u>	1,376,232	47
48	Other-(specify) <u>Hospice</u>	182,405	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 9,479,352	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

Facility Name & ID Number Manor Court of Maryville

# 0050427

Report Period Beginning: 10/1/2017

Ending: 9/30/2018

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,816	1,816	70,779	\$ 38.98	1
2	Assistant Director of Nursing	1,640	1,696	52,496	30.96	2
3	Registered Nurses	15,406	16,353	426,136	26.06	3
4	Licensed Practical Nurses	35,482	37,148	829,681	22.33	4
5	CNAs & Orderlies	103,910	108,358	1,317,576	12.16	5
6	CNA Trainees					6
7	Licensed Therapist	24,695	26,076	892,950	34.24	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,622	8,098	90,748	11.21	10
11	Social Service Workers	5,403	5,704	94,670	16.60	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,843	26,448	337,352	12.76	15
16	Dishwashers					16
17	Maintenance Workers	7,132	7,501	121,519	16.20	17
18	Housekeepers	20,517	21,581	207,400	9.61	18
19	Laundry	7,874	8,324	77,100	9.26	19
20	Administrator	1,920	2,080	109,169	52.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,204	10,605	164,509	15.51	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	2,255	2,388	32,055	13.42	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	5,800	6,160	135,812	22.05	33
34	TOTAL (lines 1 - 33)	276,519	290,335	\$ 4,959,952 *	\$ 17.08	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	\$ 11,647	L1, C3	35
36	Medical Director	Monthly	42,500	L9, C3	36
37	Medical Records Consultant	Monthly	2,000	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	11,134	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	Monthly	100	L10, C3	45
46	Other(specify) <u>Respiratory</u>	Monthly	450	L10A,C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 67,831		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' PREPARATION REPORT

**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	
<u>Johnny Law</u>	<u>Administrator</u>	<u>None</u>	\$ <u>109,169</u>	<u>Workers' Compensation Insurance</u>	\$ <u>33,747</u>	<u>IDPH License Fee</u>	\$ <u>1,988</u>	
				<u>Unemployment Compensation Insurance</u>	<u>27,072</u>	<u>Advertising: Employee Recruitment</u>	<u>13,546</u>	
				<u>FICA Taxes</u>	<u>340,294</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>176,492</u>	(Indicate # of checks performed <u>67</u> )	<u>1,676</u>	
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>180</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>				
				<u>401k</u>	<u>32,204</u>	<u>Subscriptions</u>	<u>3,393</u>	
				<u>Other Employee Benefits</u>	<u>20,699</u>	<u>IHCA Dues</u>	<u>7,811</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ <u>109,169</u></b>			<u>Other Licenses &amp; Fees</u>	<u>2,014</u>	
<b>(List each licensed administrator separately.)</b>						<u>Indirect costs</u>	<u>14</u>	
<b>B. Administrative - Other</b>				<u>Indirect costs</u>	<u>29</u>	<u>Less: Public Relations Expense</u>	<u>(2,489)</u>	
Description			Amount			<u>Non-allowable advertising</u>	( )	
<u>N/A</u>			\$			<u>Yellow page advertising</u>	( )	
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$</b>	<b>TOTAL (agree to Schedule V,</b>	<b>\$ <u>630,537</u></b>	<b>TOTAL (agree to Sch. V,</b>	<b>\$ <u>32,473</u></b>	
<b>(Attach a copy of any management service agreement)</b>				<b>line 22, col.8)</b>		<b>line 20, col. 8)</b>		
<b>C. Professional Services</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
<u>LTC Support Services, LLC</u>	<u>Support Services</u>		\$ <u>173,880</u>	<u>N/A</u>			<u>Out-of-State Travel</u>	\$
<u>RFMS, Inc.</u>	<u>Administrative Services</u>		<u>171,600</u>					
<u>Templin Healthcare Accounting</u>	<u>Accounting Services</u>		<u>3,226</u>					
<u>RSM US LLP</u>	<u>Accounting Services</u>		<u>19,903</u>				<u>In-State Travel</u>	
<u>Fox Galvin LLC</u>	<u>Legal Services</u>		<u>4,254</u>					
<u>Jack P. Cranley</u>	<u>Legal Services</u>		<u>5,152</u>					
<u>Brunton Law Office</u>	<u>Legal Services</u>		<u>44,145</u>					
<u>Esquire Deposition Solutions</u>	<u>Legal Services</u>						<u>Seminar Expense</u>	<u>110</u>
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ <u>422,160</u></b>	<b>TOTAL</b>		<b>\$</b>	<u>Entertainment Expense</u>	( )
<b>(For legal fee disclosure, see page 39 of instructions)</b>							(agree to Sch. V,	
							<b>line 24, col. 8)</b>	<b>\$ <u>110</u></b>

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' PREPARATION REPORT

\*\*See instructions.

Facility Name & ID Number Manor Court of Maryville# 0050427Report Period Beginning: 10/1/2017Ending: 9/30/2018**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. 7,811 IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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? N/A
- (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? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 69,202 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. \$ 270,836  
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. \$ 310
- (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**