



Facility Name & ID Number Manor Court of Peoria

# 0047068 Report Period Beginning: 04/01/2009 Ending: 03/31/2010

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	50	Skilled (SNF)	50	18,250	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	0	Sheltered Care (SC)	0	0	5
6		ICF/DD 16 or Less			6
7	50	TOTALS	50	18,250	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	3 Private Pay	4 Other	4 Total		
8	SNF	1,836	10,238	4,459	16,533	8	
9	SNF/PED					9	
10	ICF		0			10	
11	ICF/DD					11	
12	SC		0			12	
13	DD 16 OR LESS					13	
14	TOTALS	1,836	10,238	4,459	16,533	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.59%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold 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

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 8/22/06

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 8/1/06 NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 50 and days of care provided 3,985

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: 3/31/10 Fiscal Year: 3/31/10

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

Facility Name & ID Number Manor Court of Peoria # 0047068 Report Period Beginning: 04/01/2009 Ending: 03/31/2010

**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	110,975	7,647	3,790	122,412		122,412		122,412		1
2	Food Purchase		165,201		165,201		165,201		165,201		2
3	Housekeeping	91,439	15,037		106,476		106,476		106,476		3
4	Laundry	24,091	10,302		34,393		34,393		34,393		4
5	Heat and Other Utilities			65,945	65,945		65,945		65,945		5
6	Maintenance	40,918	27,574	20,940	89,432		89,432		89,432		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	267,423	225,761	90,675	583,859		583,859		583,859		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,750	9,750		9,750		9,750		9
10	Nursing and Medical Records	1,031,032	250,911	3,834	1,285,777		1,285,777		1,285,777		10
10a	Therapy			353,863	353,863		353,863		353,863		10a
11	Activities	59,273	2,622		61,895		61,895		61,895		11
12	Social Services	26,634			26,634		26,634		26,634		12
13	CNA Training										13
14	Program Transportation			468	468	2,089	2,557		2,557		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,116,939	253,533	367,915	1,738,387	2,089	1,740,476		1,740,476		16
	<b>C. General Administration</b>										
17	Administrative	131,835			131,835		131,835		131,835		17
18	Directors Fees							1,277	1,277		18
19	Professional Services			158,948	158,948		158,948	965	159,913		19
20	Dues, Fees, Subscriptions & Promotions			64,436	64,436		64,436	(52,957)	11,479		20
21	Clerical & General Office Expenses	27,511	18,342	25,273	71,126		71,126		71,126		21
22	Employee Benefits & Payroll Taxes			280,378	280,378		280,378		280,378		22
23	Inservice Training & Education			628	628		628		628		23
24	Travel and Seminar			925	925		925		925		24
25	Other Admin. Staff Transportation			4,178	4,178	(2,089)	2,089		2,089		25
26	Insurance-Prop.Liab.Malpractice			43,640	43,640		43,640	14,397	58,037		26
27	Other (specify):* <u>See Att Sch V</u>			49,951	49,951		49,951	(49,951)			27
28	<b>TOTAL General Administration</b>	159,346	18,342	628,357	806,045	(2,089)	803,956	(86,269)	717,687		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,543,708	497,636	1,086,947	3,128,291		3,128,291	(86,269)	3,042,022		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

Manor Court of Peoria

#0047068

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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			17,359	17,359		17,359	77,361	94,720			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			398	398		398	62,625	63,023			32
33	Real Estate Taxes			51,867	51,867		51,867	17,609	69,476			33
34	Rent-Facility & Grounds			271,900	271,900		271,900	(111,900)	160,000			34
35	Rent-Equipment & Vehicles			104	104		104		104			35
36	Other (specify):* <b>Loan fee amort</b>							550	550			36
37	<b>TOTAL Ownership</b>			341,628	341,628		341,628	46,245	387,873			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			2,602	2,602		2,602		2,602			41
42	Provider Participation Fee			27,375	27,375		27,375		27,375			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			29,977	29,977		29,977		29,977			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,543,708	497,636	1,458,552	3,499,896		3,499,896	(40,024)	3,459,872			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		V-30		9
10	Interest and Other Investment Income		V-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				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(49,131)	V-27		24
25	Fund Raising, Advertising and Promotional	(52,976)	V-20		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 Att Sch VI	(1,073)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (103,180)		\$	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)	58,958		34
35	Other- Attach Schedule See Att Sch III	4,198		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 63,156		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (40,024)		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.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

BHF USE ONLY							
48		49		50		51	52

Manor Court of Peoria

ID# 0047068

Report Period Beginning: 04/01/2009

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
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			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	0	49



## STATE OF ILLINOIS

Facility Name & ID Number Manor Court of Peoria# 0047068

Report Period Beginning:

04/01/2009 Ending:

Summary B

03/31/2010

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	58,958	0	0	0	0	0	0	0	0	0	58,958	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>0</b>	<b>58,958</b>	<b>0</b>	<b>58,958</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>0</b>	<b>58,958</b>	<b>0</b>	<b>58,958</b>	<b>45</b>								

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Residential Alternatives of Illinois, Inc.</u> <u>(Non-profit Organization)</u>	<u>100</u>	<u>See Attached Schedule I</u>		<u>See Attached Schedule I</u>		

**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			
<u>1</u>	<u>V</u>	<u>34</u>	<u>Facility rent</u>	<u>\$ 111,900</u>	<u>Peoria Manor Court, Ltd., NFP</u>	<u>N/A</u>	<u>\$ 170,858</u>	<u>\$ 58,958</u>	<u>1</u>
<u>2</u>	<u>V</u>								<u>2</u>
<u>3</u>	<u>V</u>			<u>LTC Support Services, LLC</u>					<u>3</u>
<u>4</u>	<u>V</u>			<u>See Attached Independent Accountant's Report</u>					<u>4</u>
<u>5</u>	<u>V</u>								<u>5</u>
<u>6</u>	<u>V</u>								<u>6</u>
<u>7</u>	<u>V</u>								<u>7</u>
<u>8</u>	<u>V</u>								<u>8</u>
<u>9</u>	<u>V</u>								<u>9</u>
<u>10</u>	<u>V</u>								<u>10</u>
<u>11</u>	<u>V</u>								<u>11</u>
<u>12</u>	<u>V</u>								<u>12</u>
<u>13</u>	<u>V</u>								<u>13</u>
<u>14</u>	<u>Total</u>		<u>\$ 111,900</u>			<u>\$ 170,858</u>	<u>\$ *</u>	<u>58,958</u>	<u>14</u>

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

Facility Name &amp; ID Number

Manor Court of Peoria

# 0047068

Report Period Beginning:

04/01/2009

Ending:

03/31/2010

## 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 III								\$ 1,277	18-7	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	\$ 1,277		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

Facility Name & ID Number Manor Court of Peoria

# 0047068

Report Period Beginning:

04/01/2009

Ending: 3/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Residential Alternatives of Illinois, Inc.  
 Street Address 285 S. Farnham  
 City / State / Zip Code Galesburg, IL 61401  
 Phone Number ( 309) 343-1550  
 Fax Number ( 309) 343-2857

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	See Attached Schedule II & III				\$	\$		\$ 4,198	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 4,198	25

Facility Name & ID Number

Manor Court of Peoria

# 0047068

Report Period Beginning:

04/01/2009

Ending:

03/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10										
										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	Cambridge Realty Capital					\$		\$		\$	1								
2	Ltd. Of Illinois - SNF	X	Facility Purchase	\$22,950.00	12/1/2009	4,605,300	4,596,994	1/1/2045	4.9000	62,019	2								
3											3								
4											4								
5											5								
<b>Working Capital</b>																			
6	Home office allocation adj	X	See Attached Sch III							606	6								
7	Less Interest Income	X	from page 5, line 10								7								
8	Misc Int	X	operating							398	8								
9	TOTAL Facility Related			\$22,950.00		\$ 4,605,300	\$ 4,596,994			\$ 63,023	9								
<b>B. Non-Facility Related*</b>																			
10	Cambridge Realty Capital										10								
11	Ltd. Of Illinois - ALC	X	Facility Purchase	\$31,692.00	12/1/2009	6,359,700	6,348,230	1/1/2045	4.9000	85,645	11								
12											12								
13											13								
14	TOTAL Non-Facility Related			\$31,692.00		\$ 6,359,700	\$ 6,348,230			\$ 85,645	14								
15	TOTALS (line 9+line14)					\$ 10,965,000	\$ 10,945,224			\$ 148,668	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 12,479 Line # 26

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

\*\* 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 2009 report.	\$	<b>66,634</b>	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.)	\$	<b>52,533</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>(14,101)</b>	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>105,895</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$	<b>1,998</b>	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>93,792</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2005	<b>N/A</b>	8
	2006	<b>74,609</b>	9
	2007	<b>108,364</b>	10
	2008	<b>114,558</b>	11
	2009	<b>149,676</b>	12

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2009	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**The facility was rented from an unrelated for-profit third party. The lease agreement required the lessee to pay the real estate taxes. The facility was purchased December 2009. Amount accrued includes 12 months of 2009 and 3 months of 2010. The real estate tax estimate is based on the expected tax after reassessment of property as a result of the purchase. See attached schedule XII for allocation of assisted living portion.**

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

## 2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manor Court of Peoria COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0047068

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 2009 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 2009.

	(A) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
1.	<u>13-11-352-005</u>	<u>Fieldstone Estates</u>	\$ <u>149,676.00</u>	\$ <u>62,864.00</u>
2.	<u></u>	<u>SW 1/4 Sec 11-94N-7E 3.264 AC</u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u>Lot 83B</u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u>13-11-352-026</u>	<u>Fieldstone Estates Extn 1 SW 1/4</u>	\$ <u>1,206.00</u>	\$ <u>1,206.00</u>
6.	<u></u>	<u>SEC 11-94N-7E</u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u>Lot 89B Liberty Villas III</u>	\$ <u></u>	\$ <u></u>
8.	<u>13-11-352-025</u>	<u>Fieldstone Estates Extn 1 SW 1/4</u>	\$ <u>1,206.00</u>	\$ <u>1,206.00</u>
9.	<u></u>	<u>SEC 11-94N-7E</u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u>Lot 89A Liberty Villas III</u>	\$ <u></u>	\$ <u></u>
<b>TOTALS</b>			\$ <u><u>152,088.00</u></u>	\$ <u><u>65,276.00</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?    X    YES        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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

**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 Peoria

# 0047068

Report Period Beginning:

04/01/2009 Ending:

03/31/2010

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 20,840 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

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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: \_\_\_\_\_

3. Current Period Amortization: N/A 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.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility - SNF</u>	<u>62,400</u>	<u>2009</u>	<u>\$ 147,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>62,400</b>		<b>\$ 147,000</b>	<b>3</b>

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	50	2009		\$ 4,869,143	\$ 63,858	25	\$ 63,858	\$	\$ 63,858
5									
6									
7									
8									
Improvement Type**									
9	Sign		2007	3,100	310	10	310		801
10	Fire doors		2009	3,275	218	15	218		218
11	Land Improvements		2009	229,620	5,103	15	5,103		5,103
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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)	\$ 5,105,138	\$ 69,489		\$ 69,489	\$	\$ 69,980	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 128,206	\$ 12,866	\$ 12,866	\$	3-15 yrs	\$ 67,229	71
72	Current Year Purchases	261,169	8,543	8,543		12 yrs	8,543	72
73	Fully Depreciated Assets							73
74	Indirect Costs							74
75	TOTALS	\$ 389,375	\$ 21,409	\$ 21,409	\$		\$ 75,772	75

D. Vehicle Depreciation (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	Toyota Corolla 2006	2006	\$ 15,288	\$ 3,822	\$ 3,822	\$		\$ 14,651	76
77										77
78										78
79										79
80	TOTALS			\$ 15,288	\$ 3,822	\$ 3,822	\$		\$ 14,651	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)	\$ 5,656,801	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 94,720	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 94,720	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 160,403	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	Building ALC - 2009	\$ 6,534,142	\$ 88,185	\$ 88,185	86
87	Equipment ALC - 2009	345,763	11,600	11,600	87
88	Land ALC - 2009	203,000			88
89	Land Imp ALC - 2009	317,095	7,046	7,046	89
90					90
91	TOTALS	\$ 7,400,000	\$ 106,831	\$ 106,831	91

G. Construction-in-Progress

	Description	Cost	
92		\$	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.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Edwin Enterprises, LLC - until purchased December 2009

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  YES  NO

If NO, see instructions.

		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>2000</u>	<u>50</u>	<u>08/01/06</u>	\$ <u>160,000</u>		<u>None</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		<u>50</u>		\$ <u>160,000</u>			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A

This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A.

9. Option to Buy:  YES  NO Terms: N/A - Purchased \*

**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: \$ Amt not determined Description: N/A

(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

10. Effective dates of current rental agreement:

Beginning 08/01/06

Ending 12/2010

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

Fiscal Year Ending Annual Rent

12. /2011 \$ N/A

13. /2012 \$ N/A

14. /2013 \$ N/A

\* 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.

**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		3	4
		1	2		
		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.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	<b>TOTAL</b>			\$		\$	\$		\$	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.

Facility Name & ID Number Manor Court of Peoria# 0047068Report Period Beginning: 04/01/2009Ending: 03/31/2010

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 03/31/2010

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 10,592	\$ 87,081	1
2	Cash-Patient Deposits	2,510	2,510	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	240,340	240,340	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,565	101,734	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Att Sch X</u>	690,583	850,179	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 964,590	\$ 1,281,844	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		350,000	13
14	Buildings, at Historical Cost		11,403,285	14
15	Leasehold Improvements, at Historical Cost	6,375	553,090	15
16	Equipment, at Historical Cost	150,426	750,426	16
17	Accumulated Depreciation (book methods)	(83,042)	(267,234)	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): <u>See Att Sch X</u>		552,109	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 73,759	\$ 13,341,676	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,038,349	\$ 14,623,520	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 15,844	\$ 15,844	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,510	2,510	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	31,443	31,443	31
32	Accrued Real Estate Taxes(Sch.IX-B)	63,970	105,895	32
33	Accrued Interest Payable		44,693	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Interdivision payable</u>		2,678,077	36
37	<u>Current Maturity of Mortgage Note</u>		122,102	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 113,767	\$ 3,000,564	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,823,122	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44	<u>Security Deposits</u>	35,900	35,900	44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 35,900	\$ 10,859,022	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 149,667	\$ 13,859,586	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 888,682	\$ 763,934	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,038,349	\$ 14,623,520	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>476,480</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</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>476,480</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>412,202</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>412,202</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>888,682</b>	<b>24</b> *

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

Facility Name & ID Number Manor Court of Peoria# 0047068Report Period Beginning: 04/01/2009Ending: 03/31/2010

**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	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,903,131	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,903,131	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,682	6
7	Oxygen	3,046	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 4,728	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		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	95	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 95	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Activity Fund Income</u>		28
28a	<u>See Att Sch VII</u>	4,144	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 4,144	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,912,098	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	583,859	31
32	Health Care	1,738,387	32
33	General Administration	806,045	33
<b>B. Capital Expense</b>			
34	Ownership	341,628	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	2,602	35
36	Provider Participation Fee	27,375	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,499,896	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	412,202	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 412,202	43

\* 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.

Facility Name & ID Number **Manor Court of Peoria**

# **0047068**

Report Period Beginning:

**04/01/2009**

Ending:

**03/31/2010**

**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	2,033	2,163	\$ 67,591	\$ 31.25	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	3,907	4,201	94,739	22.55	3
4	Licensed Practical Nurses	13,610	14,635	287,720	19.66	4
5	CNAs & Orderlies	42,900	46,129	507,423	11.00	5
6	CNA Trainees					6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides			0		8
9	Activity Director			0		9
10	Activity Assistants	5,462	5,811	59,273	10.20	10
11	Social Service Workers	1,669	1,776	26,634	15.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	10,373	11,153	110,975	9.95	15
16	Dishwashers					16
17	Maintenance Workers	2,959	3,148	40,918	13.00	17
18	Housekeepers	9,498	10,104	91,439	9.05	18
19	Laundry	2,680	2,851	24,091	8.45	19
20	Administrator	1,955	2,080	94,263	45.32	20
21	Assistant Administrator	1,849	1,967	37,572	19.10	21
22	Other Administrative			0		22
23	Office Manager					23
24	Clerical	2,817	2,997	27,511	9.18	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator			0		29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,985	2,112	21,648	10.25	31
32	Other Health Care(specify)	1,895	2,016	51,911	25.75	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	105,592	113,143	\$ 1,543,708 *	\$ 13.64	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	***	\$ 3,790	1-3	35
36	Medical Director	***	9,750	9-3	36
37	Medical Records Consultant	***	2,200	10-3	37
38	Nurse Consultant	***	0	10-3	38
39	Pharmacist Consultant	***	1,634	10-3	39
40	Physical Therapy Consultant	***	141,704	10a-3	40
41	Occupational Therapy Consultant	***	148,782	10a-3	41
42	Respiratory Therapy Consultant	***	0	10a-3	42
43	Speech Therapy Consultant	***	63,377	10a-3	43
44	Activity Consultant	***	0	11-3	44
45	Social Service Consultant	***	26,634	12-3	45
46	Other(specify) <u>Dental Consultant</u>	***	0	10-3	46
47					47
48	<u>*** Monthly fee</u>				48
49	TOTAL (lines 35 - 48)		\$ 397,871		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			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

**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	
Linda Patton	Administrator	None	\$ 94,263	Workers' Compensation Insurance	\$ 90,718	IDPH License Fee	\$	
Lisa Schrodt	Asst. Admin	None	37,572	Unemployment Compensation Insurance	40,115	Advertising: Employee Recruitment	7,957	
				FICA Taxes	112,748	Health Care Worker Background Check		
				Employee Health Insurance	27,481	(Indicate # of checks performed)	0	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Advertising - Promo & Yellow pages	52,976	
				401(k)	8,390	Subscriptions	1,338	
				Other Employee Benefits	926	IHCA Dues	1,940	
TOTAL (agree to Schedule V, line 17, col. 1)						Other Licenses and Fees	225	
(List each licensed administrator separately.)			\$ 131,835			Indirect Costs - See Att Sch III	19	
B. Administrative - Other						Less: Public Relations Expense	( )	
Description			Amount			Non-allowable advertising	(52,976)	
			\$			Yellow page advertising	( )	
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 11,479	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 280,378			
(Attach a copy of any management service agreement)								
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
RFMS, Inc.	Administrative Services		\$ 74,400			\$	Out-of-State Travel	\$
LTC Support Services, LLC	Support Services		60,000					
McGladrey & Pullen, LLP	Accounting Services		12,561					
American Healthcare	Healthcare Services		3,600				In-State Travel	
My Innerview	Management Services		631				Staff use of personal vehicle on facility	
Polsinelli Shughart PC	Legal Services		7,558				business and meals (under \$250 per	
Michael T. Mahoney, LTD.	Legal Services		198				travel voucher)	0
							Seminar Expense	925
							Less: non-allowable out-of-state travel	0
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 158,948				TOTAL	\$ 925

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number Manor Court of Peoria# 0047068Report Period Beginning: 04/01/2009Ending: 03/31/2010**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. See Page 21 Section F
- (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? 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? 11 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 24,564 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 27,375  
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. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 0
- (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? None  
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: McGladrey & Pullen, LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.