

		FOR BHF USE					

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0047068</u></p> <p>Facility Name: <u>Manor Court of Peoria</u></p> <p>Address: <u>6900 N Stalworth Dr</u> <u>Peoria</u> <u>61615</u> Number City Zip Code</p> <p>County: <u>Peoria</u></p> <p>Telephone Number: <u>(309) 691-2020</u> Fax # <u>(309) 683-3491</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>08/03/06</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input checked="" type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code <u>501 (c) 3</u></td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Ron Wilson</u> Telephone Number: <u>(309) 343-1550</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501 (c) 3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>4/1/2016</u> to <u>3/31/2017</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Darcee Fanning</u> (Title) <u>Regional Director</u></td> </tr> <tr> <td style="width:20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # ()</td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Darcee Fanning</u> (Title) <u>Regional Director</u>	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # ()
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SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Peoria

0047068 Report Period Beginning: 4/1/2016 Ending: 3/31/2017

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	50	Skilled (SNF)	50	18,250	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	50	TOTALS	50	18,250	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,123	9,521	4,901	15,545	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,123	9,521	4,901	15,545	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.18%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 8/22/06

J. Was the facility purchased or leased after January 1, 1978?
YES Date 8/1/06 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 50 and days of care provided 3,613

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 3/31/2017 Fiscal Year: 3/31/2017

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Peoria # 0047068 Report Period Beginning: 4/1/2016 Ending: 3/31/2017

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	138,757	18,833	5,937	163,527		163,527		163,527		1
2	Food Purchase		220,127		220,127		220,127	(200)	219,927		2
3	Housekeeping	99,392	13,229		112,621		112,621		112,621		3
4	Laundry	18,998	14,218		33,216		33,216		33,216		4
5	Heat and Other Utilities			51,231	51,231		51,231		51,231		5
6	Maintenance	64,114	28,885	43,491	136,490		136,490		136,490		6
7	Other (specify):*										7
8	TOTAL General Services	321,261	295,292	100,659	717,212		717,212	(200)	717,012		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	1,177,522	115,244	9,534	1,302,300		1,302,300		1,302,300		10
10a	Therapy										10a
11	Activities	63,999	3,288		67,287		67,287		67,287		11
12	Social Services	34,851			34,851		34,851		34,851		12
13	CNA Training										13
14	Program Transportation			5,205	5,205		5,205		5,205		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,276,372	118,532	23,739	1,418,643		1,418,643		1,418,643		16
	C. General Administration										
17	Administrative	115,760			115,760		115,760		115,760		17
18	Directors Fees							1,369	1,369		18
19	Professional Services			169,311	169,311		169,311	4,733	174,044		19
20	Dues, Fees, Subscriptions & Promotions			13,633	13,633		13,633	4	13,637		20
21	Clerical & General Office Expenses	123,413	25,398	38,263	187,074		187,074	131	187,205		21
22	Employee Benefits & Payroll Taxes			279,505	279,505		279,505		279,505		22
23	Inservice Training & Education			2,548	2,548		2,548		2,548		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			30	30		30		30		25
26	Insurance-Prop.Liab.Malpractice			35,467	35,467		35,467	8,849	44,316		26
27	Other (specify):*										27
28	TOTAL General Administration	239,173	25,398	538,757	803,328		803,328	15,086	818,414		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,836,806	439,222	663,155	2,939,183		2,939,183	14,886	2,954,069		29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number

Manor Court of Peoria

#0047068

Report Period Beginning:

4/1/2016

Ending:

3/31/3017

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			24,293	24,293		24,293	235,495	259,788			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							173,170	173,170			32
33	Real Estate Taxes							54,180	54,180			33
34	Rent-Facility & Grounds			462,000	462,000		462,000	(462,000)				34
35	Rent-Equipment & Vehicles			9,436	9,436		9,436		9,436			35
36	Other (specify):* Mort Insurance							24,458	24,458			36
37	TOTAL Ownership			495,729	495,729		495,729	25,303	521,032			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			900	900		900		900			38
39	Ancillary Service Centers		161,677	522,278	683,955		683,955		683,955			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			1,638	1,638		1,638		1,638			41
42	Provider Participation Fee			93,144	93,144		93,144		93,144			42
43	Other (specify):* Disallowed Costs	40,005		167,107	207,112		207,112	(207,112)				43
44	TOTAL Special Cost Centers	40,005	161,677	785,067	986,749		986,749	(207,112)	779,637			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,876,811	600,899	1,943,951	4,421,661		4,421,661	(166,923)	4,254,738			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	(200)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,260)	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				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	(71,939)	43		24
25	Fund Raising, Advertising and Promotional	(63,938)	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	(66,975)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (207,312)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	40,389		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 40,389		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (166,923)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' PREPARATION REPORT

Manor Court of Peoria

ID# 0047068

Report Period Beginning: 4/1/2016

Ending: 3/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Nonallowable marketing salaries	\$ (40,005)	43	1
2	Labs - Part A	(13,935)	43	2
3	X-Rays - Part A	(13,035)	43	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
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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	(66,975)		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)		Peoria Manor Court, I	Galesburg	Real Estate Entity
		Residential Alternatives of Illinois, Inc. (FH is sole mem		See Page 6 Supplemental		
		Pioneer Concepts, Inc. (FH is sole member)				
		Pinnacle Opportunities, 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	18 Director Fees	\$	Residential Alternatives of Illinois, Inc.	100.00%	\$ 1,369	\$ 1,369	1
2	V	19 Professional Services		Residential Alternatives of Illinois, Inc.	100.00%	4,733	4,733	2
3	V	20 Dues, Fees & Subscriptions		Residential Alternatives of Illinois, Inc.	100.00%	4	4	3
4	V	21 Clerical & General Office		Residential Alternatives of Illinois, Inc.	100.00%	131	131	4
5	V	26 Property Insurance		Residential Alternatives of Illinois, Inc.	100.00%	432	432	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		\$			\$ 6,669	\$ * 6,669	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	26 Insurance		Peoria Manor Court, Ltd., NFP		\$ 8,417	\$ 8,417
16	V	30 Depreciation Expense		Peoria Manor Court, Ltd., NFP		235,495	235,495
17	V	32 Interest	176	Peoria Manor Court, Ltd., NFP		158,199	158,023
18	V	32 Amortization		Peoria Manor Court, Ltd., NFP		15,147	15,147
19	V	33 Real Estate Tax		Peoria Manor Court, Ltd., NFP		54,180	54,180
20	V	34 Facility Rent	462,000	Peoria Manor Court, Ltd., NFP			(462,000)
21	V	36 Property/MIP Insurance		Peoria Manor Court, Ltd., NFP		24,458	24,458
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		\$ 462,176			\$ 495,896	\$ * 33,720

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Manor Court of Peoria

0047068

Report Period Beginning:

4/1/2016

Ending:

3/31/3017

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Manor Court of Peoria

0047068

Report Period Beginning:

4/1/2016

Ending:

3/31/3017

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				1
2	Frances House, Inc.	100%	Stern Square	Sterling, IL				2
3	Frances House, Inc.	100%	Stouffer Terrace	Oregon, IL				3
4	Frances House, Inc.	100%	Lewis Terrace	North Chicago, IL				4
5	Frances House, Inc.	100%	Seymour Terrace	North Chicago, IL				5
6	Frances House, Inc.	100%	Waukegan Terrace	Waukegan, IL				6
7	Frances House, Inc.	100%	Pine Terrace	Waukegan, IL				7
8	Pioneer Concepts, Inc.	100%	Broadway Terrace	Chicago Heights, IL	Woodgate	Matteson	CILA	8
9	Pioneer Concepts, Inc.	100%	Carole Lane Terrace	Sauk Village, IL	Thornton	Thornton	CILA	9
10	Pioneer Concepts, Inc.	100%	Flossmoor Terrace	Flossmoor, IL				10
11	Pioneer Concepts, Inc.	100%	Ravisloe Terrace	Country Club Hills, IL				11
12	Pioneer Concepts, Inc.	100%	Spaulding Terrace	Markham, IL				12
13	Pioneer Concepts, Inc.	100%	Calumet City Terrace	Calumet City, IL				13
14	Pioneer Concepts, Inc.	100%	Dolton Terrace	Dolton, IL				14
15	Pioneer Concepts, Inc.	100%	Lynwood Terrace	Lynwood, IL				15
16	Pioneer Concepts, Inc.	100%	Holland Terrace	South Holland, IL				16
17	Pioneer Concepts, Inc.	100%	Matteson Court	Matteson, IL				17
18	Pioneer Concepts, Inc.	100%	Priarie House	Sauk Village, IL				18
19	Pioneer Concepts, Inc.	100%	Torrence Place	Sauk Village, IL				19
20	Pinnacle Opportunities	100%	Chambness Square	Bourbannais, IL	Gravlin Square	Bradley, IL	CILA	20
21	Pinnacle Opportunities	100%	Collins Square	Bradley, IL				21
22	Pinnacle Opportunities	100%	Dearborn Court	Kankakee, IL				22
23	Pinnacle Opportunities	100%	River Court	Kankakee, IL				23
24	Pinnacle Opportunities	100%	Station Court	Kankakee, IL				24
25	Pinnacle Opportunities	100%	Eagle Court	Kankakee, IL				25
26	Pinnacle Opportunities	100%	Kankakee Court	Kankakee, IL				26
27	Pinnacle Opportunities	100%	Roy Court	Bourbannais, IL				27
28	Pinnacle Opportunities	100%	Hunt Terrace	Kankakee, IL				28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Manor Court of Peoria

0047068

Report Period Beginning:

4/1/2016

Ending:

3/31/3017

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	John Kniery	President & Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	\$ 242	L18, C7	1
2	Doug Biederstedt	Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	322	L18, C7	2
3	Jeff Shaw	Secretary & Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	322	L18, C7	3
4	William Kempiners	Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	322	L18, C7	4
5	Ben McMahan	President & Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	161	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	\$ 1,369		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Peoria

0047068

Report Period Beginning:

4/1/2016

Ending: 3/31/2017

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 BDA	339,815	18	\$ 25,500	\$ 18,250	\$ 1,369	1
2	19	Professional Services	Weighted Avg BDA	339,815	18	88,134	\$ 18,250	4,733	2
3	20	Dues, Fees & Subscriptions	Weighted Avg BDA	339,815	18	75	18,250	4	3
4	21	Clerical & General Office	Weighted Avg BDA	339,815	18	2,430	18,250	131	4
5	26	Property Insurance	Weighted Avg BDA	339,815	18	8,040	18,250	432	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					\$ 124,179	\$	\$ 6,669	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Manor Court of Peoria

0047068

Report Period Beginning:

4/1/2016

Ending:

3/31/3017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Cambridge Realty Capital		X	Loan Refinance	\$20,858.41	5/29/2015	\$ 4,580,100	\$ 4,421,985	1/1/2045	3.5500	\$ 158,199	1						
2	Ltd. Of Illinois - SNF											2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related				\$20,858.41		\$ 4,580,100	\$ 4,421,985			\$ 158,199	9						
B. Non-Facility Related*																		
10	Cambridge Realty Capital		X	Loan Refinance	\$28,804.47	5/29/2015	6,324,900	6,106,551	1/1/2045	3.5500	218,465	10						
11	Ltd. Of Illinois - ALC							Offset Interest Income			(176)	11						
12								Amortization			15,147	12						
13								Offset Non SNF Interest Expense			(218,465)	13						
14	TOTAL Non-Facility Related				\$28,804.47		\$ 6,324,900	\$ 6,106,551			\$ 14,971	14						
15	TOTALS (line 9+line14)						\$ 10,905,000	\$ 10,528,536			\$ 173,170	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

(See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2016 report.				\$	146,810	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.)		2015		\$	128,559	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(18,251)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	147,251	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.					(74,820)	
TOTAL REFUND	\$	For	Tax Year.		(74,820)	6
				\$	(74,820)	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	54,180	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2012	107,631	8			
	2013	113,612	9			
	2014	116,530	10			
	2015	128,559	11			
	2016	130,982	12			
This facility was leased from an unrelated for-profit entity and was purchased by a related party in December 2009. The lease agreement requires the lessee to pay the R/E taxes. Amount accrued includes 12 months of 2016 and 3 months of 2017.						
The R/E tax estimate is based on 2016 tax bill. Taxes paid are for the 2015 tax bill. The related party also pays real estate taxes for property not operated by the SNF. See Att Sch for the allocation of SNF portion.						
				FOR BHF USE ONLY		
				13	FROM R. E. TAX STATEMENT FOR 2016	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.

SEE ACCOUNTANTS' PREPARATION REPORT

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manor Court of Peoria COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0047068

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

TELEPHONE (309) 343-1550 FAX #: (309) 343-2857

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2016 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 2016.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>13-11-352-005</u>	<u>Fieldstone Estates SW 1/4 Sec 11-9N-</u>	\$ <u>125,355.28</u>	\$ <u>52,649.22</u>
2. _____	_____	\$ _____	\$ _____
3. <u>13-11-352-025</u>	<u>Fieldstone Estates Extn 1 SW 1/4 Sec</u>	\$ <u>1,406.62</u>	\$ <u>590.78</u>
4. _____	_____	\$ _____	\$ _____
5. <u>13-11-352-026</u>	<u>Fieldstone Estates Extn 1 SW 1/4 Sec</u>	\$ <u>1,406.62</u>	\$ <u>590.78</u>
6. _____	_____	\$ _____	\$ _____
7. <u>13-11-355-011</u>	<u>Fieldstone Estates Extn 1 SW 1/4 Sec</u>	\$ <u>1,406.62</u>	\$ <u>590.78</u>
8. _____	_____	\$ _____	\$ _____
9. <u>13-11-355-012</u>	<u>Fieldstone Estates Extn 1 SW 1/4 Sec</u>	\$ <u>1,406.62</u>	\$ <u>590.78</u>
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>130,981.76</u></u>	\$ <u><u>55,012.34</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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number Manor Court of Peoria

0047068

Report Period Beginning:

4/1/2016

Ending:

3/31/3017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,840 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

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

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Facility - SNF, 62,400, 2009, \$ 147,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 62,400, (blank), \$ 147,000, 3.

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	50	2009		\$ 4,869,143	\$	25	\$ 194,765	\$ 194,765	\$ 1,428,284
5									
6									
7									
8									
Improvement Type**									
9	Sign		2007	3,100	310	10	310		2,971
10	Fire Doors, Paved Parking Lot & Sidewalks		2009	232,895	220	15	15,526	15,306	113,996
11	Electromagnetic Lock		2010	8,319	832	10	832		5,615
12	Water Heater		2010	4,758	477	10	477		3,093
13	Concrete-Handycap Ramp/Sidewalk Repairs		2011	4,191	279	15	279		1,606
14	Water Heater		2013	5,248	525	10	525		2,143
15	Water Heater		2014	5,502	550	10	550		1,421
16	Water Softener		2014	8,427	843	10	843		1,966
17	Vinyl Tile installed in Dining Room		2015	5,428	543	10	543		905
18	Water Heater-Outdoor Sprinkler Room		2016	5,632	563	10	563		563
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37						\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 5,152,643	\$ 5,142		\$ 215,213	\$ 210,071	\$ 1,562,563	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 368,612	\$ 12,830	\$ 38,254	\$ 25,424	3-15 yrs	\$ 239,105	71
72	Current Year Purchases	2,790	47	47		5 yrs	47	72
73	Fully Depreciated Assets	116,646					116,646	73
74								74
75	TOTALS	\$ 488,048	\$ 12,877	\$ 38,301	\$ 25,424		\$ 355,798	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	Toyota Corolla 2006	2006	\$ 15,288	\$	\$	\$	4	\$ 15,288	76
77	Facility	Chevrolet Cheyenne 1998	2014	3,230	808	808		4	1,683	77
78	Facility	2014 Braun Entervan	2016	21,865	5,466	5,466		4	5,466	78
79										79
80	TOTALS			\$ 40,383	\$ 6,274	\$ 6,274	\$		\$ 22,437	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,828,074	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 24,293	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 259,788	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 235,495	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,940,798	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	1999 Chevy Silverado 2500 - 2012	\$ 11,559	\$	\$ 11,559	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 11,559	\$	\$ 11,559	91

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A- Facility Owned

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

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

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

N/A

N/A

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

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 9,436 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: Manor Court of Peoria
IDPH License ID Number: 0047068
Fiscal Year End: 3/31/3017

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment Rental	7,614
Office Equipment	1,473
Other Equipment Rental	349
Total - Line 16	9,436

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
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B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	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.
- SEE ACCOUNTANTS' PREPARATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	2,992	\$ 215,398	\$	2,992	\$ 215,398	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		832	59,930		832	59,930	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		3,297	237,368		3,297	237,368	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				161,677		161,677	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)			133	9,582		133	9,582	12
13	Other (specify):									13
14	TOTAL			\$	7,254	\$ 522,278	\$ 161,677	7,254	\$ 683,955	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Peoria

0047068

Report Period Beginning: 4/1/2016

Ending:

3/31/3017

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 3/31/3017

(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	\$ 4,687	\$ 240,907	1
2	Cash-Patient Deposits	7,552	7,552	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 49,000)	572,218	572,218	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(5,122)	(3,086)	6
7	Other Prepaid Expenses	4,806	6,192	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interdivision Receivable</u>	2,939,974	2,054,430	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,524,115	\$ 2,878,213	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		147,000	13
14	Buildings, at Historical Cost	53,880	4,923,023	14
15	Leasehold Improvements, at Historical Cost		229,620	15
16	Equipment, at Historical Cost	285,753	528,431	16
17	Accumulated Depreciation (book methods)	(225,385)	(1,940,798)	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):	115,526	115,526	22
23	Other(specify): <u>See Att Sch 17A</u>		638,485	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 229,774	\$ 4,641,287	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,753,889	\$ 7,519,500	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 89	\$ 89	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,552	7,552	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	28,404	28,404	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,599	14,599	31
32	Accrued Real Estate Taxes(Sch.IX-B)		61,846	32
33	Accrued Interest Payable		12,801	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 50,644	\$ 125,291	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,528,536	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Security Deposits</u>	52,500	52,500	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 52,500	\$ 10,581,036	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 103,144	\$ 10,706,327	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,650,745	\$ (3,186,827)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,753,889	\$ 7,519,500	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Facility Name: Manor Court of Peoria
IDPH License ID Number: 0047068
Fiscal Year End: 3/31/3017

Schedule 17A

XV. Balance Sheet

Line 22 Long Term Assets Other (specify):

Description	Operating	After Consolidation
Real Estate Tax Escrow		91,941
Insurance Escrow		4,725
MIP Insurance Escrow		17,637
Reserve for Replacement		211,317
Capitalized Loan Fee		339,502
Amortization Loan Fee		(26,637)
Total - Line 36	-	638,485

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,647,313	1
2	Restatements (describe):		2
3	<u>Rounding</u>	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,647,312	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,433	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)	\$ 3,433	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)	\$ 3,650,745	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,381,664	1
2	Discounts and Allowances for all Levels	(33,131)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,348,533	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	71,445	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 71,445	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	(200)	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	400	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	3,427	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,627	23
D. Non-Operating Revenue			
24	Contributions	275	24
25	Interest and Other Investment Income***	374	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 649	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Income</u>	840	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 840	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,425,094	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	717,212	31
32	Health Care	1,418,643	32
33	General Administration	803,328	33
B. Capital Expense			
34	Ownership	495,729	34
C. Ancillary Expense			
35	Special Cost Centers	893,605	35
36	Provider Participation Fee	93,144	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,421,661	40
41	Income before Income Taxes (line 30 minus line 40)**	3,433	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 3,433	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 165,677	44
45	Private Pay - Net Inpatient Revenue	2,100,139	45
46	Medicare - Net Inpatient Revenue	1,611,365	46
47	Other-(specify) <u>Medicare Replacement</u>	89,851	47
48	Other-(specify) <u>Managed Care</u>	381,501	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,348,533	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Peoria

0047068

Report Period Beginning:

4/1/2016

Ending:

3/31/2017

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,061	2,189	\$ 68,988	\$ 31.52	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,971	12,830	313,887	24.46	3
4	Licensed Practical Nurses	10,491	10,848	245,221	22.61	4
5	CNAs & Orderlies	43,217	45,006	532,151	11.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,685	5,905	63,999	10.84	10
11	Social Service Workers	2,107	2,191	34,851	15.91	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	9,018	9,158	138,757	15.15	15
16	Dishwashers					16
17	Maintenance Workers	3,934	4,202	64,114	15.26	17
18	Housekeepers	9,041	9,413	99,392	10.56	18
19	Laundry	1,624	1,748	18,998	10.87	19
20	Administrator	1,928	2,080	115,760	55.65	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,504	8,107	123,413	15.22	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,423	1,479	17,275	11.68	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	1,912	2,080	40,005	19.23	33
34	TOTAL (lines 1 - 33)	111,914	117,234	\$ 1,876,811 *	\$ 16.01	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	\$ 5,937	L1, C3	35
36	Medical Director	Monthly	9,000	L9, C3	36
37	Medical Records Consultant	Monthly	2,000	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,288	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)		\$ 20,225		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	80	1,229	L10, C3	52
53	TOTAL (lines 50 - 52)	80	\$ 1,229		53

SEE ACCOUNTANTS' PREPARATION REPORT

