

Facility Name & ID Number Manor Court of Princeton

0047324 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	<u>125</u>	Skilled (SNF)	<u>125</u>	<u>45,625</u>	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	<u>125</u>	TOTALS	<u>125</u>	<u>45,625</u>	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	<u>12,307</u>	<u>15,204</u>	<u>6,966</u>	<u>34,477</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,307</u>	<u>15,204</u>	<u>6,966</u>	<u>34,477</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.57%

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 01/03/05

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

YES Date 01/03/05 NO

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

YES NO If YES, enter number of beds certified 125 and days of care provided 6,062

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

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

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Report Period Beginning:

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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	346,090	34,926	8,227	389,243		389,243	(78,956)	310,287		1
2	Food Purchase		464,771		464,771		464,771	(100,150)	364,621		2
3	Housekeeping	177,653	38,785		216,438		216,438	(26,070)	190,368		3
4	Laundry	48,074	29,124		77,198		77,198	(9,298)	67,900		4
5	Heat and Other Utilities			231,045	231,045		231,045	(50,830)	180,215		5
6	Maintenance	70,811	26,732	84,370	181,914		181,914	(21,881)	160,033		6
7	Other (specify):*										7
8	TOTAL General Services	642,628	594,338	323,643	1,560,609		1,560,609	(287,185)	1,273,424		8
	B. Health Care and Programs										
9	Medical Director			10,170	10,170		10,170		10,170		9
10	Nursing and Medical Records	2,462,617	153,388	8,800	2,624,805		2,624,805	(171,260)	2,453,545		10
10a	Therapy										10a
11	Activities	95,458	2,010		97,468		97,468	(242)	97,226		11
12	Social Services	28,048			28,048		28,048		28,048		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,586,124	155,397	18,970	2,760,491		2,760,491	(171,502)	2,588,989		16
	C. General Administration										
17	Administrative	133,522			133,522		133,522	(16,083)	117,439		17
18	Directors Fees							4,251	4,251		18
19	Professional Services			299,651	299,651		299,651	(28,200)	271,451		19
20	Dues, Fees, Subscriptions & Promotions			19,951	19,951		19,951	(3,192)	16,759		20
21	Clerical & General Office Expenses	76,511	28,658	53,313	158,482		158,482	(19,692)	138,790		21
22	Employee Benefits & Payroll Taxes			556,853	556,853		556,853	(48,198)	508,655		22
23	Inservice Training & Education			4,653	4,653		4,653		4,653		23
24	Travel and Seminar			2,403	2,403		2,403		2,403		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			68,856	68,856		68,856	(5,691)	63,165		26
27	Other (specify):*										27
28	TOTAL General Administration	210,033	28,658	1,005,681	1,244,372		1,244,372	(116,805)	1,127,567		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,438,784	778,393	1,348,294	5,565,471		5,565,471	(575,492)	4,989,979		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.

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Report Period Beginning:

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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			61,342	61,342		61,342	313,919	375,261			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			100,800	100,800		100,800	(23,344)	77,456			33
34	Rent-Facility & Grounds			837,806	837,806		837,806	(837,806)				34
35	Rent-Equipment & Vehicles			17,565	17,565		17,565		17,565			35
36	Other (specify):*											36
37	TOTAL Ownership			1,017,513	1,017,513		1,017,513	(547,231)	470,282			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		191,303	1,075,330	1,266,632		1,266,632		1,266,632			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			239,849	239,849		239,849		239,849			42
43	Other (specify):* Non-Allowable Co	36,913		640,115	677,028		677,028	(677,028)	0			43
44	TOTAL Special Cost Centers	36,913	191,303	1,955,293	2,183,509		2,183,509	(677,028)	1,506,481			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,475,697	969,696	4,321,100	8,766,493		8,766,493	(1,799,751)	6,966,742			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	(670)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,447)	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	(248,762)	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				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	(442,402)	43		24
25	Fund Raising, Advertising and Promotional	(128,415)	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	(899,332)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,730,028)		\$	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)	(69,723)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (69,723)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,799,751)		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	\$ (3,996)	2	1
2	Adjust out Hawthorne Inn SLF expenses	(78,956)	1	2
3	Adjust out Hawthorne Inn SLF expenses	(95,484)	2	3
4	Adjust out Hawthorne Inn SLF expenses	(26,070)	3	4
5	Adjust out Hawthorne Inn SLF expenses	(9,298)	4	5
6	Adjust out Hawthorne Inn SLF expenses	(50,830)	5	6
7	Adjust out Hawthorne Inn SLF expenses	(21,881)	6	7
8	Adjust out Hawthorne Inn SLF expenses	(171,260)	10	8
9	Adjust out Hawthorne Inn SLF expenses	(242)	11	9
10	Adjust out Hawthorne Inn SLF expenses	(16,083)	17	10
11	Adjust out Hawthorne Inn SLF expenses	(36,042)	19	11
12	Adjust out Hawthorne Inn SLF expenses	(814)	20	12
13	Adjust out Hawthorne Inn SLF expenses	(17,730)	21	13
14	Adjust out Hawthorne Inn SLF expenses	(48,202)	22	14
15	Adjust out Hawthorne Inn SLF expenses		25	15
16	Adjust out Hawthorne Inn SLF expenses	(10,320)	26	16
17	Adjust out Hawthorne Inn SLF expenses	(4,075)	30	17
18	Adjust out Hawthorne Inn SLF expenses	(22,176)	33	18
19	Adjust out Hawthorne Inn SLF expenses	(184,317)	34	19
20	Disallowable lobbying expense	(2,662)	35	20
21	Nonallowable marketing events	(36,913)	43	21
22	Labs - Part A	(40,179)	20	22
23	X-Rays - Part A	(3,638)	43	23
24	Ambulance	(1,947)	43	24
25	Prior Year Medicare	(13,065)	43	25
26	Managed Care Provider	(22)	43	26
27	Offset Miscellaneous Income	(1,962)	43	27
28	Real Estate Adjustment	(1,168)	33	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	Total		(899,332)	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)				
		Residential Alternatives of Illinois, Inc. (FH is sole mem		See Page 6 Supplemental		
		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%	\$ 4,251	\$ 4,251	1
2	V	19		Residential Alternatives of Illinois, Inc.	100.00%	7,842	7,842	2
3	V	21		Residential Alternatives of Illinois, Inc.	100.00%	34	34	3
4	V	22		Residential Alternatives of Illinois, Inc.	100.00%	4	4	4
5	V	26		Residential Alternatives of Illinois, Inc.	100.00%	4,629	4,629	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		\$			\$ 16,760	\$ * 16,760	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	34 Facility Rent	\$ 653,489	Hawthorne Inn of Princeton, LLC		\$	(653,489) 15
16	V	30 Depreciation Expense		Hawthorne Inn of Princeton, LLC		566,756	566,756 16
17	V	20 License, Fees		Hawthorne Inn of Princeton, LLC		250	250 17
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 653,489			\$ 567,006	\$ * (86,483) 39

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

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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	Residential Alternatives of Illinois	100%	Hawthorne Inn of Danville	Danville	IL			Skilled Nursing Facility	1
2	Residential Alternatives of Illinois	100%	Manor Court of Clinton	Clinton	IL			Skilled Nrsng & Supp Lvg Fac	2
3	Residential Alternatives of Illinois	100%	Manor Court of Freeport	Freeport	IL			Skilled Nursing Facility	3
4	Residential Alternatives of Illinois	100%	Manor Court of Peoria	Peoria	IL			Skilled Nursing Facility	4
5	Residential Alternatives of Illinois	100%	Manor Court of Peru	Peru	IL			Skilled Nursing Facility	5
6	Residential Alternatives of Illinois	100%	Manor Court of Princeton	Princeton	IL			Skilled Nrsng Fac & Supp Lvg	6
7	Residential Alternatives of Illinois	100%				Hawthorne Inn of Freeport	Freeport, IL	Supportive Living Facility	7
8	Residential Alternatives of Illinois	100%				Hawthorne Inn of Peoria	Peoria, IL	Assisted Living Facility	8
9	Residential Alternatives of Illinois	100%				Hawthorne Inn of Peru	Peru, IL	Assisted Living Facility	9
10	Residential Alternatives of Illinois	100%				Liberty Estates of Geneseo	Geneseo, IL	Asst'd & Ind Living Facility	10
11	Residential Alternatives of Illinois	100%				Liberty Estates of Streator	Streator, IL	Asst'd & Ind Living Facility	11
12	Residential Alternatives of Illinois	100%	Freeport Rehab & Healthcare	Freeport	IL			Skilled Nursing Facility	12
13	Residential Alternatives of Illinois	100%				Liberty Estates of Danville	Danville, IL	Indendent Living Facility	13
14	Residential Alternatives of Illinois	100%				Liberty Estates of Freeport	Freeport, IL	Indendent Living Facility	14
15	Residential Alternatives of Illinois	100%				Liberty Estates of Peoria	Peoria, IL	Indendent Living Facility	15
16	Residential Alternatives of Illinois	100%				Liberty Estates of Peru	Peru, IL	Indendent Living Facility	16
17	Residential Alternatives of Iowa	100%		Coralville	IA			Long-term Care Facilities	17
18	Frances House, Inc.	100%				Casa Willis	Sterling, IL	DD Facilities	18
19	Frances House, Inc.	100%				Freeport Terrace	Freeport, IL	DD Facilities	19
20	Frances House, Inc.	100%				Gordon Jones Terrace	Lanark, IL	DD Facilities	20
21	Frances House, Inc.	100%				Hallam Terrace	Rockford, IL	DD Facilities	21
22	Frances House, Inc.	100%				Hammett House	Sterling, IL	DD Facilities	22
23	Frances House, Inc.	100%				Kanthak House	Ottawa, IL	DD Facilities	23
24	Frances House, Inc.	100%				Olson Terrace	Rockford, IL	DD Facilities	24
25	Frances House, Inc.	100%				Ridge Terrace	Freeport, IL	DD Facilities	25
26	Frances House, Inc.	100%				Canterbury Place	Rockford, IL	DD Facilities	26
27	Frances House, Inc.	100%				Glenwood Villa	Rockford, IL	DD Facilities	27
28	Frances House, Inc.	100%				Rockton Court	Rockford, IL	DD Facilities	28
29	Frances House, Inc.	100%				Rose House	Moline, IL	DD Facilities	29
30	Frances House, Inc.	100%				Seborg Terrace	Rockford, IL	DD Facilities	30

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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., NFP	Galesburg, IL	Real Estate Entity	9
10	Frances House, Inc.	100%			Danville Independence, LLC	Galesburg, IL	Real Estate Entity	10
11	Frances House, Inc.	100%			Hawthorne Inn of Princeton	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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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
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

Facility Name & ID Number Manor Court of Princeton # 0047324 Report Period Beginning: 4/1/2014 Ending: 3/31/2015

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	\$ 895	L18, C7	1
2	Doug Biederstedt	Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	671	L18, C7	2
3	Jeff Shaw	Secretary & Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	895	L18, C7	3
4	William Kempiners	Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	895	L18, C7	4
5	John Kniery	Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	895	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	\$ 4,251		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 Princeton

0047324

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

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

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

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	\$ 45,625	\$ 4,251	1
2	19	Professional Services	Weighted Avg Beds	308,225	17	52,978	45,625	7,842	2
3	21	Clerical Other	Weighted Avg Beds	308,225	17	233	45,625	34	3
4	22	Employee Benefits & PR Taxes	Weighted Avg Beds	308,225	17	25	45,625	4	4
5	26	Property Insurance	Weighted Avg Beds	308,225	17	31,275	45,625	4,629	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	\$		\$ 16,760	25

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manor Court of Princeton COUNTY Bureau
 FACILITY IDPH LICENSE NUMBER 0047324
 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 2014 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 2014.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>16-16-226-010</u>	<u>140 N. Sixth St.</u>	\$ <u>100,461.78</u>	\$ <u>80,005.24</u>
2. _____	<u>Princeton</u>	\$ _____	\$ _____
3. _____	<u>E SI OF NE COR OF PT L 98</u>	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>100,461.78</u></u>	\$ <u><u>80,005.24</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 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: 38,703 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>Facility SNF</u>		<u>2009</u>	<u>\$ 50,700</u>	1
2					2
3	TOTALS			\$ 50,700	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	98	2009		\$ 5,371,483	\$	25	\$ 214,860	\$ 214,860	\$ 1,143,939	4
5	27	2013		2,946,720		25	49,112	49,112	98,224	5
6										6
7										7
8										8
Improvement Type**										
9	Electric Signs	2005		4,098	410	10	410		4,098	9
10	Electrical Lighting - Landscaping, Fiberglass Insulation	2006		12,540	950	10-15 yrs	950		8,246	10
11	Sign	2007		2,600	260	10	260		1,972	11
12	New Roof	2008		144,175	14,418	10	14,418		98,520	12
13	Paved Parking Lot and Sidewalks	2009		174,779		15	11,652	11,652	62,144	13
14	AC Unit Kitchen	2010		5,429	543	10	543		2,488	14
15	Dry Valve for Sprinkler System	2011		7,258	728	10	728		3,085	15
16	Dining Room Wallpaper/Paint/Carpet/Desk/Countertops	2011		14,230	1,423	10	1,423		5,929	16
17	3x6 Single Face Lighted Sign	2010		2,620	262	10	262		1,288	17
18	Shower Remodels (concrete shower stalls, sealer, paint)	2011		7,350	735	10	735		3,001	18
19	Office Partitions	2011		2,893	289	10	289		1,181	19
20	Phys Ther Addition:wood frame/drywall/roof/landscaping/cabinets/paint	2010		526,495		12	43,875	43,875	201,092	20
21	Air Conditioner - 5 Ton	2011		4,400	440	10	440		1,650	21
22	Lake Patio and Shelter: Roof/Footings/Gutters/Sidewalk/Washouts Aroun	2012		23,098	8,152	12	1,925	(6,227)	4,492	22
23	Theatre Room-electrical wiring/install screen & speakers	2013		15,158	1,518	10	1,518		2,905	23
24	New Water Heater	2013		10,277	1,028	10	1,028		1,370	24
25	New Furnace	2014		4,145	276	15	276		299	25
26										26
27	Dining Room: Drywall/Beams/Trim/Paint/Wallpaper	2014		5,315	406	10	406		406	27
28	East Wing/Kitchen Doors	2014		9,000	750	10	750		750	28
29	Water Heater	2014		10,194	850	10	850		856	29
30										30
31										31
32										32
33										33
34										34
35	To Tie Depreciation to Financials				(647)			647		35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Manor Court of Princeton

0047324

Report Period Beginning:

4/1/2014

Ending:

3/31/2015

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	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)		\$ 9,304,257	\$ 32,791		\$ 346,710	\$ 313,919	\$ 1,647,935	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	\$ 1,040,976	\$ 27,002	\$ 27,002	\$	3-20	\$ 348,403	71
72	Current Year Purchases	11,796	1,549	1,549		5-10	1,549	72
73	Fully Depreciated Assets	99,540					99,540	73
74								74
75	TOTALS	\$ 1,152,312	\$ 28,551	\$ 28,551	\$		\$ 449,492	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 Van	2005	\$ 46,919	\$	\$	\$	4	\$ 46,919	76
77										77
78										78
79										79
80	TOTALS			\$ 46,919	\$	\$	\$		\$ 46,919	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)	\$ 10,554,188	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 61,342	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 375,261	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 313,919	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,144,346	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	Truck - 2004	\$ 3,500	\$	\$ 3,500	86
87	2003 GMC Van - 2005	29,800		29,800	87
88	2000 Ford F250 - 2006	8,425		8,425	88
89	See Sch 13A	1,955,811		506,015	89
90	2010 Toyota Corolla	16,300	1,358	16,300	90
91	TOTALS	\$ 2,013,836	\$ 1,358	\$ 564,040	91

G. Construction-in-Progress

	Description	Cost	
92		\$ N/A	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Manor Court of Princeton
 FYE 3/31/15
 Schedule 13A

Fixed Asset Summary

<u>FIXED ASSETS</u>	<i>Fr prior year</i>		<i>Agrees w/</i>
	MCD CR 03/31/14	2015 Additions	MCD CR 03/31/15
Land "A"	14,300	-	14,300
Buildings	1,663,532	-	1,663,532
Building Improvements	85,359	12,860	98,219
Non-care Assets	-	-	-
Equipment	179,760	-	179,760
	<u>1,942,951</u>	<u>12,860</u>	<u>1,955,811</u>

<u>Accum Depreciation</u>	<i>Fr prior year</i>		<i>Agrees w/</i>
	MCD CR 03/31/14	2015 MCD Depreciation	MCD CR 03/31/15
Buildings	306,390	72,975	379,365
Building Improvements	24,660	6,120	30,780
Non-care Assets	-	-	-
Equipment	77,895	17,975	95,870
	<u>408,945</u>	<u>97,070</u>	<u>506,015</u>

Facility Name & ID Number Manor Court of Princeton

0047324

Report Period Beginning: 4/1/2014

Ending: 3/31/2015

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

N/A

N/A

9. Option to Buy: YES NO Terms: _____ *

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: \$ 17565.00 Description: Wheelchairs \$8,807; Wound Vac \$8073; Misc Medical \$611; Other \$74

(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 Princeton # 0047324 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	3 Cost	Units	5 Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	5,147	\$ 370,549	\$	5,147	\$ 370,549	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,921	210,326		2,921	210,326	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		6,710	483,148		6,710	483,148	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				168,855		168,855	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)			157	11,306		157	11,306	12
13	Other (specify): <u>Oxygen</u>	39(2)					22,448		22,448	13
14	TOTAL			\$	14,935	\$ 1,075,329	\$ 191,303	14,935	\$ 1,266,632	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 Princeton# 0047324Report 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	\$ 99,787	\$ 99,787	1
2	Cash-Patient Deposits	15,266	15,266	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>563,903</u>)	1,916,609	1,932,786	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	47,539	47,539	6
7	Other Prepaid Expenses	2,320	2,320	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Receivable for Cost Report</u>	19,766	19,766	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,101,287	\$ 2,117,464	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,700	13
14	Buildings, at Historical Cost		8,318,203	14
15	Leasehold Improvements, at Historical Cost	284,781	986,053	15
16	Equipment, at Historical Cost	438,113	1,199,231	16
17	Accumulated Depreciation (book methods)	(481,246)	(2,144,346)	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>Inter-Company</u>	159,285	159,285	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 400,933	\$ 8,569,127	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,502,220	\$ 10,686,591	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 116,870	\$ 116,870	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,266	15,266	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	17,228	17,228	31
32	Accrued Real Estate Taxes(Sch.IX-B)	113,069	113,069	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Sch 17A</u>	310,107	310,107	36
37	<u>InterCompany</u>		8,193,907	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 572,539	\$ 8,766,446	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				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 572,539	\$ 8,766,446	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,929,681	\$ 1,920,145	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,502,220	\$ 10,686,591	48

*(See instructions.)

Facility Name: Manor Court of Princeton
IDPH License ID Number: 0047324
Fiscal Year End: 3/31/2015

Schedule 17A

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	After	
	Operating	Consolidation
Pass-Thru Blue Cross	43,980	43,980
Accrued Management	16,178	16,178
Utilities Payable	9,951	9,951
Security Deposit - No Interest	99,551	99,551
Accrued Employee Time	71,984	71,984
Accrued Medicaid Assessment	6	6
Provider Tax Act	68,457	68,457
Total - Line 36	310,107	310,107

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,648,113	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,648,113	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	281,567	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) Rounding	1	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 281,568	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)	\$ 1,929,681	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manor Court of Princeton# 0047324Report Period Beginning: 4/1/2014Ending: 3/31/2015

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	\$ 6,745,797	1
2	Discounts and Allowances for all Levels	(59,392)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,686,405	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	63,434	6
7	Oxygen	3,630	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 67,064	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	7,293	13
14	Non-Patient Meals	670	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	2,210,303	16
17	Sale of Drugs	5,385	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	6,790	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,230,441	23
D. Non-Operating Revenue			
24	Contributions	1,682	24
25	Interest and Other Investment Income***	12,347	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 14,029	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Sch 19A</u>	50,121	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 50,121	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,048,060	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,560,609	31
32	Health Care	2,760,491	32
33	General Administration	1,244,372	33
B. Capital Expense			
34	Ownership	1,017,513	34
C. Ancillary Expense			
35	Special Cost Centers	1,943,660	35
36	Provider Participation Fee	239,849	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,766,493	40
41	Income before Income Taxes (line 30 minus line 40)**	281,567	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 281,567	43

		3	
III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,151,664	44
45	Private Pay - Net Inpatient Revenue	2,086,956	45
46	Medicare - Net Inpatient Revenue	3,209,717	46
47	Other-(specify) <u>Medicare Replacement</u>	149,185	47
48	Other-(specify) <u>Managed Care</u>	88,883	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,686,405	49

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No^ 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 Princeton
IDPH License ID Number: 0047324
Fiscal Year End: 3/31/2015

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

<u>Description</u>	<u>Amount</u>
Link Revenue	15,934
Late Fee	8,802
Processing Fee	739
Transportation	57
Vending	6,533
Maintenance Fee Income	16,095
Miscellaneous Income	1,962
Total - Line 28	<u><u>50,121</u></u>

Facility Name & ID Number Manor Court of Princeton

0047324

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	1,824	1,998	\$ 59,381	\$ 29.72	1
2	Assistant Director of Nursing					2
3	Registered Nurses	22,388	23,911	504,236	21.09	3
4	Licensed Practical Nurses	19,387	20,425	384,029	18.80	4
5	CNAs & Orderlies	107,633	112,907	1,241,134	10.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,266	9,863	95,458	9.68	10
11	Social Service Workers	1,908	2,060	28,048	13.62	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,813	27,299	274,372	10.05	15
16	Dishwashers					16
17	Maintenance Workers	7,292	7,527	62,282	8.27	17
18	Housekeepers	13,903	14,505	156,255	10.77	18
19	Laundry	4,256	4,610	42,284	9.17	19
20	Administrator	1,318	1,486	87,860	59.13	20
21	Assistant Administrator	1,473	1,609	29,579	18.38	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,536	7,036	67,295	9.56	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,559	1,687	40,849	24.21	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,433	1,485	15,262	10.28	31
32	Other Health C: MDS/SCU Coord	1,939	2,115	46,466	21.97	32
33	Other(specify) <u>See Att 20A</u>	27,842	29,493	340,907	11.56	33
34	TOTAL (lines 1 - 33)	255,770	270,016	\$ 3,475,697 *	\$ 12.87	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	\$ 8,227	L1, C3	35
36	Medical Director	Monthly	10,170	L9, C3	36
37	Medical Records Consultant	Monthly	1,960	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,840	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)		\$ 27,197		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

Facility Name: Manor Court of Princeton
IDPH License ID Number: 0047324
Fiscal Year End: 3/31/2015

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
RFMS	Administrative Services	144,000
McGladrey & Pullen	Accounting Services	23,826
LTC	Support Services	125,461
Templin Healthcare Accounting	Accounting Services	5,944
Kathleen Dilbeck	Legal Services	40
Olivero & Olivero	Legal Services	340
Bureau County Circuit Clerk	Legal Services	40
Total (agree to Schedule V, line 19, column 3)		<u><u>299,651</u></u>
Allocated from Management Company Professional Services		7,842
Removal of SLF Services		(36,042)
Total (agree to Schedule V, line 19, column 8)		<u><u>271,451</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 Princeton# 0047324

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 6934
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes - IHCA Dues 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. \$ 28,173 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. \$ 239,849
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. \$ 670
- (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. N/A
Attach invoices and a summary of services for all architect and appraisal fees.