

Facility Name & ID Number Manor Court of Peru

0047316 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

	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	104	Skilled (SNF)	104	37,960	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	26	Sheltered Care (SC)	26	9,490	5
6		ICF/DD 16 or Less			6
7	130	TOTALS	130	47,450	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	8,094	13,413	13,033	34,540	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		7,088		7,088	12
13	DD 16 OR LESS					13
14	TOTALS	8,094	20,501	13,033	41,628	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.73%

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 02/08/05

J. Was the facility purchased or leased after January 1, 1978?
YES Date 01/01/05 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 114 and days of care provided 11,090

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 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 Peru # 0047316 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	403,620	52,688	14,823	471,131		471,131		471,131		1
2	Food Purchase		420,229		420,229		420,229	(308)	419,921		2
3	Housekeeping	277,020	30,608		307,628		307,628		307,628		3
4	Laundry	38,187	26,198		64,385		64,385		64,385		4
5	Heat and Other Utilities			141,427	141,427		141,427		141,427		5
6	Maintenance	64,990	29,921	36,930	131,841		131,841		131,841		6
7	Other (specify):*										7
8	TOTAL General Services	783,817	559,644	193,180	1,536,641		1,536,641	(308)	1,536,333		8
	B. Health Care and Programs										
9	Medical Director			22,000	22,000		22,000		22,000		9
10	Nursing and Medical Records	2,978,816	289,792	19,278	3,287,886		3,287,886		3,287,886		10
10a	Therapy										10a
11	Activities	128,196	1,641		129,837		129,837		129,837		11
12	Social Services	87,023			87,023		87,023		87,023		12
13	CNA Training										13
14	Program Transportation			3,227	3,227		3,227		3,227		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,194,035	291,433	44,505	3,529,973		3,529,973		3,529,973		16
	C. General Administration										
17	Administrative	61,007			61,007		61,007		61,007		17
18	Directors Fees							3,205	3,205		18
19	Professional Services			344,137	344,137		344,137	11,076	355,213		19
20	Dues, Fees, Subscriptions & Promotions			19,513	19,513		19,513	9	19,522		20
21	Clerical & General Office Expenses	138,233	37,139	85,138	260,510		260,510	306	260,816		21
22	Employee Benefits & Payroll Taxes			568,777	568,777		568,777		568,777		22
23	Inservice Training & Education			2,444	2,444		2,444		2,444		23
24	Travel and Seminar			171	171		171		171		24
25	Other Admin. Staff Transportation			216	216		216		216		25
26	Insurance-Prop.Liab.Malpractice			53,220	53,220		53,220	14,543	67,763		26
27	Other (specify):*										27
28	TOTAL General Administration	199,240	37,139	1,073,616	1,309,995		1,309,995	29,139	1,339,134		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,177,092	888,216	1,311,301	6,376,609		6,376,609	28,831	6,405,440		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.

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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			64,989	64,989		64,989	646,378	711,367			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53	53		53	521,652	521,705			32
33	Real Estate Taxes							138,163	138,163			33
34	Rent-Facility & Grounds			985,800	985,800		985,800	(985,800)				34
35	Rent-Equipment & Vehicles			15,324	15,324		15,324		15,324			35
36	Other (specify):* MIP Insurance							71,741	71,741			36
37	TOTAL Ownership			1,066,166	1,066,166		1,066,166	392,134	1,458,300			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		367,611	1,620,536	1,988,147		1,988,147		1,988,147			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			2,976	2,976		2,976	(2,976)				41
42	Provider Participation Fee			191,460	191,460		191,460		191,460			42
43	Other (specify):* Disallowed Costs	49,784		241,069	290,853		290,853	(290,853)				43
44	TOTAL Special Cost Centers	49,784	367,611	2,056,041	2,473,436		2,473,436	(293,829)	2,179,607			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,226,876	1,255,827	4,433,508	9,916,211		9,916,211	127,136	10,043,347			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	(308)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,866)	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	(53)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(157,040)	43		24
25	Fund Raising, Advertising and Promotional	(28,458)	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	(106,465)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (294,190)		\$	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)	421,326		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 421,326		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 127,136		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

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Nonallowable marketing salaries	\$ (49,784)	43	1
2	Labs - Part A	(37,696)	43	2
3	X-Rays - Part A	(16,009)	43	3
4	Offset Vending Machine revenue	(2,976)	41	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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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	(106,465)		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)		Peru Becker, Ltd., NFI	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%	\$ 3,205	\$ 3,205	1
2	V	19 Professional Services		Residential Alternatives of Illinois, Inc.	100.00%	11,076	11,076	2
3	V	20 Dues, Fees & Subscriptions		Residential Alternatives of Illinois, Inc.	100.00%	9	9	3
4	V	21 Clerical & General Office		Residential Alternatives of Illinois, Inc.	100.00%	306	306	4
5	V	26 Property Insurance		Residential Alternatives of Illinois, Inc.	100.00%	1,010	1,010	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		\$			\$ 15,606	\$ * 15,606	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		Peru Becker, Ltd., NFP	0.00%	\$ 13,533	\$ 13,533
16	V	30 Depreciation Expense		Peru Becker, Ltd., NFP	0.00%	646,378	646,378
17	V	32 Interest	371	Peru Becker, Ltd., NFP	0.00%	494,833	494,462
18	V	32 Amortization		Peru Becker, Ltd., NFP	0.00%	27,243	27,243
19	V	33 Real Estate Tax		Peru Becker, Ltd., NFP	0.00%	138,163	138,163
20	V	34 Facility Rent	985,800	Peru Becker, Ltd., NFP	0.00%		(985,800)
21	V	36 Property/MIP Insurance		Peru Becker, Ltd., NFP	0.00%	71,741	71,741
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		\$ 986,171			\$ 1,391,891	\$ * 405,720

* 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				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

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VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Frances House, Inc.	100%	Smith Square	Moline, IL				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

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VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	John Kniery	President & Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	\$ 566	L18, C7	1
2	Doug Biederstedt	Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	754	L18, C7	2
3	Jeff Shaw	Secretary & Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	754	L18, C7	3
4	William Kempiners	Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	754	L18, C7	4
5	Ben McMahan	President & Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	377	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	\$ 3,205		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

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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	\$ 42,705	\$ 3,205	1
2	19	Professional Services	Weighted Avg BDA	339,815	18	88,134	\$ 42,705	11,076	2
3	20	Dues, Fees & Subscriptions	Weighted Avg BDA	339,815	18	75	42,705	9	3
4	21	Clerical & General Office	Weighted Avg BDA	339,815	18	2,430	42,705	306	4
5	26	Property Insurance	Weighted Avg BDA	339,815	18	8,040	42,705	1,010	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	\$	\$ 15,606	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Manor Court of Peru

0047316

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	2	3	4	5	6	7	8	9	10											
										Name of Lender	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	Refinance - w/ trade premium			\$	\$		\$	1									
2	Ltd. Of Illinois - SNF			of \$517,374 as of 3/31/17	\$63,289.78	6/1/2013	13,860,000	13,440,711	5/1/2043	3.8000	494,833									
3											3									
4											4									
5											5									
Working Capital																				
6											6									
7											7									
8							Miscellaneous Interest				53									
9	TOTAL Facility Related				\$63,289.78		\$ 13,860,000	\$ 13,440,711			\$ 494,886									
B. Non-Facility Related*																				
10	Cambridge Realty Capital						5,940,000	5,538,573	5/1/2043	3.8000	212,071									
11	Ltd. Of Illinois - Non SNF							Offset Interest Income			(424)									
12								Amortization			27,243									
13								Offset Non SNF Interest Expense			(212,071)									
14	TOTAL Non-Facility Related						\$ 5,940,000	\$ 5,538,573			\$ 26,819									
15	TOTALS (line 9+line14)						\$ 19,800,000	\$ 18,979,284			\$ 521,705									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 71,741 Line # 36

* 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.			\$	205,913	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		\$	164,672	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(41,241)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	238,618	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.		Adjust out SLF portion of expense		(59,214)	
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	(59,214)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	138,163	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2012	54,897		8	
	2013	55,482		9	
	2014	43,087		10	
	2015	164,672		11	
	2016	190,843		12	
This facility was leased from an unrelated for-profit entity and was purchased by a related party in July 2009.					
Amount accrued includes 12 months of 2016 and 3 months of 2017. The real estate tax estimate is					
based on the 2015 tax bills. Taxes paid are for the 2015 tax bill. The related party also pays real estate taxes					
for property not operated by the SNF.					
				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 Peru COUNTY La Salle

FACILITY IDPH LICENSE NUMBER 0047316

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>17-09-139-001</u>	<u>Liberty Village Second Add Lot 7</u>	\$ <u>110,753.64</u>	\$ <u>77,527.55</u>
2. _____	_____	\$ _____	\$ _____
3. <u>17-09-124-003</u>	<u>Liberty Lane Village Subd Lot 1, 3</u>	\$ <u>1,968.20</u>	\$ <u>1,377.74</u>
4. _____	_____	\$ _____	\$ _____
5. <u>17-09-124-004</u>	<u>Liberty Lane Village Subd Lot 1, 2</u>	\$ <u>78,121.56</u>	\$ <u>54,685.09</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>190,843.40</u></u>	\$ <u><u>133,590.38</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 Peru

0047316 Report Period Beginning:

4/1/2016 Ending:

3/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,166 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: _____
 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.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility - SNF</u>	<u>3.42 acres</u>	<u>2009</u>	<u>\$ 350,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	#VALUE!		\$ 350,000	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	130	2009		\$ 13,641,000	\$	25	\$ 545,670	\$ 545,670	\$ 4,228,963
5									
6									
7									
8									
Improvement Type**									
9	Electric Sign and Water Heater		2005	7,758		10			7,758
10	Roof		2006	5,050	252	10	252		5,050
11	Sprinkler System, Asphalt Ramp, Paved parking lot & sidewalks		2009	1,060,899	1,208	8-15 yrs	71,208	70,000	551,639
12	Call Light System in Therapy		2010	4,877	488	10	488		3,496
13	Wander Security Panel		2012	3,140	314	10	314		1,413
14	Vinyl Tile/Wallpaper/Paint in Dining Room		2013	11,511	1,151	10	1,151		4,604
15	Water Heater		2013	8,877	887	10	887		3,477
16	Air Conditioner		2013	3,150	315	10	315		1,234
17	Mag Lock/Electromagnetic Lock		2013	2,998	300	10	300		1,149
18	Water Softener - Entire SNF Facility		2014	6,540	654	10	654		2,071
19	Fire Alarm - Manor Court Building		2014	6,830	683	10	683		1,764
20	Water Heater - Services Resident Rooms		2015	3,197	320	10	320		719
21	Single Faced Lighted Sign - Outside of SNF Building		2014	3,345	335	10	335		948
22	New PTAC units - Resident Rooms		2015	3,522	704	5	704		1,115
23	New Nurse Call System		2015	108,573	10,857	10	10,857		17,367
24	New Water Heater		2015	5,502	550	10	550		917
25	Amber Message Sign		2015	12,675	1,268	10	1,268		1,901
26	New Water Heater		2016	5,631	563	10	563		704
27	Hot Water Heater - Laundry Room/Hallway		2016	10,041	502	10	502		502
28	Cubicle Workstations - PT Treatment Rooms		2016	3,552	271	12	271		271
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

Facility Name & ID Number Manor Court of Peru

0047316

Report Period Beginning:

4/1/2016

Ending:

3/31/3017

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)		\$ 14,918,668	\$ 21,622		\$ 637,292	\$ 615,670	\$ 4,837,062	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	\$ 637,177	\$ 36,098	\$ 66,806	\$ 30,708	3-15 yrs	\$ 426,409	71
72	Current Year Purchases	32,616	3,674	3,674		3-7 yrs	3,674	72
73	Fully Depreciated Assets	120,440					120,440	73
74								74
75	TOTALS	\$ 790,233	\$ 39,772	\$ 70,480	\$ 30,708		\$ 550,523	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	2003 GMC Van	2005	\$ 29,800	\$	\$	\$	4	\$ 29,800	76
77	Patient Care	2003 Chevy Silverado	2013	14,380	3,595	3,595		4	11,989	77
78										78
79										79
80	TOTALS			\$ 44,180	\$ 3,595	\$ 3,595	\$		\$ 41,789	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)	\$ 16,103,081	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 64,989	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 711,367	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 646,378	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,429,374	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	2010 Toyota Corolla - 2010	\$ 16,300	\$	\$ 16,300	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 16,300	\$	\$ 16,300	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$ 175	92
93			93
94			94
95		\$ 175	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: \$ 15,324 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 Peru
IDPH License ID Number: 0047316
Fiscal Year End: 3/31/3017

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment Rental	13,975
Office Equipment	851
Other Equipment Rental	498
Total - Line 16	15,324

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	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	\$	8,690	\$ 625,661	\$	8,690	\$ 625,661	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,419	102,182		1,419	102,182	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		11,711	843,211		11,711	843,211	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				367,611		367,611	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)			687	49,482		687	49,482	12
13	Other (specify):									13
14	TOTAL			\$	22,507	\$ 1,620,536	\$ 367,611	22,507	\$ 1,988,147	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 Peru**
XV. BALANCE SHEET - Unrestricted Operating Fund.

0047316
 As of **3/31/3017**

Report Period Beginning: **4/1/2016**
 (last day of reporting year)

Ending: **3/31/3017**

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	\$ 12,784	\$ 37,328	1
2	Cash-Patient Deposits	21,955	21,955	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>174,000</u>)	1,382,180	1,470,668	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	25,297	43,143	6
7	Other Prepaid Expenses	660	2,743	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interdivision Receivable</u>	12,656,312	10,570,478	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 14,099,188	\$ 12,146,315	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		350,000	13
14	Buildings, at Historical Cost	224,146	14,918,668	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	546,435	834,413	16
17	Accumulated Depreciation (book methods)	(436,248)	(5,429,374)	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 (spe CIP)	175	175	22
23	Other(specify): <u>See Att Sch 17A</u>		1,756,838	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 334,508	\$ 12,430,720	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 14,433,696	\$ 24,577,035	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 291,777	\$ 291,777	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,955	21,955	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	107,367	107,367	30
31	Accrued Taxes Payable (excluding real estate taxes)	85,506	85,506	31
32	Accrued Real Estate Taxes(Sch.IX-B)		238,618	32
33	Accrued Interest Payable		40,059	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)	\$ 506,605	\$ 785,282	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		18,979,284	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Security Deposits</u>	43,500	43,500	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 43,500	\$ 19,022,784	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 550,105	\$ 19,808,066	46
47	TOTAL EQUITY(page 18, line 24)	\$ 13,883,591	\$ 4,768,969	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 14,433,696	\$ 24,577,035	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Facility Name: Manor Court of Peru
IDPH License ID Number: 0047316
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		127,174
Insurance Escrow		6,300
MIP Insurance Escrow		65,434
Reserve for Replacement		481,669
Capitalized Loan Fee		1,309,348
Amortization Loan Fee		(233,087)
Total - Line 36	-	1,756,838

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 12,228,671	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 12,228,671	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,654,920	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)	\$ 1,654,920	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)	\$ 13,883,591	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	\$ 11,167,552	1
2	Discounts and Allowances for all Levels	(103,507)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,064,045	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	477,690	6
7	Oxygen	5,249	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 482,939	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	6,591	12
13	Barber and Beauty Care	8,112	13
14	Non-Patient Meals	308	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	7,718	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 22,729	23
D. Non-Operating Revenue			
24	Contributions	1,115	24
25	Interest and Other Investment Income***	303	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,418	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,571,131	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,536,641	31
32	Health Care	3,529,973	32
33	General Administration	1,309,995	33
B. Capital Expense			
34	Ownership	1,066,166	34
C. Ancillary Expense			
35	Special Cost Centers	2,281,976	35
36	Provider Participation Fee	191,460	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,916,211	40
41	Income before Income Taxes (line 30 minus line 40)**	1,654,920	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,654,920	43

		3	
III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,126,323	44
45	Private Pay - Net Inpatient Revenue	3,823,114	45
46	Medicare - Net Inpatient Revenue	5,290,659	46
47	Other-(specify) <u>Medicare Replacement</u>	190,774	47
48	Other-(specify) <u>Managed Care</u>	633,175	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,064,045	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 Peru

0047316

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	1,711	1,847	\$ 51,784	\$ 28.03	1
2	Assistant Director of Nursing	1,784	2,011	56,572	28.13	2
3	Registered Nurses	34,040	36,369	962,450	26.46	3
4	Licensed Practical Nurses	21,787	23,220	543,208	23.39	4
5	CNAs & Orderlies	99,467	105,951	1,320,115	12.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,954	10,887	128,196	11.78	10
11	Social Service Workers	4,392	4,716	87,023	18.45	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	34,654	34,654	403,620	11.65	15
16	Dishwashers					16
17	Maintenance Workers	5,491	5,924	64,990	10.97	17
18	Housekeepers	24,456	25,658	277,020	10.80	18
19	Laundry	3,462	3,754	38,187	10.17	19
20	Administrator	2,136	2,240	61,007	27.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,521	8,996	138,233	15.37	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	3,890	4,088	44,687	10.93	31
32	Other Health C: <u>MDS Coord</u>					32
33	Other(specify) <u>Marketing</u>	1,872	2,080	49,784	23.93	33
34	TOTAL (lines 1 - 33)	257,615	272,393	\$ 4,226,876 *	\$ 15.52	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	\$ 14,823	L1, C3	35
36	Medical Director	Monthly	22,000	L9, C3	36
37	Medical Records Consultant	Monthly	2,080	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,221	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)		\$ 49,124		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Tiffany Green	Administrator	None	\$ 6,077	Workers' Compensation Insurance	\$ 69,605	IDPH License Fee	\$	
Lorrie Lieske	Administrator	None	54,930	Unemployment Compensation Insurance	17,608	Advertising: Employee Recruitment	3,745	
				FICA Taxes	288,942	Health Care Worker Background Check (Indicate # of checks performed 56)	1,400	
				Employee Health Insurance	162,634	Patient Background Checks	297	
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*				
				401k	22,527	Subscriptions	845	
				Other Employee Benefits	7,461	IHCA Dues	8,151	
						Other Licenses & Fees	2,402	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 61,007			Indirect costs	9	
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount			Non-allowable advertising	()	
N/A			\$			Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 568,777	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 19,522	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
RFMS, Inc.	Administrative Services		\$ 144,000	N/A			Out-of-State Travel	\$
LTC Support Services, LLC	Support Services		161,184					
McGladrey LLP	Accounting Services		30,728				In-State Travel	
Templin Healthcare Accounting	Accounting Services		4,380					
Polsinelli	Legal Services		3,845				Seminar Expense	171
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 344,137	TOTAL		\$	Entertainment Expense (agree to Sch. V, line 24, col. 8)	()
							TOTAL	\$ 171

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name & ID Number Manor Court of Peru

0047316

Report Period Beginning: 4/1/2016

Ending: 3/31/3017

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. 8,151 IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 3-7 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 82,778 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 191,460
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. \$ 308
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% line 14
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: RSM US LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' PREPARATION REPORT