

		FOR BHF USE					

LL1

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: 0043224

Facility Name: Eagle Court

Address: 1890 East Eagle St Kankakee 60901
Number City Zip Code

County: Kankakee

Telephone Number: See Attached Fax # See Attached

HFS ID Number:

Date of Initial License for Current Owners: See Attached

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501 (c) 3

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 4/1/2015 to 3/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) Lisa Winnett
(Title) Director of Operations

Paid
Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date) _____
(Print Name and Title) Larry Templin Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP
P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Eagle Court

0043224 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,748			5,748	13
14	TOTALS	5,748			5,748	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.16%

D. How many bed-hold days during this year were paid by the Department? 77 (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 See Attached

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date See Attached NO ☐

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL ☒ 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 Eagle Court # 0043224 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	83,558	6,366	2,821	92,745		92,745		92,745			1
2	Food Purchase		63,121		63,121		63,121		63,121			2
3	Housekeeping	29,635	5,406	321	35,362		35,362		35,362			3
4	Laundry		3,019		3,019		3,019		3,019			4
5	Heat and Other Utilities			27,208	27,208		27,208		27,208			5
6	Maintenance	11,372	14,846	15,228	41,446		41,446	67	41,513			6
7	Other (specify):*											7
8	TOTAL General Services	124,565	92,758	45,578	262,901		262,901	67	262,968			8
	B. Health Care and Programs											
9	Medical Director			3,080	3,080		3,080		3,080			9
10	Nursing and Medical Records	521,564	3,612	14,743	539,919		539,919		539,919			10
10a	Therapy											10a
11	Activities		604	1,670	2,274		2,274		2,274			11
12	Social Services											12
13	CNA Training	25,065			25,065		25,065		25,065			13
14	Program Transportation			5,557	5,557		5,557		5,557			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	546,629	4,216	25,050	575,895		575,895		575,895			16
	C. General Administration											
17	Administrative	15,498			15,498		15,498		15,498			17
18	Directors Fees							318	318			18
19	Professional Services			83,132	83,132		83,132	(1,441)	81,691			19
20	Dues, Fees, Subscriptions & Promotions			2,800	2,800		2,800	20	2,820			20
21	Clerical & General Office Expenses	15,905	7,058	7,974	30,937		30,937	5	30,942			21
22	Employee Benefits & Payroll Taxes			99,046	99,046		99,046	2	99,048			22
23	Inservice Training & Education			11,146	11,146		11,146		11,146			23
24	Travel and Seminar			507	507		507		507			24
25	Other Admin. Staff Transportation			2,141	2,141		2,141	1	2,142			25
26	Insurance-Prop.Liab.Malpractice			8,943	8,943		8,943		8,943			26
27	Other (specify):*											27
28	TOTAL General Administration	31,403	7,058	215,689	254,150		254,150	(1,095)	253,055			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	702,597	104,032	286,317	1,092,946		1,092,946	(1,028)	1,091,918			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			55,520	55,520		55,520	38	55,558			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			160	160		160		160			35
36	Other (specify):*											36
37	TOTAL Ownership			55,680	55,680		55,680	38	55,718			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,948	67,948		67,948		67,948			42
43	Other (specify):* Disallowed Costs			262	262		262	(262)				43
44	TOTAL Special Cost Centers			68,210	68,210		68,210	(262)	67,948			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	702,597	104,032	410,207	1,216,836		1,216,836	(1,252)	1,215,584			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	38	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,441)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(262)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,665)		\$	30

BHF USE ONLY							
48		49		50		51	
						52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	413		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 413		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,252)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eagle Court# 0043224

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	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	67	0	0	0	0	0	0	0	0	0	67	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	67	0	0	0	0	0	0	0	0	0	67	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	318	0	0	0	0	0	0	0	0	0	318	18
19	Professional Services	(1,441)	0	0	0	0	0	0	0	0	0	0	(1,441)	19
20	Fees, Subscriptions & Promotions	0	20	0	0	0	0	0	0	0	0	0	20	20
21	Clerical & General Office Expenses	0	5	0	0	0	0	0	0	0	0	0	5	21
22	Employee Benefits & Payroll Taxes	0	2	0	0	0	0	0	0	0	0	0	2	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	1	0	0	0	0	0	0	0	0	0	1	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(1,441)	346	0	0	0	0	0	0	0	0	0	(1,095)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,441)	413	0	0	0	0	0	0	0	0	0	(1,028)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Eagle Court # 0043224 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	38	0	0	0	0	0	0	0	0	0	0	38	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	38	0	0	0	0	0	0	0	0	0	0	38	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):*	(262)	0	0	0	0	0	0	0	0	0	0	(262)	43
44	TOTAL Special Cost Centers	(262)	0	0	0	0	0	0	0	0	0	0	(262)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,665)	413	0	0	0	0	0	0	0	0	0	(1,252)	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
Frances House, Inc.	100	Frances House, Inc. (FH)		See Page 6 Supplemental		
		Pioneer Concepts, Inc. (FH is sole member)				
		Pinnacle Opportunities, Inc. (FH is sole member)				
		Residential Alternatives of Illinois, Inc. (FH is sole member)				
		See Page 6 Supplemental for specific homes				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ 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)	
1	V	6	Maintenance Supplies	\$	Frances House, Inc.	100.00%	\$ 67	\$ 67	1
2	V	20	Dues, Fees & Subscriptions		Frances House, Inc.	100.00%	15	15	2
3	V	21	Clerical & General Office Exp		Frances House, Inc.	100.00%	1	1	3
4	V	22	Employee Benefits		Frances House, Inc.	100.00%	2	2	4
5	V	25	Vehicle Expense		Frances House, Inc.	100.00%	1	1	5
6	V	18	Directors Fees		Frances House, Inc.-Pinnacle Opportunities facilities	100.00%	318	318	6
7	V	20	Dues, Fees & Subscriptions		Frances House, Inc.-Pinnacle Opportunities facilities	100.00%	5	5	7
8	V	21	Clerical & General Office Exp		Frances House, Inc.-Pinnacle Opportunities facilities	100.00%	4	4	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 413	\$ * 413	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Eagle Court

0043224

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Eagle Court# 0043224

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Eagle Court # 0043224 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	See Attached Schedule 7A								\$ 0	L18, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Eagle Court # 0043224 Report Period Beginning: 4/1/2015 Ending: 3/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	6	Maintenance Supplies	Bed Days Available	5,900	33	2,072		192	\$ 67	1
2	20	Dues, Fees & Subscriptions	Bed Days Available	5,900	33	458		192	15	2
3	21	Clerical & General Office Exp	Bed Days Available	5,900	33	40		192	1	3
4	22	Employee Benefits	Bed Days Available	5,900	33	65		192	2	4
5	25	Vehicle Expense	Bed Days Available	5,900	33	17		192	1	5
6	18	Directors Fees	Bed Days Avail-PIN Only	1,056	6	1,748		192	318	6
7	20	Dues, Fees & Subscriptions	Bed Days Avail-PIN Only	1,056	6	25		192	5	7
8	21	Clerical & General Office Exp	Bed Days Avail-PIN Only	1,056	6	20		192	4	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					\$ 4,445	\$		\$ 413	25

SEE ACCOUNTANTS' PREPARATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$					\$	1
2	N/A												2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$				\$		9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$		14
15	TOTALS (line 9+line14)						\$				\$		15

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

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

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

B. Real Estate Taxes

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.**

IL478-2471

FACILITY NAME	<u>Eagle Court</u>	COUNTY	<u>Kankakee</u>
---------------	--------------------	--------	-----------------

CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

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

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

C. Tax Bills

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 6,400

B. General Construction Type: Exterior BrickFrame WoodNumber of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YESXNO

If so, please complete the following:

1. Total Amount Incurred:2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	3 Facilities		1997	\$ 96,424	1
2					2
3	TOTALS			\$ 96,424	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	6		1997	1993	\$ 233,992	\$ 9,360	25	\$ 9,360		\$ 178,614
5	4		1997	1993	\$ 155,995	\$ 6,239	25	\$ 6,239		\$ 119,076
6	6		1997	1993	\$ 233,992	\$ 9,360	25	\$ 9,360		\$ 178,614
7										
8										
	Improvement Type**									
9	Eagle Court:									
10		Parking Lot, Sidewalks & Landscaping	1997		11,099		15			11,099
11		Fire Alarm System	2002		1,672		10			1,672
12		Shower Repair	2003		3,460	231	15	231		2,998
13		Carpet	2004		2,215		5			2,215
14		Shelving, Doors & Tile Siding	2009		49,423	4,119	12	4,119		29,860
15		Carpet & Vinyl Flooring	2009		10,304	1,288	8	1,288		9,338
16		Lights, Art, Lamps & TV	2009		4,154	495	7	495		4,155
17		Blinds	2009		1,674		5			1,674
18		New Roof	2015		8,045	469	10	469		469
19										
20	Kankakee Court:									
21		Parking Lot, Sidewalks & Landscaping	1997		7,399		15			7,399
22		Carpet	2004		2,280		5			2,280
23		Kitchen & Bathroom remodel and fixtures	2010		8,987	599	15	599		3,595
24		New furnace and air conditioner	2014		4,750	950	5	950		1,663
25		New Roof	2015		7,187	299	10	299		299
26										
27	Roy Court:									
28		Parking Lot, Sidewalks & Landscaping	1997		11,099		15			11,099
29		Bathroom Remodel	2001		4,030		10			4,030
30		Carpet	2004		1,130		5			1,130
31		Kitchen Cabinets/All Materials & New Roof	2008		28,536	2,195	10-15 yrs	2,195		16,787
32		Carpet	2009		3,603		5			3,603
33		Furnace	2011		5,300	530	10	530		2,694
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

Facility Name & ID Number Eagle Court

0043224

Report Period Beginning:

4/1/2015

Ending:

3/31/2016

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 800,326	\$ 36,134		\$ 36,134	\$	\$ 594,363	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$88,296	\$5,932	\$5,970	\$38	3-15 yrs	\$38,610	71
72	Current Year Purchases	8,217	411	411		5 yrs	411	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$96,513	\$6,343	\$6,381	\$38		\$39,021	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	2009 Ford E350 Van	2009	\$44,030			\$	4	\$44,030	76
77	Patient Care	2002 Ford Van	2002	\$10,833				4	10,833	77
78	Patient Care	2006 Ford E350	2006	\$45,900				4	45,900	78
79	Patient Care	2013 Ford E350	2012	52,170	13,043	13,043		4	45,649	79
80	TOTALS			\$152,933	\$13,043	\$13,043	\$		\$146,412	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$1,146,196	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$55,520	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$55,558	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$38	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$779,796	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A				86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	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

**

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

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

N/A

N/A

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

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

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 160

Description: Miscellaneous

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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 \$

* 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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☒ YES

☐ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☒

☐

☐

138

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		25,065		25,065
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 25,065	\$	\$ 25,065
10	SUM OF line 9, col. 1 and 2 (e)	\$ 25,065			

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	12
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	12

(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.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	\$ 418,522	\$ 418,522	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	105,093	105,093	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,974	5,974	6
7	Other Prepaid Expenses	3,792	3,792	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interdivision Receivable</u>	672,196	672,196	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,205,577	\$ 1,205,577	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	96,424	96,424	13
14	Buildings, at Historical Cost	800,326	800,326	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	249,446	249,446	16
17	Accumulated Depreciation (book methods)	(779,796)	(779,796)	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>Unrealized Gain on Invest.</u>	82,041	82,041	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 448,441	\$ 448,441	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,654,018	\$ 1,654,018	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 50,775	\$ 50,775	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	32,211	32,211	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,716	1,716	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Accrued Liabilities</u>	1,651	1,651	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 86,353	\$ 86,353	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 86,353	\$ 86,353	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,567,665	\$ 1,567,665	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,654,018	\$ 1,654,018	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,631,359	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,631,359	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(63,694)	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)	\$ (63,694)	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)	\$ 1,567,665	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Eagle Court

0043224

Report Period Beginning: 4/1/2015

Ending: 3/31/2016

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	\$ 1,127,575	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,127,575	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	25,065	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 25,065	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	502	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 502	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)	\$ 1,153,142	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	262,901	31
32	Health Care	575,895	32
33	General Administration	254,150	33
	B. Capital Expense		
34	Ownership	55,680	34
	C. Ancillary Expense		
35	Special Cost Centers	262	35
36	Provider Participation Fee	67,948	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,216,836	40
41	Income before Income Taxes (line 30 minus line 40)**	(63,694)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (63,694)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,127,575	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,127,575	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

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	346	373	9,600	25.75	3
4	Licensed Practical Nurses	751	776	15,863	20.45	4
5	CNAs & Orderlies	36,361	38,536	468,467	12.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	7,000	7,000	83,558	11.94	15
16	Dishwashers					16
17	Maintenance Workers	875	921	11,372	12.35	17
18	Housekeepers	2,150	2,546	29,635	11.64	18
19	Laundry					19
20	Administrator	327	334	8,183	24.51	20
21	Assistant Administrator	409	409	7,315	17.90	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,280	1,296	15,905	12.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	3,156	3,214	52,699	16.40	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	52,655	55,404	\$ 702,597 *	\$ 12.68	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	\$ 2,821	L1, C3	35
36	Medical Director	Monthly	3,080	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	235	L10, C3	38
39	Pharmacist Consultant	Monthly	160	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Dental	Monthly	7,063	L10, C3	46
47	Psychological Consultant	Monthly	7,285	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 20,644		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	%	Amount	Description		Amount	Description	Amount
Willie Morris	Administrator	None	\$ 1,167	Workers' Compensation Insurance		\$ 12,258	IDPH License Fee	\$
Deborah Blake	Administrator	None	7,016	Unemployment Compensation Insurance		4,243	Advertising: Employee Recruitment	591
Krista Grable	Asst Administrator	None	7,315	FICA Taxes		52,226	Health Care Worker Background Check	
				Employee Health Insurance		25,301	(Indicate # of checks performed)	
				Employee Meals		1,802	Patient Background Checks	
				Illinois Municipal Retirement Fund (IMRF)*				
				401k		1,264	Subscriptions	583
				Other Employee Benefits		1,952	IHCA Dues	912
TOTAL (agree to Schedule V, line 17, col. 1)							Other Licenses & Fees	714
(List each licensed administrator separately.)			\$ 15,498				Indirect costs	20
B. Administrative - Other							Less: Public Relations Expense	()
Description			Amount	Indirect costs		2	Non-allowable advertising	()
N/A			\$				Yellow page advertising	()
							TOTAL (agree to Sch. V, line 20, col. 8)	
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 99,048	\$ 2,820	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
RFMS, Inc.	Administrative Services		\$ 40,800				Out-of-State Travel	\$
LTC Support Services, LLC	Support Services		30,720	N/A				
McGladrey LLP	Accounting Services		7,304					
Templin Healthcare Accounting	Accounting Services		1,014				In-State Travel	
Polsinelli Shughart	Legal Services		2,558					
Roger Benson, Attorney at Law	Legal Services		714					
Davis & Campbell	Legal Services		22					
							Seminar Expense	507
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(For legal fee disclosure, see page 39 of instructions)			\$ 83,132				TOTAL	\$ 507

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT**

****See instructions.**

- (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.

912 IHCA
- (3)

Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?

N/A
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A
- (5)

Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

5 yrs
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

842

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.

\$

67,948

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 benefit on Schedule V.

\$

1,802

Has any meal income been offset against related costs?

No

Indicate the amount.

\$

N/A
- (16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

None

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

N/A
- (17)

Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name:

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