		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.

I. IDPH License ID Number: 0043281

Facility Name: Matteson Court

Address: 237 Central Avenue (Number) Matteson (City) 60443 (Zip Code)

County: Cook

Telephone Number: (709) 720-4933 **Fax #** (709) 720-4934

HFS ID Number:

Date of Initial License for Current Owners: 05/15/95

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501 (c) 3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 4/1/2016 to 3/31/3017 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	Lisa Winnett
	(Title)	Director of Operations
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	Larry Templin Partner
	(Firm Name & Address)	Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525
	(Telephone)	(630) 361-2868 Fax # ( )

In the event there are further questions about this report, please contact:
Name: Ron Wilson Telephone Number: (309) 343-1550
Email Address:

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Matteson Court # 0043281 Report Period Beginning: 4/1/2016 Ending: 3/31/3017

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,539			5,539	13
14	TOTALS	5,539			5,539	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.85%

D. How many bed reserve days during this year were paid by the Department?
46 (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 [X] 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 [X]

I. On what date did you start providing long term care at this location?
Date started 05/15/95

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/31/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] 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 Matteson Court # 0043281 Report Period Beginning: 4/1/2016 Ending: 3/31/3017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	37,257	3,020	1,091	41,368		41,368		41,368			1
2	Food Purchase		48,425		48,425		48,425		48,425			2
3	Housekeeping	20,499	7,171	1	27,671		27,671		27,671			3
4	Laundry		3,901		3,901		3,901		3,901			4
5	Heat and Other Utilities			14,008	14,008		14,008		14,008			5
6	Maintenance	12,726	5,845	16,520	35,091		35,091		35,091			6
7	Other (specify):*											7
8	**TOTAL General Services**	70,482	68,362	31,620	170,464		170,464		170,464			8
	B. Health Care and Programs											
9	Medical Director			1,950	1,950		1,950		1,950			9
10	Nursing and Medical Records	174,429	7,191	13,162	194,782		194,782		194,782			10
10a	Therapy			375	375		375		375			10a
11	Activities		2,974	891	3,865		3,865		3,865			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation			6,793	6,793		6,793		6,793			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	174,429	10,165	23,171	207,765		207,765		207,765			16
	C. General Administration											
17	Administrative	24,433			24,433		24,433		24,433			17
18	Directors Fees											18
19	Professional Services			76,331	76,331		76,331	914	77,245			19
20	Dues, Fees, Subscriptions & Promotions			2,553	2,553		2,553	10	2,563			20
21	Clerical & General Office Expenses	18,489	4,007	6,266	28,762		28,762	13	28,775			21
22	Employee Benefits & Payroll Taxes			46,338	46,338		46,338	1	46,339			22
23	Inservice Training & Education			3,327	3,327		3,327		3,327			23
24	Travel and Seminar			275	275		275		275			24
25	Other Admin. Staff Transportation			2,911	2,911		2,911		2,911			25
26	Insurance-Prop.Liab.Malpractice			4,683	4,683		4,683		4,683			26
27	Other (specify):*											27
28	**TOTAL General Administration**	42,922	4,007	142,684	189,613		189,613	938	190,551			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	287,833	82,534	197,475	567,842		567,842	938	568,780			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 Matteson Court #0043281 Report Period Beginning: 4/1/2016 Ending: 3/31/3017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			36,836	36,836		36,836		36,836			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			460	460		460		460			35
36	Other (specify):*											36
37	TOTAL Ownership			37,296	37,296		37,296		37,296			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			46,110	46,110		46,110		46,110			42
43	Other (specify):* Disallowed Costs			95	95		95	(95)				43
44	TOTAL Special Cost Centers			46,205	46,205		46,205	(95)	46,110			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	287,833	82,534	280,976	651,343		651,343	843	652,186			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

Facility Name & ID Number Matteson Court # 0043281 Report Period Beginning: 4/1/2016 Ending: 3/31/3017

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				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				24
25	Fund Raising, Advertising and Promotional	(95)	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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (95)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 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)	938		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 938		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 843		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 Yes	2 No	3 Amount	4 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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Matteson Court

ID# 0043281

Report Period Beginning: 4/1/2016

Ending: 3/31/3017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Matteson Court # 0043281 Report Period Beginning: 4/1/2016 Ending: 3/31/3017

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	914	0	0	0	0	0	0	0	0	0	914	19
20	Fees, Subscriptions & Promotions	0	10	0	0	0	0	0	0	0	0	0	10	20
21	Clerical & General Office Expenses	0	13	0	0	0	0	0	0	0	0	0	13	21
22	Employee Benefits & Payroll Taxes	0	1	0	0	0	0	0	0	0	0	0	1	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	938	0	0	0	0	0	0	0	0	0	938	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	938	0	0	0	0	0	0	0	0	0	938	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Matteson Court # 0043281 Report Period Beginning: 4/1/2016 Ending: 3/31/3017

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(95)	0	0	0	0	0	0	0	0	0	0	(95)	43
44	**TOTAL Special Cost Centers**	(95)	0	0	0	0	0	0	0	0	0	0	(95)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(95)	938	0	0	0	0	0	0	0	0	0	843	45

Facility Name & ID Number Matteson Court # 0043281 Report Period Beginning: 4/1/2016 Ending: 3/31/3017

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
Frances House, Inc.	100	Frances House, Inc. (FH)		See Page 6 Supplemental		
		Pioneer Concepts, Inc. (FH is sole member)				
		Pinnacle Opportunities, Inc. (FH is sole member)				
		Residential Alternatives of Illinois, 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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	20	Dues, Fees & Subscriptions	$	Frances House, Inc.	100.00%	$ 7	$ 7	1
2	V	21	Clerical & General Office Exp		Frances House, Inc.	100.00%	7	7	2
3	V	22	Employee Benefits		Frances House, Inc.	100.00%	1	1	3
4	V	19	Professional Services		Frances House, Inc. - Pioneer Concepts Facilities	100.00%	914	914	4
5	V	20	Dues, Fees & Subscriptions		Frances House, Inc. - Pioneer Concepts Facilities	100.00%	3	3	5
6	V	21	Clerical & General Office Exp		Frances House, Inc. - Pioneer Concepts Facilities	100.00%	6	6	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 938	$ * 938	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Matteson Court # 0043281 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 Free	Freeport, IL	Supportive Living F	7
8	Residential Alternatives of Illinois	100%			Hawthorne Inn of Peo	Peoria, IL	Assisted Living Faci	8
9	Residential Alternatives of Illinois	100%			Hawthorne Inn of Peru	Peru, IL	Assisted Living Faci	9
10	Residential Alternatives of Illinois	100%			Liberty Estates of Gen	Geneseo, IL	Asst'd & Ind Living	10
11	Residential Alternatives of Illinois	100%			Liberty Estates of Stre	Streator, IL	Asst'd & Ind Living	11
12	Residential Alternatives of Illinois	100%			Liberty Estates of Dan	Danville, IL	Indendent Living Fa	12
13	Residential Alternatives of Illinois	100%			Liberty Estates of Free	Freeport, IL	Indendent Living Fa	13
14	Residential Alternatives of Illinois	100%			Liberty Estates of Peo	Peoria, IL	Indendent Living Fa	14
15	Residential Alternatives of Illinois	100%			Liberty Estates of Peru	Peru, IL	Indendent Living Fa	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 Matteson Court # 0043281 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 Matteson Court # 0043281 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	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	See Attached Schedule 7A								$ 0	L18, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		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 Matteson Court # 0043281 Report Period Beginning: 4/1/2016 Ending: 3/31/3017

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	20	Dues, Fees & Subscriptions	Bed Days Available	5,916	33	$ 207	$	192	$ 7	1
2	21	Clerical & General Office Exp	Bed Days Available	5,916	33	211	$	192	7	2
3	22	Employee Benefits	Bed Days Available	5,916	33	26		192	1	3
4	19	Professional Services	Bed Days Avail-PIO only	1,692	10	8,053		192	914	4
5	20	Dues, Fees & Subscriptions	Bed Days Avail-PIO only	1,692	10	25		192	3	5
6	21	Clerical & General Office Exp	Bed Days Avail-PIO only	1,692	10	56		192	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					$ 8,578	$		$ 938	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Matteson Court # 0043281 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							$	$			$	1
2	N/A											2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

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

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.)

Facility Name & ID Number Matteson Court # 0043281 Report Period Beginning: 4/1/2016 Ending: 3/31/3017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	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. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	N/A	8
	2013	N/A	9
	2014	N/A	10
	2015	N/A	11
	2016	N/A	12

The facility is owned by a non-profit organization. Real estate taxes are not assessed due to the tax exempt status of the facility. Therefore, no accrual for real estate tax is required.

	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 Matteson Court COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0043281

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE ( ) _____ FAX #: ( ) _____

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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? _____ 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 Matteson Court # 0043281 Report Period Beginning: 4/1/2016 Ending: 3/31/3017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,680 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: 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	Facility		1997	$ 116,188	1
2					2
3	TOTALS			$ 116,188	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Matteson Court # 0043281 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1997	1994	$ 544,726	$ 21,789	25	$ 21,789	$	$ 437,597	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Parking lot/Sidewalks/Landscaping			1994	19,800		15			19,800	9
10	Patio/Sidewalk/Carpet/Congoleum/Upgrades & Painting			2002	28,476		5-10 yrs			28,476	10
11	Congoleum vet			2007	7,665	703	10	703		7,665	11
12	Sprinkler Heads			2009	4,898	196	25	196		1,551	12
13	Roof Repairs			2009	17,135	1,713	10	1,713		13,422	13
14	Metal Doors/Frames			2009	3,925	196	20	196		1,488	14
15	Air Conditioning Unit			2010	2,900		5			2,900	15
16	Bathroom #1 - Vanity/Shower/Floor Tile/Drywall/Paint/Vent/Light/Toilet/			2011	12,709	1,059	12	1,059		6,090	16
17	Bathroom #2 - Vanity/Shower/Floor Tile/Drywall/Paint/Vent/Light/Toilet/			2011	12,409	1,034	12	1,034		5,773	17
18	Bathroom #3 - Vanity/Shower/Floor Tile/Drywall/Paint/Vent/Light/Toilet/			2011	13,984	1,165	12	1,165		6,312	18
19	Bathroom #4 - Vanity/Shower/Floor Tile/Drywall/Paint/Vent/Light/Toilet/			2011	13,759	1,147	12	1,147		6,211	19
20	Dining Room/Kitchen/Bedroom-Contracted amoun			2011	35,714	2,976	12	2,976		16,617	20
21	Hallway/3 Closets - Drywall/Prime and Paint			2011	3,886	324	12	324		1,754	21
22	New Furnace			2013	2,999	300	10	300		1,050	22
23	AC Coil			2015	2,975	297	10	297		421	23
24	Concrete Sidewalk			2016	2,765	108	15	108		108	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*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 Matteson Court # 0043281 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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)		$ 730,725	$ 33,007		$ 33,007	$	$ 557,235	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Matteson Court # 0043281 Report Period Beginning: 4/1/2016 Ending: 3/31/3017

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	$ 56,645	$ 3,829	$ 3,829	$	3-15 yrs	$ 29,475	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 56,645	$ 3,829	$ 3,829	$		$ 29,475	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	2002 Ford E350 Van	2002	$ 22,551	$	$	$	4	$ 22,551	76
77										77
78										78
79										79
80	TOTALS			$ 22,551	$	$	$		$ 22,551	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)	$ 926,109	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 36,836	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 36,836	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 609,261	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	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Matteson Court # 0043281 Report Period Beginning: 4/1/2016 Ending: 3/31/3017

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

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 *

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 460 Description: Miscellaneous
(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	N/A				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 & ID Number Matteson Court # 0043281 Report Period Beginning: 4/1/2016 Ending: 3/31/3017

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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

Facility Name & ID Number Matteson Court # 0043281 Report Period Beginning: 4/1/2016 Ending: 3/31/3017

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	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 Matteson Court # 0043281 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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,317,860	$ 1,317,860	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 9,950)	88,144	88,144	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,956	5,956	6
7	Other Prepaid Expenses	607	607	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interdivision Receivable	2,850,956	2,850,956	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,263,523	$ 4,263,523	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	116,188	116,188	13
14	Buildings, at Historical Cost	730,725	730,725	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	79,196	79,196	16
17	Accumulated Depreciation (book methods)	(609,151)	(609,261)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Unreal Gain (Loss) on Invest.	(29,267)	(29,267)	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 287,691	$ 287,581	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,551,214	$ 4,551,104	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 14,525	$ 14,525	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	15,122	15,122	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,970	1,970	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Liabilities	193	193	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 31,810	$ 31,810	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 31,810	$ 31,810	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,519,404	$ 4,519,294	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,551,214	$ 4,551,104	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Facility Name & ID Number Matteson Court # 0043281 Report Period Beginning: 4/1/2016 Ending: 3/31/3017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,329,130	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,329,130	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	190,274	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)**	$ 190,274	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)**	$ 4,519,404	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Matteson Court # 0043281 Report Period Beginning: 4/1/2016 Ending: 3/31/3017

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 841,617	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 841,617	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	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)**	$ 841,617	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	170,464	31
32	Health Care	207,765	32
33	General Administration	189,613	33
	B. Capital Expense		
34	Ownership	37,296	34
	C. Ancillary Expense		
35	Special Cost Centers	95	35
36	Provider Participation Fee	46,110	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 651,343	40
41	**Income before Income Taxes (line 30 minus line 40)****	190,274	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 190,274	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 841,617	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 841,617	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 Matteson Court # 0043281 Report Period Beginning: 4/1/2016 Ending: 3/31/3017

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
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	442	457	12,200	26.70	4
5	CNAs & Orderlies	11,183	12,192	136,604	11.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	3,000	3,000	37,257	12.42	15
16	Dishwashers					16
17	Maintenance Workers	886	910	12,726	13.98	17
18	Housekeepers	2,187	2,267	20,499	9.04	18
19	Laundry					19
20	Administrator	615	627	20,372	32.49	20
21	Assistant Administrator	216	242	4,061	16.78	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,185	1,286	18,489	14.38	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,616	1,739	25,625	14.74	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	21,330	22,720	$ 287,833 *	$ 12.67	34

SEE ACCOUNTANTS' PREPARATION REPORT

* 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	$ 1,091	L1, C3	35
36	Medical Director	Monthly	1,950	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,155	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) Dental	Monthly	4,038	L10, C3	46
47	Psychological Consultant	Monthly	6,969	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)		$ 16,203		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

Facility Name & ID Number Matteson Court # 0043281 Report Period Beginning: 4/1/2016 Ending: 3/31/3017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Juanita Boykins	Administrator	None	$ 7,291
Mercedes Vaughn	Administrator	None	6,937
Olukemi Akinbusuyi	Administrator	None	6,144
Juanita McFadden	Asst Administrator	None	4,061
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 24,433

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
RFMS, Inc.	Administrative Services	$ 33,990
LTC Support Services, LLC	Support Services	27,684
McGladrey LLP	Accounting Services	3,582
Templin Healthcare Accounting	Accounting Services	1,001
Polsinelli	Legal Services	5,294
Michigan Peer Review Org	Legal Services	540
Federal Insurance Company	Legal Services	4,240
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 76,331

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 3,858
Unemployment Compensation Insurance	7,543
FICA Taxes	26,566
Employee Health Insurance	4,027
Employee Meals	1,387
Illinois Municipal Retirement Fund (IMRF)*	
401k	2,040
Other Employee Benefits	917
Indirect costs	1
TOTAL (agree to Schedule V, line 22, col.8)	$ 46,339

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	561
Health Care Worker Background Check	
(Indicate # of checks performed 30)	300
Patient Background Checks	
Subscriptions	740
IHCA Dues	873
Other Licenses & Fees	79
Indirect costs	10
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,563

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	275
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 275

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number **Matteson Court** **#** **0043281** **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. **873** **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?

(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? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,892** 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. $ **46,110**
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.

SEE ACCOUNTANTS' PREPARATION REPORT

(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. $ **1,387** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **RSM US LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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