

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: <u>0047068</u> Facility Name: <u>Manor Court of Peoria</u> Address: <u>6900 N Stalworth Dr</u> <u>Peoria</u> <u>61615</u> Number City Zip Code County: <u>Peoria</u> Telephone Number: <u>(309) 691-2020</u> Fax # <u>(309) 683-3491</u> HFS ID Number: _____ Date of Initial License for Current Owners: <u>08/03/06</u> Type of Ownership: <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> 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: _____	<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 _____	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER <p style="text-align: center;"> I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>4/1/2015</u> to <u>3/31/2016</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 style="text-align: center;"> Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. </p> <table style="width: 100%; border: none;"> <tr> <td style="width: 15%; border: none; vertical-align: top;">Officer or Administrator of Provider</td> <td style="border: none;"> (Signed) _____ (Date) _____ (Type or Print Name) <u>Darcee Fanning</u> (Title) <u>Regional Director</u> </td> </tr> <tr> <td style="border: none; vertical-align: top;">Paid Preparer</td> <td style="border: none;"> (Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # () _____ </td> </tr> </table> <p style="text-align: center; font-weight: bold;">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) _____ (Date) _____ (Type or Print Name) <u>Darcee Fanning</u> (Title) <u>Regional Director</u>	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # () _____
<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 _____						
Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>Darcee Fanning</u> (Title) <u>Regional Director</u>							
Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # () _____							

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Peoria

0047068 Report Period Beginning: 4/1/2015 Ending: 3/31/2016

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	50	Skilled (SNF)	50	18,300	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	50	TOTALS	50	18,300	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,399	10,033	4,926	16,358	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,399	10,033	4,926	16,358	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.39%

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 Non-allowable costs have been eliminated in Schedule V, Column 7

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 50 and days of care provided 3,771

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 3/31/2016 Fiscal Year: 3/31/2016

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Peoria # 0047068 Report Period Beginning: 4/1/2015 Ending: 3/31/2016

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	147,364	8,234	6,130	161,728		161,728		161,728		1
2	Food Purchase		172,930		172,930		172,930	(982)	171,948		2
3	Housekeeping	94,086	14,135		108,221		108,221		108,221		3
4	Laundry	17,400	12,808		30,208		30,208		30,208		4
5	Heat and Other Utilities			49,305	49,305		49,305		49,305		5
6	Maintenance	66,012	26,319	50,797	143,128		143,128		143,128		6
7	Other (specify):*										7
8	TOTAL General Services	324,862	234,426	106,232	665,520		665,520	(982)	664,538		8
	B. Health Care and Programs										
9	Medical Director			9,750	9,750		9,750		9,750		9
10	Nursing and Medical Records	1,230,930	113,613	7,315	1,351,858		1,351,858		1,351,858		10
10a	Therapy			502,823	502,823		502,823		502,823		10a
11	Activities	60,200	4,262		64,462		64,462		64,462		11
12	Social Services	25,829			25,829		25,829		25,829		12
13	CNA Training										13
14	Program Transportation			7,926	7,926		7,926		7,926		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,316,959	117,875	527,814	1,962,648		1,962,648		1,962,648		16
	C. General Administration										
17	Administrative	146,100			146,100		146,100		146,100		17
18	Directors Fees							1,452	1,452		18
19	Professional Services			169,823	169,823		169,823	3,249	173,072		19
20	Dues, Fees, Subscriptions & Promotions			8,613	8,613		8,613	4	8,617		20
21	Clerical & General Office Expenses	104,545	24,721	28,150	157,416		157,416		157,416		21
22	Employee Benefits & Payroll Taxes			287,495	287,495		287,495	40	287,535		22
23	Inservice Training & Education			1,168	1,168		1,168		1,168		23
24	Travel and Seminar			479	479		479	2	481		24
25	Other Admin. Staff Transportation			398	398		398		398		25
26	Insurance-Prop.Liab.Malpractice			37,092	37,092		37,092	9,617	46,709		26
27	Other (specify):*										27
28	TOTAL General Administration	250,645	24,721	533,218	808,584		808,584	14,364	822,948		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,892,466	377,022	1,167,264	3,436,752		3,436,752	13,382	3,450,134		29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number

Manor Court of Peoria

#0047068

Report Period Beginning:

4/1/2015

Ending:

3/31/2016

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			24,568	24,568		24,568	233,328	257,896			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			495	495		495	183,345	183,840			32
33	Real Estate Taxes							49,644	49,644			33
34	Rent-Facility & Grounds			446,600	446,600		446,600	(446,600)				34
35	Rent-Equipment & Vehicles			8,742	8,742		8,742		8,742			35
36	Other (specify):* MIP							40,597	40,597			36
37	TOTAL Ownership			480,405	480,405		480,405	60,314	540,719			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,890	1,890		1,890		1,890			38
39	Ancillary Service Centers		160,388		160,388		160,388		160,388			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			1,933	1,933		1,933		1,933			41
42	Provider Participation Fee			98,502	98,502		98,502		98,502			42
43	Other (specify):* Disallowed Costs	39,534		74,843	114,377		114,377	(114,377)				43
44	TOTAL Special Cost Centers	39,534	160,388	177,168	377,090		377,090	(114,377)	262,713			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,932,000	537,410	1,824,837	4,294,247		4,294,247	(40,681)	4,253,566			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(468)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,260)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,167)	30		9
10	Interest and Other Investment Income	(75)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(8,395)	43		24
25	Fund Raising, Advertising and Promotional	(37,983)	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	(64,253)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (117,601)		\$	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)	76,920		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 76,920		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (40,681)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' PREPARATION REPORT

Manor Court of Peoria

ID# 0047068

Report Period Beginning: 4/1/2015

Ending: 3/31/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs - Part A	\$ (12,853)	43	1
2	X-Rays - Part A	(10,788)	43	2
3	Disallow Donation Expense	(564)	43	3
4	Marketing Salaries	(39,534)	43	4
5	Offset Vending Machine Revenue	(514)	2	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	(64,253)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manor Court of Peoria# 0047068

Report Period Beginning:

4/1/2015

Ending:

3/31/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(982)	0	0	0	0	0	0	0	0	0	0	(982)	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	(982)	0	0	0	0	0	0	0	0	0	0	(982)	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	1,452	0	0	0	0	0	0	0	0	0	1,452	18
19	Professional Services	0	3,249	0	0	0	0	0	0	0	0	0	3,249	19
20	Fees, Subscriptions & Promotions	0	4	0	0	0	0	0	0	0	0	0	4	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	40	0	0	0	0	0	0	0	0	0	40	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2	0	0	0	0	0	0	0	0	0	2	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	697	8,920	0	0	0	0	0	0	0	0	9,617	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	5,444	8,920	0	0	0	0	0	0	0	0	14,364	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(982)	5,444	8,920	0	0	0	0	0	0	0	0	13,382	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manor Court of Peoria# 0047068

Report Period Beginning:

4/1/2015

Ending:

3/31/2016

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(2,167)	0	235,495	0	0	0	0	0	0	0	0	233,328	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(75)	0	183,420	0	0	0	0	0	0	0	0	183,345	32
33	Real Estate Taxes	0	0	49,644	0	0	0	0	0	0	0	0	49,644	33
34	Rent-Facility & Grounds	0	0	(446,600)	0	0	0	0	0	0	0	0	(446,600)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	40,597	0	0	0	0	0	0	0	0	40,597	36
37	TOTAL Ownership	(2,242)	0	62,556	0	0	0	0	0	0	0	0	60,314	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):*	(114,377)	0	0	0	0	0	0	0	0	0	0	(114,377)	43
44	TOTAL Special Cost Centers	(114,377)	0	0	0	0	0	0	0	0	0	0	(114,377)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(117,601)	5,444	71,476	0	0	0	0	0	0	0	0	(40,681)	45

Facility Name & ID Number

Manor Court of Peoria

0047068

Report Period Beginning:

4/1/2015

Ending:

3/31/2016

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Residential Alternatives of Illinois, Inc. (Non-profit Organization)	100	Frances House, Inc. (FH)		Peoria Manor Court, I	Galesburg	Real Estate Entity
		Residential Alternatives of Illinois, Inc. (FH is sole mem		See Page 6 Supplemental		
		Pioneer Concepts, Inc. (FH is sole member)				
		Pinnacle Opportunities, Inc. (FH is sole member)				
		See Page 6 Supplemental for specific homes				

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	18 Director Fees	\$	Residential Alternatives of Illinois, Inc.	100.00%	\$ 1,452	\$ 1,452	1	
2	V	19 Professional Services		Residential Alternatives of Illinois, Inc.	100.00%	3,249	3,249	2	
3	V	20 Dues, Fees & Subscriptions		Residential Alternatives of Illinois, Inc.	100.00%	4	4	3	
4	V	22 Employee Benefits & PR Taxes		Residential Alternatives of Illinois, Inc.	100.00%	40	40	4	
5	V	24 Travel and Seminar		Residential Alternatives of Illinois, Inc.	100.00%	2	2	5	
6	V	26 Property Insurance		Residential Alternatives of Illinois, Inc.	100.00%	697	697	6	
7	V							7	
8	V							8	
9	V							9	
10	V							10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$			\$ 5,444	\$ *	5,444	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	26 Insurance		Peoria Manor Court, Ltd., NFP		8,920	\$ 8,920
16	V	30 Depreciation Expense		Peoria Manor Court, Ltd., NFP		235,495	235,495
17	V	32 Interest	163	Peoria Manor Court, Ltd., NFP		171,483	171,320
18	V	32 Amortization		Peoria Manor Court, Ltd., NFP		12,100	12,100
19	V	33 Real Estate Tax		Peoria Manor Court, Ltd., NFP		49,644	49,644
20	V	34 Facility Rent	446,600	Peoria Manor Court, Ltd., NFP			(446,600)
21	V	36 Property/MIP Insurance		Peoria Manor Court, Ltd., NFP		40,597	40,597
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 446,763			\$ 518,239	\$ * 71,476

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Manor Court of Peoria

0047068

Report Period Beginning:

4/1/2015

Ending:

3/31/2016

VII. RELATED PARTIES

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Manor Court of Peoria

0047068

Report Period Beginning:

4/1/2015

Ending:

3/31/2016

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				8
9	Pioneer Concepts, Inc.	100%	Carole Lane Terrace	Sauk Village, IL				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				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%	Gravlin Square-CILA	Bradley, IL				28
29	Pinnacle Opportunities	100%	Hunt Terrace	Kankakee, IL				29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Manor Court of Peoria

0047068

Report Period Beginning:

4/1/2015

Ending:

3/31/2016

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Irwin Jann	President & Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	\$ 78	L18, C7	1
2	Doug Biederstedt	Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	311	L18, C7	2
3	Jeff Shaw	Secretary & Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	311	L18, C7	3
4	William Kempiners	Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	311	L18, C7	4
5	John Kniery	Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	311	L18, C7	5
6											6
7											7
8											8
9	No board members provide services or have business entities that provide services to the facility.										9
10											10
11											11
12											12
13								TOTAL	\$ 1,322		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Peoria

0047068

Report Period Beginning:

4/1/2015

Ending: 3/31/2016

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	18	Director Fees	Weighted Avg BDA 353,445	18	\$ 28,040	\$	18,300	\$ 1,452	1
2	19	Professional Services	Weighted Avg BDA 353,445	18	62,749		18,300	3,249	2
3	20	Dues, Fees & Subscriptions	Weighted Avg BDA 353,445	18	75		18,300	4	3
4	22	Employee Benefits & PR Taxes	Weighted Avg BDA 353,445	18	773		18,300	40	4
5	24	Travel and Seminar	Weighted Avg BDA 353,445	18	47		18,300	2	5
6	26	Property Insurance	Weighted Avg BDA 353,445	18	13,455		18,300	697	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				\$ 105,139	\$		\$ 5,444	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Manor Court of Peoria

0047068

Report Period Beginning:

4/1/2015

Ending:

3/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Cambridge Realty Capital		X	Facility Purchase	\$22,950.00	12/1/2009	\$ 4,605,300	\$	1/1/2045	4.9000	\$ 36,968	1						
2	Ltd. Of Illinois - SNF			Laon Refinance	\$20,858.41	5/29/2015	4,580,100	4,513,535	1/1/2045	3.5500	134,515	2						
3												3						
4												4						
5												5						
Working Capital																		
6	Finance Charges		X								495	6						
7												7						
8								Offset Interest Income			(238)	8						
9	TOTAL Facility Related				\$43,808.41		\$ 9,185,400	\$ 4,513,535			\$ 171,740	9						
B. Non-Facility Related*																		
10	Cambridge Realty Capital		X	Facility Purchase	\$31,692.00	12/1/2009	6,359,700		1/1/2045	4.9000	51,052	10						
11	Ltd. Of Illinois - ALC			Loan Refinance	\$28,804.47	5/29/2015	6,324,900	6,232,978	1/1/2045	3.5500	185,757	11						
12								Amortization			12,100	12						
13								Offset Non SNF Interest Expense			(236,809)	13						
14	TOTAL Non-Facility Related				\$60,496.47		\$ 12,684,600	\$ 6,232,978			\$ 12,100	14						
15	TOTALS (line 9+line14)						\$ 21,870,000	\$ 10,746,513			\$ 183,840	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 40,597 Line # 36

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

(See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2015 report.		\$	147,737	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.)	2014	\$	116,530	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(31,207)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	146,810	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.			(68,556)	
			2,597	
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(65,959)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	49,644	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2011	109,111	8
	2012	107,631	9
	2013	113,612	10
	2014	116,530	11
	2015	128,559	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2015	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

This facility was leased from an unrelated for-profit entity and was purchased by a related party in December 2009. The lease agreement requires the lessee to pay the R/E taxes. Amount accrued includes 12 months of 2015 and 3 months of 2016. The R/E tax estimate is based on 2014 tax bill. Taxes paid are for the 2014 tax bill. The related party also pays real estate taxes for property not operated by the SNF. See Att Sch for the allocation of SNF portion.

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manor Court of Peoria COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0047068

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>13-11-352-005</u>	<u>Fieldstone Estates SW 1/4 Sec 11-9N-</u>	\$ <u>123,138.28</u>	\$ <u>51,718.00</u>
2. _____	_____	\$ _____	\$ _____
3. <u>13-11-352-025</u>	<u>Fieldstone Estates Extn 1 SW 1/4 Sec</u>	\$ <u>1,355.20</u>	\$ <u>569.18</u>
4. _____	_____	\$ _____	\$ _____
5. <u>13-11-352-026</u>	<u>Fieldstone Estates Extn 1 SW 1/4 Sec</u>	\$ <u>1,355.20</u>	\$ <u>569.18</u>
6. _____	_____	\$ _____	\$ _____
7. <u>13-11-355-011</u>	<u>Fieldstone Estates Extn 1 SW 1/4 Sec</u>	\$ <u>1,355.20</u>	\$ <u>569.18</u>
8. _____	_____	\$ _____	\$ _____
9. <u>13-11-355-012</u>	<u>Fieldstone Estates Extn 1 SW 1/4 Sec</u>	\$ <u>1,355.20</u>	\$ <u>569.18</u>
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>128,559.08</u></u>	\$ <u><u>53,994.72</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Manor Court of Peoria

0047068 Report Period Beginning:

4/1/2015 Ending:

3/31/2016

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	50	2009		\$ 4,869,143	\$	25	\$ 194,766	\$ 194,766	\$ 1,233,518	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Sign		2007	3,100	310	10	310		2,661	9
10	Fire Doors, Paved Parking Lot & Sidewalks		2009	232,895	218	15	15,524	15,306	98,469	10
11	Electromagnetic Lock		2010	8,319	832	10	832		4,783	11
12	Water Heater		2010	4,758	476	10	476		2,616	12
13	Concrete-Handycap Ramp/Sidewalk Repairs		2011	4,191	279	15	279		1,327	13
14	Water Heater		2013	5,248	525	10	525		1,618	14
15	Water Heater		2014	5,502	550	10	550		871	15
16	Water Softener		2014	8,427	843	10	843		1,124	16
17	Vinyl Tile installed in Dining Room		2015	5,428	362	10	362		362	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

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
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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)	\$	\$		\$	\$	\$	70
		5,147,011	4,395		214,467	210,072	1,347,349	

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 429,996	\$ 16,608	\$ 42,031	\$ 25,423	3-15 yrs	\$ 273,447	71
72	Current Year Purchases	11,801	590	590		5 yrs	590	72
73	Fully Depreciated Assets	43,461					43,461	73
74								74
75	TOTALS	\$ 485,258	\$ 17,198	\$ 42,621	\$ 25,423		\$ 317,498	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	Toyota Corolla 2006	2006	\$ 15,288	\$	\$	\$	4	\$ 15,288	76
77	Facility	Chevrolet Cheyenne 1998	2014	3,230	808	808		4	875	77
78										78
79										79
80	TOTALS			\$ 18,518	\$ 808	\$ 808	\$		\$ 16,163	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,797,787	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 22,401	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 257,896	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 235,495	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,681,010	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	1999 Chevy Silverado 2500 - 2012	\$ 11,559	\$ 2,167	\$ 11,559	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 11,559	\$ 2,167	\$ 11,559	91

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

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

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

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

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

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: \$ 8,742 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: Manor Court of Peoria
IDPH License ID Number: 0047068
Fiscal Year End: 3/31/2016

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment Rental	6,449
Office Equipment	1,512
Other Equipment Rental	781
Total - Line 16	8,742

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>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	2,888	\$ 207,948	\$	2,888	\$ 207,948	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		777	55,941		777	55,941	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		3,219	231,756		3,219	231,756	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				160,388		160,388	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	10A(3)			100	7,178		100	7,178	12
13	Other (specify):									13
14	TOTAL			\$	6,984	\$ 502,823	\$ 160,388	6,984	\$ 663,211	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Peoria

0047068

Report Period Beginning: 4/1/2015

Ending:

3/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 3/31/2016

(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	\$ 5,894	\$ 281,251	1
2	Cash-Patient Deposits	7,573	7,573	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 28,100)	430,188	493,725	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,603	9,155	6
7	Other Prepaid Expenses	2,818	2,818	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interdivision Receivable</u>	3,279,720	2,306,548	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,731,796	\$ 3,101,070	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		147,000	13
14	Buildings, at Historical Cost	48,248	4,917,391	14
15	Leasehold Improvements, at Historical Cost		229,620	15
16	Equipment, at Historical Cost	261,098	503,776	16
17	Accumulated Depreciation (book methods)	(201,093)	(1,681,010)	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 17A</u>		590,091	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 108,253	\$ 4,706,868	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,840,049	\$ 7,807,938	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 67,088	\$ 67,092	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,573	7,573	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	37,849	37,849	30
31	Accrued Taxes Payable (excluding real estate taxes)	33,726	33,726	31
32	Accrued Real Estate Taxes(Sch.IX-B)		61,660	32
33	Accrued Interest Payable		13,353	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 146,236	\$ 221,253	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,746,513	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Security Deposits</u>	46,500	46,500	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 46,500	\$ 10,793,013	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 192,736	\$ 11,014,266	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,647,313	\$ (3,206,328)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,840,049	\$ 7,807,938	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Facility Name: Manor Court of Peoria
IDPH License ID Number: 0047068
Fiscal Year End: 3/31/2016

Schedule 17A

XV. Balance Sheet

Line 23 Other Assets (specify):

Description	Operating	After Consolidation
	-	
Real Estate Tax - Escrow	-	42,210
Insurance - Escrow	-	4,200
MIP - Escrow	-	19,383
Replacement Reserve	-	196,286
Capitalized Loan Fee	-	339,502
Amortization Loan Fee	-	(11,490)
Total - Line 22	-	590,091

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,381,788	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,381,788	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	265,525	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)	\$ 265,525	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,647,313	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,506,271	1
2	Discounts and Allowances for all Levels	(33,275)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,472,996	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	64,049	6
7	Oxygen	11,323	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 75,372	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	514	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	468	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	48	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,500	19
20	Radiology and X-Ray	124	20
21	Other Medical Services	5,546	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 11,200	23
D. Non-Operating Revenue			
24	Contributions	129	24
25	Interest and Other Investment Income***	75	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 204	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)	\$ 4,559,772	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	665,520	31
32	Health Care	1,962,648	32
33	General Administration	808,584	33
B. Capital Expense			
34	Ownership	480,405	34
C. Ancillary Expense			
35	Special Cost Centers	278,588	35
36	Provider Participation Fee	98,502	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,294,247	40
41	Income before Income Taxes (line 30 minus line 40)**	265,525	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 265,525	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 203,055	44
45	Private Pay - Net Inpatient Revenue	2,157,543	45
46	Medicare - Net Inpatient Revenue	1,559,755	46
47	Other-(specify) Medicare Replacement	121,470	47
48	Other-(specify) Managed Care	431,173	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,472,996	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Peoria

0047068

Report Period Beginning: 4/1/2015

Ending: 3/31/2016

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	1,904	2,080	\$ 67,478	\$ 32.44	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,645	14,102	352,243	24.98	3
4	Licensed Practical Nurses	7,574	7,822	168,711	21.57	4
5	CNAs & Orderlies	48,102	50,215	581,121	11.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,314	5,412	60,200	11.12	10
11	Social Service Workers	1,751	1,844	25,829	14.01	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	9,751	10,381	147,364	14.20	15
16	Dishwashers					16
17	Maintenance Workers	3,757	3,973	66,012	16.62	17
18	Housekeepers	8,533	9,009	94,086	10.44	18
19	Laundry	1,347	1,383	17,400	12.58	19
20	Administrator	1,952	2,080	122,797	59.04	20
21	Assistant Administrator	996	1,120	23,303	20.81	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,173	6,561	104,545	15.93	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,245	1,311	14,563	11.11	31
32	Other Health C: MDS Coord	1,813	1,874	46,814	24.98	32
33	Other(specify) <u>Marketing</u>	1,872	1,997	39,534	19.80	33
34	TOTAL (lines 1 - 33)	115,729	121,164	\$ 1,932,000 *	\$ 15.95	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 6,130	L1, C3	35
36	Medical Director	Monthly	9,750	L9, C3	36
37	Medical Records Consultant	Monthly	2,000	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,558	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 21,438		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Linda Patton	Administrator	0	\$ 122,797	Workers' Compensation Insurance	\$ 48,997	IDPH License Fee	\$	
Beth Lister	Assist Administrator	0	23,303	Unemployment Compensation Insurance	7,804	Advertising: Employee Recruitment	737	
				FICA Taxes	143,671	Health Care Worker Background Check (Indicate # of checks performed 95)	947	
				Employee Health Insurance	67,229	Patient Background Checks	95	
				Employee Meals		Subscriptions	413	
				Illinois Municipal Retirement Fund (IMRF)*		IHCA Dues	2,921	
				401 (k)	14,255	Other Licenses & Fees	3,595	
				Other Employee Benefits	5,539	Indirect costs	4	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 146,100					
B. Administrative - Other								
Description			Amount					
N/A			\$	Indirect Costs	40			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 287,535	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 8,617	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
RFMS, Inc.	Administrative Services		\$ 74,400	N/A			Out-of-State Travel	\$
LTC Support Services, LLC	Support Services		72,480					
McGladrey LLP	Accounting Services		20,531				In-State Travel	430
Davis & Campbell, LLC	Legal Services		280					
Duane Morris LLP	Legal Services		150				Seminar Expense	49
Michael T Mahoney	Legal Services		100				Indirect costs	2
Polsinelli	Legal Services		1,882					
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 169,823	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 481

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name & ID Number Manor Court of Peoria

0047068

Report Period Beginning: 4/1/2015

Ending: 3/31/2016

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. 2,921 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? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 30,477 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. \$ 98,502
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 468
- (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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' PREPARATION REPORT