

Facility Name & ID Number Manor Court of Clinton

0047134 Report Period Beginning: 4/1/2014 Ending: 3/31/2015

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	134	Skilled (SNF)	134	48,910	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	134	TOTALS	134	48,910	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	21,905	12,076	9,210	43,191	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,905	12,076	9,210	43,191	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.31%

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

Note : 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 04/15/2005

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

YES Date 04/15/2005 NO

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

YES NO If YES, enter number of beds certified 134 and days of care provided 7,943

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 03/31/15 Fiscal Year: 03/31/15

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

Facility Name & ID Number

Manor Court of Clinton

0047134

Report Period Beginning:

4/1/2014

Ending:

3/31/2015

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	350,916	42,070	8,898	401,885		401,885	(71,129)	330,756		1
2	Food Purchase		496,686		496,686		496,686	(92,179)	404,507		2
3	Housekeeping	219,389	46,504		265,893		265,893	(26,245)	239,648		3
4	Laundry	56,575	31,990		88,565		88,565	(8,741)	79,824		4
5	Heat and Other Utilities			177,472	177,472		177,472	(30,171)	147,301		5
6	Maintenance	74,116	21,485	134,561	230,162		230,162	(17,094)	213,068		6
7	Other (specify):*										7
8	TOTAL General Services	700,996	638,736	320,932	1,660,663		1,660,663	(245,559)	1,415,104		8
	B. Health Care and Programs										
9	Medical Director			12,937	12,937		12,937		12,937		9
10	Nursing and Medical Records	2,993,346	170,327	10,292	3,173,966		3,173,966	(169,112)	3,004,854		10
10a	Therapy										10a
11	Activities	101,637	6,082		107,718		107,718	(600)	107,118		11
12	Social Services	54,549			54,549		54,549		54,549		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,149,532	176,409	23,229	3,349,170		3,349,170	(169,712)	3,179,458		16
	C. General Administration										
17	Administrative	143,050			143,050		143,050	(14,120)	128,930		17
18	Directors Fees							4,557	4,557		18
19	Professional Services			427,246	427,246		427,246	(33,827)	393,419		19
20	Dues, Fees, Subscriptions & Promotions			12,969	12,969		12,969	(3,256)	9,713		20
21	Clerical & General Office Expenses	124,802	44,288	75,658	244,748		244,748	(12,085)	232,663		21
22	Employee Benefits & Payroll Taxes			666,548	666,548		666,548	(45,158)	621,390		22
23	Inservice Training & Education			8,138	8,138		8,138		8,138		23
24	Travel and Seminar			3,386	3,386		3,386		3,386		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			78,922	78,922		78,922	(5,073)	73,849		26
27	Other (specify):*										27
28	TOTAL General Administration	267,852	44,288	1,272,866	1,585,006		1,585,006	(108,962)	1,476,044		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,118,380	859,433	1,617,027	6,594,839		6,594,839	(524,233)	6,070,606		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 & ID Number Manor Court of Clinton

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Report Period Beginning:

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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	
	D. Ownership											
30	Depreciation			75,250	75,250		75,250	(295)	74,955			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			218,660	218,660		218,660	(37,172)	181,488			33
34	Rent-Facility & Grounds			1,215,036	1,215,036		1,215,036	(206,556)	1,008,480			34
35	Rent-Equipment & Vehicles			14,181	14,181		14,181		14,181			35
36	Other (specify):*											36
37	TOTAL Ownership			1,523,127	1,523,127		1,523,127	(244,023)	1,279,104			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		296,664	1,347,240	1,643,904		1,643,904	(5,422)	1,638,482			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			285,724	285,724		285,724		285,724			42
43	Other (specify):* Non-Allowable Co	55,248		602,877	658,125		658,125	(658,125)	(0)			43
44	TOTAL Special Cost Centers	55,248	296,664	2,235,841	2,587,753		2,587,753	(663,547)	1,924,206			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,173,627	1,156,097	5,375,995	10,705,719		10,705,719	(1,431,803)	9,273,916			45

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

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VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(46)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,648)	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	2,506	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				17
18	Fines and Penalties	(45,065)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(406)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(456,620)	43		24
25	Fund Raising, Advertising and Promotional	(39,850)	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	(902,641)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,449,770)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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)	17,967		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 17,967		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,431,803)		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					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Vending Machine Income	\$ (2,732)	2	1
2	Adjust out Hawthorne Inn of Clinton SLF expenses	(71,129)	1	2
3	Adjust out Hawthorne Inn of Clinton SLF expenses	(89,401)	2	3
4	Adjust out Hawthorne Inn of Clinton SLF expenses	(26,245)	3	4
5	Adjust out Hawthorne Inn of Clinton SLF expenses	(8,741)	4	5
6	Adjust out Hawthorne Inn of Clinton SLF expenses	(30,171)	5	6
7	Adjust out Hawthorne Inn of Clinton SLF expenses	(17,094)	6	7
8	Adjust out Hawthorne Inn of Clinton SLF expenses	(169,112)	10	8
9	Adjust out Hawthorne Inn of Clinton SLF expenses	(600)	11	9
10	Adjust out Hawthorne Inn of Clinton SLF expenses	(14,120)	17	10
11	Adjust out Hawthorne Inn of Clinton SLF expenses	(41,827)	19	11
12	Adjust out Hawthorne Inn of Clinton SLF expenses	(446)	20	12
13	Adjust out Hawthorne Inn of Clinton SLF expenses	(9,845)	21	13
14	Adjust out Hawthorne Inn of Clinton SLF expenses	(45,162)	22	14
15	Adjust out Hawthorne Inn of Clinton SLF expenses	(10,036)	26	15
16	Adjust out Hawthorne Inn of Clinton SLF expenses	(2,801)	30	16
17	Adjust out Hawthorne Inn of Clinton SLF expenses	(37,172)	33	17
18	Adjust out Hawthorne Inn of Clinton SLF expenses	(206,556)	34	18
19	Non-Allowable Marketing	(49,795)	34	19
20	Part A Labs	(22,821)	43	20
21	Part A X-rays	(24,477)	43	21
22	Disallowable Lobbying Expense	(2,847)	43	22
23	Managed Care Provider	(22)	43	23
24	Outpatient Medicare	(607)	43	24
25	Collection Fees - Refund	5	43	25
26	Offset Miscellaneous Income	(2,240)	43	26
27	Offset Oxygen Income	(5,422)	43	27
28	Adjust out Hawthorne Inn of Clinton SLF expenses	(11,226)	43	28
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48				48
49	Total		(902,641)	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
Residential Alternatives of Illinois, Inc. (Non-profit Organization)	100	Frances House, Inc. (FH)		See Page 6 Supplemental		
		Residential Alternatives of Illinois, Inc. (FH is sole mem				
		Residential Alternatives of Iowa				
		Pioneer Concepts, Inc. (FH is sole member)				
		Pinnacle Opportunities, Inc. (FH is sole member)				
		Concepts Plus, Inc. (FH is sole member)				
		See Page 6 Supplemental for specific homes				

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	18	\$	Residential Alternatives of Illinois, Inc.	100.00%	\$ 4,557	\$ 4,557	1
2	V	19		Residential Alternatives of Illinois, Inc.	100.00%	8,406	8,406	2
3	V	21		Residential Alternatives of Illinois, Inc.	100.00%	37	37	3
4	V	22		Residential Alternatives of Illinois, Inc.	100.00%	4	4	4
5	V	26		Residential Alternatives of Illinois, Inc.	100.00%	4,963	4,963	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$ 17,967	\$ * 17,967	14

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

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4/1/2014

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3/31/2015

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	Residential Alternatives of Illinois	100%	Hawthorne Inn of Danville	Danville IL			Skilled Nursing Facility
2	Residential Alternatives of Illinois	100%	Manor Court of Clinton	Clinton IL			Skilled Nrsng & Supp Lvg Fac
3	Residential Alternatives of Illinois	100%	Manor Court of Freeport	Freeport IL			Skilled Nursing Facility
4	Residential Alternatives of Illinois	100%	Manor Court of Peoria	Peoria IL			Skilled Nursing Facility
5	Residential Alternatives of Illinois	100%	Manor Court of Peru	Peru IL			Skilled Nursing Facility
6	Residential Alternatives of Illinois	100%	Manor Court of Princeton	Princeton IL			Skilled Nrsng Fac & Supp Lvg
7	Residential Alternatives of Illinois	100%			Hawthorne Inn of Freeport	Freeport, IL	Supportive Living Facility
8	Residential Alternatives of Illinois	100%			Hawthorne Inn of Peoria	Peoria, IL	Assisted Living Facility
9	Residential Alternatives of Illinois	100%			Hawthorne Inn of Peru	Peru, IL	Assisted Living Facility
10	Residential Alternatives of Illinois	100%			Liberty Estates of Geneseo	Geneseo, IL	Asst'd & Ind Living Facility
11	Residential Alternatives of Illinois	100%			Liberty Estates of Streator	Streator, IL	Asst'd & Ind Living Facility
12	Residential Alternatives of Illinois	100%	Freeport Rehab & Healthcare	Freeport IL			Skilled Nursing Facility
13	Residential Alternatives of Illinois	100%			Liberty Estates of Danville	Danville, IL	Indendent Living Facility
14	Residential Alternatives of Illinois	100%			Liberty Estates of Freeport	Freeport, IL	Indendent Living Facility
15	Residential Alternatives of Illinois	100%			Liberty Estates of Peoria	Peoria, IL	Indendent Living Facility
16	Residential Alternatives of Illinois	100%			Liberty Estates of Peru	Peru, IL	Indendent Living Facility
17	Residential Alternatives of Iowa	100%		Coralville IA			Long-term Care Facilities
18	Frances House, Inc.	100%			Casa Willis	Sterling, IL	DD Facilities
19	Frances House, Inc.	100%			Freeport Terrace	Freeport, IL	DD Facilities
20	Frances House, Inc.	100%			Gordon Jones Terrace	Lanark, IL	DD Facilities
21	Frances House, Inc.	100%			Hallam Terrace	Rockford, IL	DD Facilities
22	Frances House, Inc.	100%			Hammett House	Sterling, IL	DD Facilities
23	Frances House, Inc.	100%			Kanthak House	Ottawa, IL	DD Facilities
24	Frances House, Inc.	100%			Olson Terrace	Rockford, IL	DD Facilities
25	Frances House, Inc.	100%			Ridge Terrace	Freeport, IL	DD Facilities
26	Frances House, Inc.	100%			Cantebury Place	Rockford, IL	DD Facilities
27	Frances House, Inc.	100%			Glenwood Villa	Rockford, IL	DD Facilities
28	Frances House, Inc.	100%			Rockton Court	Rockford, IL	DD Facilities
29	Frances House, Inc.	100%			Rose House	Moline, IL	DD Facilities
30	Frances House, Inc.	100%			Seborg Terrace	Rockford, IL	DD Facilities

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Facility Name & ID Number

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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	Frances House, Inc.	100%			Smith Square	Moline, IL	DD Facility	1
2	Frances House, Inc.	100%			Stern Square	Sterling, IL	DD Facility	2
3	Frances House, Inc.	100%			Stouffer Terrace	Oregon, IL	DD Facility	3
4	Frances House, Inc.	100%			Lewis Terrace	North Chicago, IL	Group Home	4
5	Frances House, Inc.	100%			Seymour Terrace	North Chicago, IL	Group Home	5
6	Frances House, Inc.	100%			Waukegan Terrace	Waukegan, IL	Group Home	6
7	Frances House, Inc.	100%			Pine Terrace	Waukegan, IL	Group Home	7
8	Frances House, Inc.	100%			Peoria Manor Court	Galesburg, IL	Real Estate Entity	8
9	Frances House, Inc.	100%			Peru Becker, Ltd., NF	Galesburg, IL	Real Estate Entity	9
10	Frances House, Inc.	100%			Danville Independence	Galesburg, IL	Real Estate Entity	10
11	Frances House, Inc.	100%			Hawthorne Inn of Prin	Galesburg, IL	Real Estate Entity	11
12	Pioneer Concepts, Inc.	100%			Broadway Terrace	Chicago Heights, IL	DD Facility	12
13	Pioneer Concepts, Inc.	100%			Carole Lane Terrace	Sauk Village, IL	DD Facility	13
14	Pioneer Concepts, Inc.	100%			Flossmoor Terrace	Flossmoor, IL	DD Facility	14
15	Pioneer Concepts, Inc.	100%			Ravisloe Terrace	Country Club Hills, IL	DD Facility	15
16	Pioneer Concepts, Inc.	100%			Spaulding Terrace	Markham, IL	DD Facility	16
17	Pioneer Concepts, Inc.	100%			Calumet City Terrace	Calumet City, IL	DD Facility	17
18	Pioneer Concepts, Inc.	100%			Dolton Terrace	Dolton, IL	DD Facility	18
19	Pioneer Concepts, Inc.	100%			Lynwood Terrace	Lynwood, IL	DD Facility	19
20	Pioneer Concepts, Inc.	100%			Holland Terrace	South Holland, IL	DD Facility	20
21	Pioneer Concepts, Inc.	100%			Matteson Court	Matteson, IL	DD Facility	21
22	Pioneer Concepts, Inc.	100%			Priarie House	Sauk Village, IL	DD Facility	22
23	Pioneer Concepts, Inc.	100%			Torrence Place	Sauk Village, IL	DD Facility	23
24	Pinnacle Opportunities	100%			Chambness Square	Bourbannais, IL	DD Facility	24
25	Pinnacle Opportunities	100%			Collins Square	Bradley, IL	DD Facility	25
26	Pinnacle Opportunities	100%			Dearborn Court	Kankakee, IL	DD Facility	26
27	Pinnacle Opportunities	100%			River Court	Kankakee, IL	DD Facility	27
28	Pinnacle Opportunities	100%			Station Court	Kankakee, IL	DD Facility	28
29	Pinnacle Opportunities	100%			Eagle Court	Kankakee, IL	DD Facility	29
30	Pinnacle Opportunities	100%			Kankakee Court	Kankakee, IL	DD Facility	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	Pinnacle Opportunities	100%			Roy Court	Bourbannais, IL	DD Facility	1
2	Pinnacle Opportunities	100%			Gravlin Square	Bradley, IL	DD Facility	2
3								3
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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	Irwin Jann	President & Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	\$ 959	L18, C7	1
2	Doug Biederstedt	Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	720	L18, C7	2
3	Jeff Shaw	Secretary & Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	959	L18, C7	3
4	William Kempiners	Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	959	L18, C7	4
5	John Kniery	Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	959	L18, C7	5
6											6
7											7
8											8
9	No board members provide services or have business entities that provide services to the facility.										9
10											10
11											11
12											12
13								TOTAL	\$ 4,557		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 Clinton

0047134

Report Period Beginning:

4/1/2014

Ending: 3/31/2015

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

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

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	18	Director Fees	Weighted Avg Beds	308,225	17	\$ 28,715	\$ 48,910	\$ 4,557	1
2	19	Professional Services	Weighted Avg Beds	308,225	17	52,978	48,910	8,406	2
3	21	Clerical Other	Weighted Avg Beds	308,225	17	233	48,910	37	3
4	22	Employee Benefits & PR Taxes	Weighted Avg Beds	308,225	17	25	48,910	4	4
5	26	Property Insurance	Weighted Avg Beds	308,225	17	31,275	48,910	4,963	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				\$ 113,226	\$		\$ 17,967	25

Facility Name & ID Number

Manor Court of Clinton

0047134

Report Period Beginning:

4/1/2014

Ending:

3/31/2015

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		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	A. Directly Facility Related																
	Long-Term																
1							\$	\$			\$						
2	N/A																
3																	
4																	
5																	
	Working Capital																
6																	
7																	
8																	
9	TOTAL Facility Related						\$	\$			\$						
	B. Non-Facility Related*																
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$	\$			\$						

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

** 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 2014 report.				\$	<u>259,915</u> 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.)	2013			\$	<u>208,602</u> 2
3. Under or (over) accrual (line 2 minus line 1).				\$	<u>(51,312)</u> 3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	<u>269,972</u> 4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
			SLF Portion of Expense		<u>(37,172)</u>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	<u>181,488</u> 7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	<u>200,299</u>	8		
	2011	<u>182,497</u>	9		
	2012	<u>187,648</u>	10		
	2013	<u>208,602</u>	11		
	2014	<u>215,969</u>	12		
<u>This facility is leased from an unrelated for-profit entity. The lease agreement requires the lessee to pay the real estate taxes. Amount accrued includes 12 months of 2014 and 3 months of 2015. The real estate tax estimate is based on 2014 tax bill. Taxes paid are for the 2013 tax bill. See Att Sch VII for the portion of real estate taxes allocated to the SNF portion.</u>					
				FOR BHF USE ONLY	
				13	FROM R. E. TAX STATEMENT FOR 2014 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

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

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,256 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>N/A Facility Leased</u>			\$	1
2					2
3	TOTALS			\$	3

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	134			\$	\$		\$	\$	\$
5									
6									
7									
8									
	Improvement Type**								
9	Electric Sign	2005		4,433	443	10	443		4,433
10	Canopy, Fiberglass Insulation	2006		16,622	1,108	15	1,108		10,089
11	Sign, Tub Installation	2007		8,636	864	10	864		6,952
12	Install smoke seams/seals, Relocate dry pendent sprinkler head:	2008		11,394	789	10-25 yrs	789		5,262
13	Hot Water Supply Boiler	2010		9,445	472	20	472		2,438
14	Cable Sytem	2010		2,500	250	10	250		1,250
15	Door Alarm for Wandering Residents	2012		3,564	356	10	356		1,039
16	Workstation-Cabinets with Overhead Doors/File Cabinets/Chair/Partition	2012		7,550	755	10	755		1,762
17	Conference Room Remodel-Vct/Drywall/Paint Walls/Paint Doors/Electric	2013		36,011	3,001	12	3,001		6,252
18	Telephone System in New Offices-Dialysis and MDS Offices	2013		2,581	258	10	258		538
19	New Roof	2013		99,165	9,917	10	9,917		14,049
20	Dialysis Room electrical work	2013		3,740	187	20	187		312
21	Workstation-Cabinets with Overhead Doors/File Cabinets/Chair/Partition	2013		9,879	823	12	823		1,646
22	Double Face Lighted Sign with Message Center	2014		36,383	3,638	10	3,638		4,548
23									
24	Single Faced Lighted Sign - Outside of SKN Bounce Back	2014		3,013	251	10	251		251
25	PTAC Units in Resident Rooms	2014		2,591	432	5	432		432
26	Tie Depreciation to Financials				295			(295)	
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

Facility Name & ID Number Manor Court of Clinton

0047134

Report Period Beginning:

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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)		\$ 257,507	\$ 23,839		\$ 23,544	\$ (295)	\$ 61,253	70

**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	\$ 308,439	\$ 36,410	\$ 36,410	\$	3-20 years	\$ 164,293	71
72	Current Year Purchases	24,063	2,160	2,160		5-10 years	2,160	72
73	Fully Depreciated Assets	131,305					131,305	73
74								74
75	TOTALS	\$ 463,807	\$ 38,570	\$ 38,570	\$		\$ 297,758	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	2005	\$ 46,919	\$	\$	\$	4	\$ 46,919	76
77	Patient Care	2013 Ford E350 Van	2013	51,365	12,841	12,841		4	24,612	77
78										78
79										79
80	TOTALS			\$ 98,284	\$ 12,841	\$ 12,841	\$		\$ 71,531	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)	\$ 819,598	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 75,250	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 74,955	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (295)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 430,542	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	2003 GMC Van - 2005	\$ 29,800	\$	\$ 29,800	86
87	2006 Toyota Corolla - 2006	14,900		14,900	87
88	1991 Ford F250 - 2007	6,159		6,159	88
89					89
90					90
91	TOTALS	\$ 50,859	\$	\$ 50,859	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$ 4,136	92
93			93
94			94
95		\$ 4,136	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.

Facility Name & ID Number

Manor Court of Clinton

0047134

Report Period Beginning: 4/1/2014

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XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Mid-Illini Healthcare, 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:	2004	98	4/15/2006	\$ 1215036.00	10	5	3
4	Additions	2006	63					4
5	Allocated to SLF				-206556.00			5
6								6
7	TOTAL		161		\$ 1,008,480			7

10. Effective dates of current rental agreement:

Beginning 4/15/2005

Ending 4/14/2015

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

Fiscal Year Ending Annual Rent

12. 3/31/2016 \$ 1,374,000

13. 3/31/2017 \$ 1,374,000

14. 3/31/2018 \$ 1,374,000

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

N/A

9. Option to Buy: YES NO Terms: Fair Market Value*

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: \$ 30028 Description: Wound Vac \$8,151; Pneumonia \$2,587; Gcat \$1,691; DVT \$1,240; Other \$512

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Manor Court of Clinton # 0047134 Report Period Beginning: 4/1/2014 Ending: 3/31/2015
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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. 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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	8,320	\$ 599,038	\$	8,320	\$ 599,038	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,424	174,516		2,424	174,516	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		7,571	545,099		7,571	545,099	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				262,550		262,550	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)			397	28,587		397	28,587	12
13	Other (specify): <u>Oxygen</u>	39(2)					34,114		34,114	13
14	TOTAL			\$	18,712	\$ 1,347,240	\$ 296,664	18,712	\$ 1,643,904	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 Clinton# 0047134Report Period Beginning: 4/1/2014

Ending:

3/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 3/31/2015

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 24,483	\$ 24,483	1
2	Cash-Patient Deposits	15,396	15,396	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>406,700</u>)	2,130,288	2,130,288	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	55,067	55,067	6
7	Other Prepaid Expenses	1,988	1,988	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Receivable for Cost Report</u>	103,962	103,962	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,331,184	\$ 2,331,184	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	247,366	257,507	15
16	Equipment, at Historical Cost	623,092	562,091	16
17	Accumulated Depreciation (book methods)	(481,696)	(430,542)	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 (spec <u>Constr in Progress</u>)	4,136	4,136	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 392,898	\$ 393,192	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,724,082	\$ 2,724,376	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 136,554	\$ 136,554	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,396	15,396	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	24,415	24,415	31
32	Accrued Real Estate Taxes(Sch.IX-B)	269,972	269,972	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Utilities Payable</u>	20,868	20,868	36
37	<u>See Sch 17A</u>	189,875	189,875	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 657,080	\$ 657,080	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Sch 17A</u>	2,469,591	2,469,591	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,469,591	\$ 2,469,591	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,126,672	\$ 3,126,672	46
47	TOTAL EQUITY(page 18, line 24)	\$ (402,589)	\$ (402,296)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,724,082	\$ 2,724,376	48

*(See instructions.)

Facility Name: Manor Court of Clinton
IDPH License ID Number: 0047134
Fiscal Year End: 3/31/2015

Schedule 17A

XV. Balance Sheet

Line 37 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Accrued Employee Time	83,188	83,188
Accrued Medicaid Assessment	6	6
Provider Tax Act	89,721	89,721
Accrued Legal Fees	16,961	16,961
Total - Line 37	189,875	189,875

XV. Balance Sheet

Line 43 Other Long-term Liabilities (specify):

Description	Operating	After Consolidation
InterCompany	2,399,300	2,399,300
Security Deposits	70,292	70,292
Total - Line 43	2,469,591	2,469,591

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (774,331)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (774,331)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	371,742	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 371,742	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (402,589)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,925,719	1
2	Discounts and Allowances for all Levels	(80,857)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,844,862	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	22,543	6
7	Oxygen	5,422	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 27,965	8
C. Other Operating Revenue			
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	2,690	13
14	Non-Patient Meals	46	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,146,579	16
17	Sale of Drugs	2,188	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	8,466	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,159,970	23
D. Non-Operating Revenue			
24	Contributions	5,366	24
25	Interest and Other Investment Income***	21,073	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 26,439	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Sch 19A</u>	18,225	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 18,225	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,077,461	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,660,663	31
32	Health Care	3,349,170	32
33	General Administration	1,585,006	33
B. Capital Expense			
34	Ownership	1,523,127	34
C. Ancillary Expense			
35	Special Cost Centers	2,302,029	35
36	Provider Participation Fee	285,724	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,705,719	40
41	Income before Income Taxes (line 30 minus line 40)**	371,742	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 371,742	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,867,038	44
45	Private Pay - Net Inpatient Revenue	2,149,739	45
46	Medicare - Net Inpatient Revenue	4,146,426	46
47	Other-(specify) <u>Medicare Replacement</u>	278,355	47
48	Other-(specify) <u>Managed Care</u>	403,304	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,844,862	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.

^ - This entity is a cash basis taxpayer

Facility Name: Manor Court of Clinton
IDPH License ID Number: 0047134
Fiscal Year End: 3/31/2015

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

<u>Description</u>	<u>Amount</u>
Link Revenue	9,349
Late Fee	2,632
Processing Fee	10
Vending	3,994
Misc Income	2,240
Total - Line 28	<u><u>18,225</u></u>

Facility Name & ID Number Manor Court of Clinton

0047134

Report Period Beginning: 4/1/2014

Ending: 3/31/2015

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	1,776	1,987	\$ 70,779	\$ 35.62	1
2	Assistant Director of Nursing	1,600	1,680	51,629	30.73	2
3	Registered Nurses	17,500	18,606	397,862	21.38	3
4	Licensed Practical Nurses	30,413	31,809	653,302	20.54	4
5	CNAs & Orderlies	119,364	125,077	1,472,952	11.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,934	10,346	101,637	9.82	10
11	Social Service Workers	2,032	2,116	54,549	25.78	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,820	29,196	287,402	9.84	15
16	Dishwashers					16
17	Maintenance Workers	8,025	8,025	66,800	8.32	17
18	Housekeepers	13,833	14,843	197,734	13.32	18
19	Laundry	5,878	6,009	50,991	8.49	19
20	Administrator	1,795	1,875	95,022	50.68	20
21	Assistant Administrator	1,795	1,875	33,908	18.08	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,266	12,866	124,802	9.70	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)	1,952	2,080	48,192	23.17	30
31	Medical Records	1,690	1,778	21,889	12.31	31
32	Other Health C: MDS/SCU Coord	4,065	4,329	107,629	24.86	32
33	Other(specify) <u>See Att Sch 20A</u>	25,185	26,493	336,548	12.70	33
34	TOTAL (lines 1 - 33)	286,923	300,990	\$ 4,173,627 *	\$ 13.87	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	\$ 8,898	L1, C3	35
36	Medical Director	Monthly	12,937	L9, C3	36
37	Medical Records Consultant	Monthly	1,880	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,412	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 32,127		49

C. CONTRACT NURSES

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

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	
Jennifer Westbrook	Administrator	None	\$ 95,021	Workers' Compensation Insurance	\$ 124,549	IDPH License Fee	\$	
Andrea Goodlow	Asst. Administrator	None	33,909	Unemployment Compensation Insurance	23,124	Advertising: Employee Recruitment	1,578	
Salary Allocated to SLF			14,120	FICA Taxes	292,638	Health Care Worker Background Check		
				Employee Health Insurance	156,376	(Indicate # of checks performed <u>39</u>)	464	
				Employee Meals		<u>Patient Background Checks</u> <u>39</u>	464	
				Illinois Municipal Retirement Fund (IMRF)*		<u>Subscriptions</u>	125	
				<u>401 (k)</u>	15,462	<u>IHCA Dues</u>	7,416	
				<u>Employee Appreciation</u>	6,674	<u>Other Licenses & Fees</u>	2,513	
				<u>Other Employee Benefits</u>	2,567			
TOTAL (agree to Schedule V, line 17, col. 1)						<u>Less: Lobbying Fees</u>	(2,847)	
(List each licensed administrator separately.)			\$ 143,050			<u>Less: Public Relations Expense</u>	()	
						<u>Non-allowable advertising</u>	()	
						<u>Yellow page advertising</u>	()	
B. Administrative - Other						TOTAL (agree to Sch. V, line 20, col. 8)		
Description			Amount			\$ 9,713		
N/A			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(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	
Brady, Connolly, and Masuda	Legal Services	\$ (25)	N/A		\$	Out-of-State Travel	\$	
Davis & Campbell L.L.C	Legal Services	2,468						
Lamkin & Lamkin	Legal Services	406						
LTC	Support Services	219,491				In-State Travel		
McGladrey & Pullen	Accounting Services	26,506						
Polsinelli	Legal Services	640						
RFMS	Administrativfe Services	171,600						
Templin Healthcare	Accounting Services	6,160				Seminar Expense	3,386	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL				
(For legal fee disclosure, see page 39 of instructions)			\$ 427,246		\$	Entertainment Expense	()	
						(agree to Sch. V, line 24, col. 8)		
						TOTAL	\$ 3,386	

* Attach copy of IMRF notifications

**See instructions.

Facility Name: Manor Court of Clinton
IDPH License ID Number: 0047134
Fiscal Year End: 3/31/2015

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Brady, Connolly, and Masuda	Legal Services	(25)
Davis & Campbell L.L.C	Legal Services	2,468
Lamkin & Lamkin	Legal Services	406
LTC	Support Services	219,491
McGladrey & Pullen	Accounting Services	26,506
Polsinelli	Legal Services	640
RFMS	Administrative Services	171,600
Templin Healthcare	Accounting Services	6,160
Total (agree to Schedule V, line 19, column 3)		<u><u>427,246</u></u>
Non-Allowable Legal Fees		(406)
Allocated from Management Company	Professional Services	8,407
	Cost Allocation to Supportive Living Facility	(41,828)
Total (agree to Schedule V, line 19, column 8)		<u><u>393,419</u></u>

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												N/A
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Manor Court of Clinton

0047134

Report Period Beginning: 4/1/2014

Ending: 3/31/2015

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. IHCA 7,416
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes - IHCA Dues \$2847 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? 5-10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 52,492 Line 10(2)
- (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. \$ 285,724
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. \$ 46
- (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? Adequate records have been maintained.
- 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 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.