

		FOR BHF USE					

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**2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)**

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

<p>I. IDPH License ID Number: <u>0047316</u></p> <p>Facility Name: <u>Manor Court of Peru</u></p> <p>Address: <u>3230 Becker Drive</u> <u>Peru</u> <u>61354</u> <small>Number City Zip Code</small></p> <p>County: <u>La Salle</u></p> <p>Telephone Number: <u>(815) 220-1440</u> Fax # <u>None</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>08/19/05</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501 (c) 3</u> </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Ron Wilson</u> Telephone Number: <u>(309) 343-1550</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501 (c) 3</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>04/01/2010</u> to <u>03/31/2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Darcee Fanning</u> (Title) <u>Regional Director</u></td> </tr> <tr> <td style="width:20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) <u>See Attached Independent Accountant's Report</u> (Print Name and Title) <u>McGladrey & Pullen, LLP</u> <u>117 E. Main Street, Suite 210</u> (Firm Name & Address) <u>P.O. Box 1070</u> <u>Galesburg, IL 61401</u> (Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</u></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Darcee Fanning</u> (Title) <u>Regional Director</u>	Paid Preparer	(Signed) <u>See Attached Independent Accountant's Report</u> (Print Name and Title) <u>McGladrey & Pullen, LLP</u> <u>117 E. Main Street, Suite 210</u> (Firm Name & Address) <u>P.O. Box 1070</u> <u>Galesburg, IL 61401</u> (Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</u>
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Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Darcee Fanning</u> (Title) <u>Regional Director</u>							
Paid Preparer	(Signed) <u>See Attached Independent Accountant's Report</u> (Print Name and Title) <u>McGladrey & Pullen, LLP</u> <u>117 E. Main Street, Suite 210</u> (Firm Name & Address) <u>P.O. Box 1070</u> <u>Galesburg, IL 61401</u> (Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</u>							

Facility Name & ID Number Manor Court of Peru

0047316 Report Period Beginning: 04/01/2010 Ending: 03/31/2011

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	85	Skilled (SNF)	85	31,025	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	45	Sheltered Care (SC)	45	16,425	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 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	7,853	6,873	11,354	26,080	8
9	SNF/PED					9
10	ICF		0			10
11	ICF/DD					11
12	SC		14,422		14,422	12
13	DD 16 OR LESS					13
14	TOTALS	7,853	21,295	11,354	40,502	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.36%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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 85 and days of care provided 11,052

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 03/31/2011 Fiscal Year: 03/31/2011

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

Facility Name & ID Number Manor Court of Peru # 0047316 Report Period Beginning: 04/01/2010 Ending: 03/31/2011

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	263,078	19,811	6,984	289,873		289,873		289,873		1
2	Food Purchase		427,125		427,125		427,125	(120)	427,005		2
3	Housekeeping	150,512	26,135		176,647		176,647		176,647		3
4	Laundry	52,159	18,295		70,454		70,454		70,454		4
5	Heat and Other Utilities			122,172	122,172		122,172		122,172		5
6	Maintenance	49,711	27,851	24,967	102,529		102,529		102,529		6
7	Other (specify):*										7
8	TOTAL General Services	515,460	519,217	154,123	1,188,800		1,188,800	(120)	1,188,680		8
	B. Health Care and Programs										
9	Medical Director			13,750	13,750		13,750		13,750		9
10	Nursing and Medical Records	2,476,259	423,369	8,202	2,907,830		2,907,830		2,907,830		10
10a	Therapy			744,490	744,490		744,490		744,490		10a
11	Activities	109,358	959		110,317		110,317		110,317		11
12	Social Services	48,343			48,343		48,343		48,343		12
13	CNA Training			1,326	1,326		1,326		1,326		13
14	Program Transportation			113	113	2,748	2,861		2,861		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,633,960	424,328	767,881	3,826,169	2,748	3,828,917		3,828,917		16
	C. General Administration										
17	Administrative	109,351			109,351		109,351		109,351		17
18	Directors Fees							3,475	3,475		18
19	Professional Services			255,112	255,112		255,112	4,190	259,302		19
20	Dues, Fees, Subscriptions & Promotions			56,174	56,174		56,174	(44,810)	11,364		20
21	Clerical & General Office Expenses	95,311	39,697	33,318	168,326		168,326		168,326		21
22	Employee Benefits & Payroll Taxes			511,545	511,545		511,545		511,545		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,425	1,425		1,425		1,425		24
25	Other Admin. Staff Transportation			5,495	5,495	(2,748)	2,747		2,747		25
26	Insurance-Prop.Liab.Malpractice			61,350	61,350		61,350	109,932	171,282		26
27	Other (specify):* See Att Sch V	33,647		134,387	168,034		168,034	(168,034)			27
28	TOTAL General Administration	238,309	39,697	1,058,806	1,336,812	(2,748)	1,334,064	(95,247)	1,238,817		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,387,729	983,242	1,980,810	6,351,781		6,351,781	(95,367)	6,256,414		29

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

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

Facility Name & ID Number

Manor Court of Peru

#0047316

Report Period Beginning:

04/01/2010

Ending:

03/31/2011

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			38,443	38,443		38,443	635,865	674,308			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,243	2,243		2,243	725,892	728,135			32
33	Real Estate Taxes							90,392	90,392			33
34	Rent-Facility & Grounds			972,276	972,276		972,276	(972,276)				34
35	Rent-Equipment & Vehicles			9,239	9,239		9,239		9,239			35
36	Other (specify):* Loan Fee Amort							10,036	10,036			36
37	TOTAL Ownership			1,022,201	1,022,201		1,022,201	489,909	1,512,110			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			6,493	6,493		6,493		6,493			41
42	Provider Participation Fee			46,538	46,538		46,538		46,538			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			53,031	53,031		53,031		53,031			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,387,729	983,242	3,056,042	7,427,013		7,427,013	394,542	7,821,555			45

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

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	(120)	V-2		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		V-30		9
10	Interest and Other Investment Income	(279)	V-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		V-21		18
19	Entertainment				19
20	Contributions	(285)	V-27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(132,490)	V-27		24
25	Fund Raising, Advertising and Promotional	(44,816)	V-20		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 Att Sch VI	(37,976)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (215,966)		\$	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)	601,301		34
35	Other- Attach Schedule See Att Sch III	9,207		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 610,508		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 394,542		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.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY

48		49		50		51		52	
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Manor Court of Peru

ID# 0047316

Report Period Beginning: 04/01/2010

Ending: 03/31/2011

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

Facility Name & ID Number Manor Court of Peru# 0047316

Report Period Beginning:

04/01/2010 Ending:

Summary B

03/31/2011

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

	Capital Expense	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)	
	D. Ownership													
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	601,301	0	0	0	0	0	0	0	0	0	601,301	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	601,301	0	0	0	0	0	0	0	0	0	601,301	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	0	601,301	0	0	0	0	0	0	0	0	0	601,301	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Residential Alternatives of Illinois, Inc. (Non-profit Organization)	100	Frances House, Inc. (FH)				
		Residential Alternatives of Illinois, Inc. (FH is sole member)		See Attached Schedule I		
		Residential Alternatives of Iowa				
		Pioneer Concepts, Inc. (FH is sole member)				
		Pinnacle Opportunities, Inc. (FH is sole member)				
		Concepts Plus, Inc. (FH is sole member)				
		See Attached Schedule I 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	34 Facility Rent	\$ 972,276	Peru Becker, Ltd., NFP	N/A	\$ 1,573,577	\$ 601,301	1
2	V							2
3	V			LTC Support Services, LLC				3
4	V			See Attached Independent Accountant's Report				4
5	V							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		\$ 972,276			\$ 1,573,577	\$ * 601,301	14

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

Facility Name & ID Number

Manor Court of Peru

0047316

Report Period Beginning:

04/01/2010

Ending:

03/31/2011

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	See Attached Schedule III								\$ 3,475	18-7	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	\$ 3,475		13

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

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

Facility Name & ID Number Manor Court of Peru

0047316 Report Period Beginning: 04/01/2010

Ending: 3/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	See Attached Schedule II & III				\$	\$		\$ 9,207	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	TOTALS				\$	\$		\$ 9,207	25

Facility Name & ID Number

Manor Court of Peru

0047316

Report Period Beginning:

04/01/2010

Ending:

03/31/2011

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		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						\$	\$			\$	1								
2	Ltd. Of Illinois - SNF		X	Facility Purchase	\$72,624.00	7/1/2009	13,860,000	13,634,399	8/1/2044	5.3000	726,171	2								
3												3								
4												4								
5												5								
	Working Capital																			
6	Home office allocation adj	X		See Attached Sch III								6								
7	Less Interest Income		X	from page 5, line 10							(279)	7								
8	Miscellaneous		X								2,243	8								
9	TOTAL Facility Related				\$72,624.00		\$ 13,860,000	\$ 13,634,399			\$ 728,135	9								
	B. Non-Facility Related*																			
10	Cambridge Realty Capital											10								
11	Ltd. Of Illinois - Non SNF		X	Facility Purchase	\$31,124.00	7/1/2009	5,940,000	5,843,314	8/1/2044	5.3000	311,216	11								
12												12								
13												13								
14	TOTAL Non-Facility Related				\$31,124.00		\$ 5,940,000	\$ 5,843,314			\$ 311,216	14								
15	TOTALS (line 9+line14)						\$ 19,800,000	\$ 19,477,713			\$ 1,039,351	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 99,978 Line # 26

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																						
1. Real Estate Tax accrual used on 2010 report.		\$	54,863		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.)		\$	45,189		2																			
3. Under or (over) accrual (line 2 minus line 1).		\$	(9,674)		3																			
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	138,806		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.		\$	129,132		7																			
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:	2006	<u>20,751</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="3" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2010</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2010	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR BHF USE ONLY																								
13	FROM R. E. TAX STATEMENT FOR 2010	\$	13																					
14	PLUS APPEAL COST FROM LINE 5	\$	14																					
15	LESS REFUND FROM LINE 6	\$	15																					
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																					
	2007	<u>22,710</u>	9																					
	2008	<u>21,109</u>	10																					
	2009	<u>33,641</u>	11																					
	2010	<u>45,530</u>	12																					
<p>The facility was rented from an unrelated for-profit third party and was purchased by a related party in July 2009. Amount of accrued real estate tax includes 12 months of 2010 and 3 months of 2011. The real estate tax estimate is based on the 2010 bills. The related party also pays real estate taxes for property not operated by the SNF. See Attached Schedule XIII for allocation of assisted living portions.</p>																								

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.

Facility Name & ID Number Manor Court of Peru

0047316

Report Period Beginning:

04/01/2010 Ending:

03/31/2011

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: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility - SNF</u>	<u>3.42 acres</u>	<u>2009</u>	<u>\$ 350,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	#VALUE!		\$ 350,000	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	130	2009		\$ 13,641,000	\$ 537,874	25	\$ 537,874	\$	\$ 941,280
5									
6									
7									
8									
	Improvement Type**								
9	Electric Sign and Water Heater		2005	7,758	777	10	777		4,550
10	Roof		2006	5,050	505	10	505		2,273
11	Sprinkler System		2009	2,645	176	15	176		367
12	Asphalt Ramp		2009	8,254	1,032	8	1,032		1,548
13	Paved parking lot & sidewalks		2009	1,050,000	70,000	15	70,000		122,500
14	Call Light System in Therapy		2010	4,877	487	10	487		568
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

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)	\$ 14,719,584	\$ 610,851		\$ 610,851	\$	\$ 1,073,086	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 639,996	\$ 62,163	\$ 62,163	\$	3-15 yrs	\$ 194,825	71
72	Current Year Purchases	18,997	1,294	1,294		5-15 yrs	1,294	72
73	Fully Depreciated Assets							73
74	Indirect Costs							74
75	TOTALS	\$ 658,993	\$ 63,457	\$ 63,457	\$		\$ 196,119	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 yrs	\$ 29,800	76
77	Snow Removal	1990 Ford F250 Snow Plow	2005	5,800				4 yrs	5,800	77
78										78
79										79
80	TOTALS			\$ 35,600	\$	\$	\$		\$ 35,600	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)	\$ 15,764,177	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 674,308	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 674,308	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)	\$ 1,304,805	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	Building ALC - 2009	\$ 5,847,200	\$ 241,654	\$ 422,894	86
87	Equipment ALC - 2009	204,000	20,472	35,826	87
88	Land ALC - 2009	150,000			88
89	Land Imp ALC - 2009	450,000	30,000	52,500	89
90	2010 Toyota Corolla - 2010	16,300	2,717	2,717	90
91	TOTALS	\$ 6,667,500	\$ 294,843	\$ 513,937	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.

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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 N/A
by the length of the lease N/A.

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 9,239 Description: See Attached Schedule XII

(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					18
19					19
20					20
21	TOTAL		\$	\$	21

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. _____ \$ _____

13. _____ \$ _____

14. _____ \$ _____

* 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.

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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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 prescripts							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.

Facility Name & ID Number Manor Court of Peru# 0047316Report Period Beginning: 04/01/2010Ending: 03/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 03/31/2011

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 62,667	\$ 220,580	1
2	Cash-Patient Deposits	8,975	8,975	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	453,793	453,793	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	44,605	87,245	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Att Sch X</u>	4,133,099	4,233,624	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,703,139	\$ 5,004,217	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		500,000	13
14	Buildings, at Historical Cost		19,488,200	14
15	Leasehold Improvements, at Historical Cost	28,584	1,528,584	15
16	Equipment, at Historical Cost	403,093	914,893	16
17	Accumulated Depreciation (book methods)	(190,003)	(1,818,742)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Att Sch X</u>		749,682	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 241,674	\$ 21,362,617	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,944,813	\$ 26,366,834	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 90,666	\$ 90,666	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,975	8,975	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	113,645	113,645	31
32	Accrued Real Estate Taxes(Sch.IX-B)		138,806	32
33	Accrued Interest Payable		86,027	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Interdivision Payable</u>		3,122,266	36
37	<u>Current Maturity of Mortgage Note</u>		217,902	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 213,286	\$ 3,778,287	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		19,259,811	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44	<u>Security Deposits</u>	77,966	77,966	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 77,966	\$ 19,337,777	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 291,252	\$ 23,116,064	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,653,561	\$ 3,250,770	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,944,813	\$ 26,366,834	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,573,492	1
2	Restatements (describe):		2
3	To adjust accrued real estate taxes	(55,064)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,518,428	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,135,133	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)	\$ 1,135,133	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)	\$ 4,653,561	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manor Court of Peru

0047316

Report Period Beginning: 04/01/2010

Ending: 03/31/2011

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,492,764	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,492,764	3
B. Ancillary Revenue			
4	Day Care	29,890	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	6,992	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 36,882	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	5,929	12
13	Barber and Beauty Care	9,557	13
14	Non-Patient Meals	120	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,356	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	770	19
20	Radiology and X-Ray	105	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 18,837	23
D. Non-Operating Revenue			
24	Contributions	2,045	24
25	Interest and Other Investment Income***	279	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,324	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund Income		28
28a	See Att Sch VII	11,339	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,339	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,562,146	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,188,800	31
32	Health Care	3,826,169	32
33	General Administration	1,336,812	33
B. Capital Expense			
34	Ownership	1,022,201	34
C. Ancillary Expense			
35	Special Cost Centers	6,493	35
36	Provider Participation Fee	46,538	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,427,013	40
41	Income before Income Taxes (line 30 minus line 40)**	1,135,133	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,135,133	43

* 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.

Facility Name & ID Number **Manor Court of Peru**

0047316

Report Period Beginning: **04/01/2010**

Ending:

03/31/2011

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	1,908	2,051	\$ 61,541	\$ 30.01	1
2	Assistant Director of Nursing	1,721	1,851	51,599	27.88	2
3	Registered Nurses	16,525	17,769	440,306	24.78	3
4	Licensed Practical Nurses	19,717	21,212	466,869	22.01	4
5	CNAs & Orderlies	101,062	108,668	1,301,847	11.98	5
6	CNA Trainees					6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides			0		8
9	Activity Director			0		9
10	Activity Assistants	9,913	10,659	109,358	10.26	10
11	Social Service Workers	3,535	3,801	48,343	12.72	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,237	27,136	263,078	9.69	15
16	Dishwashers					16
17	Maintenance Workers	3,242	3,486	49,711	14.26	17
18	Housekeepers	15,906	17,104	150,512	8.80	18
19	Laundry	5,880	6,322	52,159	8.25	19
20	Administrator	1,759	1,891	72,725	38.46	20
21	Assistant Administrator	1,934	2,080	36,626	17.61	21
22	Other Administrative	1,896	2,039	33,647	16.50	22
23	Office Manager					23
24	Clerical	7,201	7,743	95,311	12.31	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator			0		29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,575	1,693	17,697	10.45	31
32	Other Health Care(specify)	4,763	5,122	136,400	26.63	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	223,774	240,627	\$ 3,387,729 *	\$ 14.08	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	***	\$ 6,984	1-3	35
36	Medical Director	***	13,750	9-3	36
37	Medical Records Consultant	***	920	10-3	37
38	Nurse Consultant	***	0	10-3	38
39	Pharmacist Consultant	***	7,282	10-3	39
40	Physical Therapy Consultant	***	368,403	10a-3	40
41	Occupational Therapy Consultant	***	295,457	10a-3	41
42	Respiratory Therapy Consultant	***	0	10a-3	42
43	Speech Therapy Consultant	***	68,599	10a-3	43
44	Activity Consultant	***	0	11-3	44
45	Social Service Consultant	***	0	12-3	45
46	Other(specify) <u>Dental Consultant</u>	***	0	10-3	46
47					47
48	<u>*** Monthly fee</u>				48
49	TOTAL (lines 35 - 48)		\$ 761,395		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function				Description	Amount	Description	Amount		
Darcee Fanning	Administrator	None	\$ 35,241	Workers' Compensation Insurance	\$ 131,965	IDPH License Fee	\$			
LisaFunsinn	Administrator	None	37,484	Unemployment Compensation Insurance	14,714	Advertising: Employee Recruitment		3,666		
Angela Taylor	Asst. Admin	None	36,626	FICA Taxes	220,795	Health Care Worker Background Check				
				Employee Health Insurance	122,585	(Indicate # of checks performed <u>351</u>)		3,516		
				Employee Meals		Patient Background Checks				
				Illinois Municipal Retirement Fund (IMRF)*		Advertising - Promo & Yellow pages		44,816		
				401(k)	19,380	Subscriptions		829		
				Other Employee Benefits	2,106	IHCA Dues		3,197		
						Other Licenses and Fees		150		
						Indirect Costs - See Att Sch III		6		
						Less: Public Relations Expense	(
						Non-allowable advertising		(44,816)		
						Yellow page advertising	(
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 109,351	TOTAL (agree to Schedule V, line 22, col.8)			\$ 511,545	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 11,364
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description	Amount		
			\$			\$	Out-of-State Travel	\$		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL			\$	TOTAL		
(Attach a copy of any management service agreement)										
C. Professional Services										
Vendor/Payee	Type		Amount							
RFMS, Inc.	Administrative Services		\$ 144,000							
LTC Support Services, LLC	Support Services		96,720							
McGladrey & Pullen, LLP	Accounting Services		8,640							
My Innerview	Management Services		580							
American Healthcare	Healthcare Services		5,172							
TOTAL (agree to Schedule V, line 19, column 3)			\$ 255,112							
(If total legal fees exceed \$5,000, attach copy of invoices.)										

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Manor Court of Peru# 0047316Report Period Beginning: 04/01/2010 Ending: 03/31/2011**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. See Page 21 Section F
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 25,396 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 46,538
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. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 120
- (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: McGladrey & Pullen, LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.