

		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>0047134</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Manor Court of Clinton</u>		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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>1 Park Lane West</u> <u>Clinton</u> <u>61727</u>																									
Number City Zip Code																									
County: <u>Dewitt</u>																									
Telephone Number: <u>(217) 935-8500</u> Fax # <u>(217) 935-8520</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Darcee Fanning</u></td></tr><tr><td>(Title) <u>Regional Director</u></td></tr><tr><td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Larry Templin Partner</u></td></tr><tr><td>(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 9, Dunlap, IL 61525</u></td></tr><tr><td>(Telephone) <u>(630) 361-2868</u> Fax # ()</td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Darcee Fanning</u>	(Title) <u>Regional Director</u>	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	Paid Preparer	(Print Name and Title) <u>Larry Templin Partner</u>	(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 9, Dunlap, IL 61525</u>	(Telephone) <u>(630) 361-2868</u> 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												
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Date of Initial License for Current Owners: <u>04/15/2005</u>																									
Type of Ownership:																									
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>501 (c) 3</u></td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code <u>501 (c) 3</u>	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust			☐ Other _____	
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	☐ "Sub-S" Corp.	_____																							
	☐ Limited Liability Co.	_____																							
	☐ Trust																								
	☐ Other _____																								
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: _____																									

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Clinton

0047134 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	<u>134</u>	Skilled (SNF)	<u>134</u>	<u>49,044</u>	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	<u>134</u>	TOTALS	<u>134</u>	<u>49,044</u>	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	<u>23,611</u>	<u>12,394</u>	<u>7,260</u>	<u>43,265</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>23,611</u>	<u>12,394</u>	<u>7,260</u>	<u>43,265</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.22%

SEE ACCOUNTANTS' PREPARATION REPORT

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 04/15/2005

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 04/15/2005 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 134 and days of care provided 6,469

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ 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.

Facility Name & ID Number Manor Court of Clinton # 0047134 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	385,456	42,576	8,858	436,890		436,890	(76,538)	360,352			1
2	Food Purchase		498,168		498,168		498,168	(94,374)	403,794			2
3	Housekeeping	215,025	49,359		264,384		264,384	(26,808)	237,576			3
4	Laundry	63,608	34,448	801	98,857		98,857	(10,024)	88,833			4
5	Heat and Other Utilities			184,459	184,459		184,459	(31,358)	153,101			5
6	Maintenance	88,054	34,365	85,848	208,267		208,267	(15,865)	192,402			6
7	Other (specify):*											7
8	TOTAL General Services	752,143	658,916	279,966	1,691,025		1,691,025	(254,967)	1,436,058			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	3,079,601	215,922	27,093	3,322,616		3,322,616	(226,507)	3,096,109			10
10a	Therapy			1,333,975	1,333,975		1,333,975		1,333,975			10a
11	Activities	110,463	5,252		115,715		115,715	(533)	115,182			11
12	Social Services	59,607			59,607		59,607		59,607			12
13	CNA Training											13
14	Program Transportation			7,275	7,275		7,275	(721)	6,554			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,249,671	221,174	1,392,343	4,863,188		4,863,188	(227,761)	4,635,427			16
	C. General Administration											
17	Administrative	131,898			131,898		131,898	(13,374)	118,524			17
18	Directors Fees							3,891	3,891			18
19	Professional Services			426,959	426,959		426,959	(33,923)	393,036			19
20	Dues, Fees, Subscriptions & Promotions			15,025	15,025		15,025	(506)	14,519			20
21	Clerical & General Office Expenses	126,843	43,092	78,967	248,902		248,902	(9,259)	239,643			21
22	Employee Benefits & Payroll Taxes			627,180	627,180		627,180	(52,872)	574,308			22
23	Inservice Training & Education			6,092	6,092		6,092		6,092			23
24	Travel and Seminar			2,316	2,316		2,316	7	2,323			24
25	Other Admin. Staff Transportation			1,542	1,542		1,542		1,542			25
26	Insurance-Prop.Liab.Malpractice			86,612	86,612		86,612	(8,994)	77,618			26
27	Other (specify):*											27
28	TOTAL General Administration	258,741	43,092	1,244,693	1,546,526		1,546,526	(115,030)	1,431,496			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,260,555	923,182	2,917,002	8,100,739		8,100,739	(597,758)	7,502,981			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			75,584	75,584		75,584	295	75,879			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			50	50		50	(50)				32
33	Real Estate Taxes			217,200	217,200		217,200	(36,924)	180,276			33
34	Rent-Facility & Grounds			1,367,376	1,367,376		1,367,376	(232,454)	1,134,922			34
35	Rent-Equipment & Vehicles			10,405	10,405		10,405	(20)	10,385			35
36	Other (specify):*											36
37	TOTAL Ownership			1,670,615	1,670,615		1,670,615	(269,153)	1,401,462			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,125	1,125		1,125		1,125			38
39	Ancillary Service Centers		229,186		229,186		229,186		229,186			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			3,474	3,474		3,474		3,474			41
42	Provider Participation Fee			293,287	293,287		293,287		293,287			42
43	Other (specify):* Disallowed Costs	67,082		449,314	516,396		516,396	(516,396)				43
44	TOTAL Special Cost Centers	67,082	229,186	747,200	1,043,468		1,043,468	(516,396)	527,072			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,327,637	1,152,368	5,334,817	10,814,822		10,814,822	(1,383,307)	9,431,515			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	(28)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,117)	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	295	30		9
10	Interest and Other Investment Income	(50)	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	(1,512)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(371,549)	43		24
25	Fund Raising, Advertising and Promotional	(44,604)	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	(973,331)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,397,896)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	14,589		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 14,589		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,383,307)		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	Offset Vending Machine Income	\$ (5,280)	2	1
2	Adjust out Hawthorne Inn of Clinton SLF expenses	(76,538)	1	2
3	Adjust out Hawthorne Inn of Clinton SLF expenses	(89,066)	2	3
4	Adjust out Hawthorne Inn of Clinton SLF expenses	(26,808)	3	4
5	Adjust out Hawthorne Inn of Clinton SLF expenses	(10,024)	4	5
6	Adjust out Hawthorne Inn of Clinton SLF expenses	(31,358)	5	6
7	Adjust out Hawthorne Inn of Clinton SLF expenses	(15,865)	6	7
8	Adjust out Hawthorne Inn of Clinton SLF expenses	(226,507)	10	8
9	Adjust out Hawthorne Inn of Clinton SLF expenses	(533)	11	9
10	Adjust out Hawthorne Inn of Clinton SLF expenses	(721)	14	10
11	Adjust out Hawthorne Inn of Clinton SLF expenses	(13,374)	17	11
12	Adjust out Hawthorne Inn of Clinton SLF expenses	(41,118)	19	12
13	Adjust out Hawthorne Inn of Clinton SLF expenses	(516)	20	13
14	Adjust out Hawthorne Inn of Clinton SLF expenses	(9,259)	21	14
15	Adjust out Hawthorne Inn of Clinton SLF expenses	(52,979)	22	15
16	Adjust out Hawthorne Inn of Clinton SLF expenses	(10,861)	26	16
17	Adjust out Hawthorne Inn of Clinton SLF expenses	(36,924)	33	17
18	Adjust out Hawthorne Inn of Clinton SLF expenses	(232,454)	34	18
19	Adjust out Hawthorne Inn of Clinton SLF expenses	(20)	35	19
20	Adjust out Hawthorne Inn of Clinton SLF expenses	(7,605)	43	20
21	Non-Allowable Marketing	(60,280)	43	21
22	Part A Labs	(14,069)	43	22
23	Part A X-rays	(9,635)	43	23
24	Loss on Disposal of Fixed asset	(1,537)	43	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	(973,331)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manor Court of Clinton# 0047134

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	(76,538)	0	0	0	0	0	0	0	0	0	0	(76,538)	1
2	Food Purchase	(94,374)	0	0	0	0	0	0	0	0	0	0	(94,374)	2
3	Housekeeping	(26,808)	0	0	0	0	0	0	0	0	0	0	(26,808)	3
4	Laundry	(10,024)	0	0	0	0	0	0	0	0	0	0	(10,024)	4
5	Heat and Other Utilities	(31,358)	0	0	0	0	0	0	0	0	0	0	(31,358)	5
6	Maintenance	(15,865)	0	0	0	0	0	0	0	0	0	0	(15,865)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(254,967)	0	0	0	0	0	0	0	0	0	0	(254,967)	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	(226,507)	0	0	0	0	0	0	0	0	0	0	(226,507)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(533)	0	0	0	0	0	0	0	0	0	0	(533)	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	(721)	0	0	0	0	0	0	0	0	0	0	(721)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(227,761)	0	0	0	0	0	0	0	0	0	0	(227,761)	16
	C. General Administration													
17	Administrative	(13,374)	0	0	0	0	0	0	0	0	0	0	(13,374)	17
18	Directors Fees	0	3,891	0	0	0	0	0	0	0	0	0	3,891	18
19	Professional Services	(42,630)	8,707	0	0	0	0	0	0	0	0	0	(33,923)	19
20	Fees, Subscriptions & Promotions	(516)	10	0	0	0	0	0	0	0	0	0	(506)	20
21	Clerical & General Office Expenses	(9,259)	0	0	0	0	0	0	0	0	0	0	(9,259)	21
22	Employee Benefits & Payroll Taxes	(52,979)	107	0	0	0	0	0	0	0	0	0	(52,872)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	7	0	0	0	0	0	0	0	0	0	7	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(10,861)	1,867	0	0	0	0	0	0	0	0	0	(8,994)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(129,619)	14,589	0	0	0	0	0	0	0	0	0	(115,030)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(612,347)	14,589	0	0	0	0	0	0	0	0	0	(597,758)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manor Court of Clinton # 0047134 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	295	0	0	0	0	0	0	0	0	0	0	295	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(50)	0	0	0	0	0	0	0	0	0	0	(50)	32
33	Real Estate Taxes	(36,924)	0	0	0	0	0	0	0	0	0	0	(36,924)	33
34	Rent-Facility & Grounds	(232,454)	0	0	0	0	0	0	0	0	0	0	(232,454)	34
35	Rent-Equipment & Vehicles	(20)	0	0	0	0	0	0	0	0	0	0	(20)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(269,153)	0	0	0	0	0	0	0	0	0	0	(269,153)	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):*	(516,396)	0	0	0	0	0	0	0	0	0	0	(516,396)	43
44	TOTAL Special Cost Centers	(516,396)	0	0	0	0	0	0	0	0	0	0	(516,396)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,397,896)	14,589	0	0	0	0	0	0	0	0	0	(1,383,307)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Residential Alternatives of Illinois, Inc. (Non-profit Organization)	100	Frances House, Inc. (FH)				
		Residential Alternatives of Illinois, Inc. (FH is sole 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:	
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	18	Director Fees	\$	Residential Alternatives of Illinois, Inc.	100.00%	\$ 3,891	\$ 3,891	1
2	V	19	Professional Services		Residential Alternatives of Illinois, Inc.	100.00%	8,707	8,707	2
3	V	20	Dues, Fees & Subscriptions		Residential Alternatives of Illinois, Inc.	100.00%	10	10	3
4	V	22	Employee Benefits & PR Taxes		Residential Alternatives of Illinois, Inc.	100.00%	107	107	4
5	V	24	Travel and Seminar		Residential Alternatives of Illinois, Inc.	100.00%	7	7	5
6	V	26	Property Insurance		Residential Alternatives of Illinois, Inc.	100.00%	1,867	1,867	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 14,589	\$ * 14,589	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Manor Court of Clinton

0047134

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				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 Clinton

0047134

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 Clinton # 0047134 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	\$ 208	L18, C7	1
2	Doug Biederstedt	Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	833	L18, C7	2
3	Jeff Shaw	Secretary & Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	833	L18, C7	3
4	William Kempiners	Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	833	L18, C7	4
5	John Kniery	Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	833	L18, C7	5
6											6
7											7
8											8
9	No board members provide services or have business entities that provide services to the facility.										9
10											10
11											11
12											12
13								TOTAL	\$ 3,540		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 Clinton
---------------------------	------------------------

0047134

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

Residential Alternatives of Illinois, Inc.

Street Address

285 S. Farnham

City / State / Zip Code

Galesburg, IL 61401

Phone Number

(309) 343-1550

Fax Number

(309) 343-2857

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	18	Director Fees	Weighted Avg BDA	353,445	18	\$ 28,040	\$ 49,044	\$ 3,891	1
2	19	Professional Services	Weighted Avg BDA	353,445	18	62,749	49,044	8,707	2
3	20	Dues, Fees & Subscriptions	Weighted Avg BDA	353,445	18	75	49,044	10	3
4	22	Employee Benefits & PR Taxes	Weighted Avg BDA	353,445	18	773	49,044	107	4
5	24	Travel and Seminar	Weighted Avg BDA	353,445	18	47	49,044	7	5
6	26	Property Insurance	Weighted Avg BDA	353,445	18	13,455	49,044	1,867	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	\$	\$ 14,589	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 # 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

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	269,973	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	\$	215,969	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(54,004)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	271,204	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.		SLF Portion of Expense		(36,924)	
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	(36,924)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	180,276	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	182,497	8	
		2012	187,648	9	
		2013	208,602	10	
		2014	215,969	11	
		2015	217,630	12	
This facility is leased from an unrelated for-profit entity. The lease agreement requires the lessee to pay the real estate taxes. Amount accrued includes 12 months of 2015 and 3 months of 2016. The real estate tax estimate is based on 2015 tax bill. Taxes paid are for the 2014 tax bill. See Att Sch for the portion of real estate taxes allocated to the SNF portion.				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

- 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 Clinton COUNTY Dewitt

FACILITY IDPH LICENSE NUMBER 0047134

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>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
				<u>Nursing Home</u>
1.	<u>07-34-304-001</u>	<u>Lot 1 & out Lot A & B</u>	\$ <u>217,629.98</u>	\$ <u>180,633.00</u>
2.	<u></u>	<u>Liberty Village Subdivision</u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u><u>217,629.98</u></u>	\$ <u><u>180,633.00</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 providecopies of their original **second installment** tax bill.

A. Square Feet: 42,256

B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☒ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred: N/A

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	N/A Facility Leased			\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Clinton

0047134

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	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	134				\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Electric Sign		2005		4,433		10			4,433
10	Canopy, Fiberglass Insulation		2006		16,622	1,108	15	1,108		11,198
11	Sign, Tub Installation		2007		8,636	864	10	864		7,815
12	Install smoke seams/seals, Relocate dry pendent sprinkler head:		2008		11,394	789	10-25 yrs	789		6,052
13	Hot Water Supply Boiler		2010		9,445	472	20	472		2,911
14	Cable Sytem		2010		2,500	250	10	250		1,500
15	Door Alarm for Wandering Residents		2012		3,564	356	10	356		1,396
16	Workstation-Cabinets with Overhead Doors/File Cabinets/Chair/Partition		2012		7,550	755	10	755		2,517
17	Conference Room Remodel-Vct/Drywall/Paint Walls/Paint Doors/Electric		2013		36,011	3,001	12	3,001		9,252
18	Telephone System in New Offices-Dialysis and MDS Offices		2013		2,581	258	10	258		796
19	New Roof		2013		99,165	9,917	10	9,917		23,966
20	Dialysis Room electrical work		2013		3,740	187	20	187		499
21	Workstation-Cabinets with Overhead Doors/File Cabinets/Chair/Partition		2013		9,879	823	12	823		2,470
22	Double Face Lighted Sign with Message Center		2014		36,383	3,638	10	3,638		8,186
23										23
24	Single Faced Lighted Sign - Outside of SKN Bounce Back		2014		3,013	301	10	301		552
25	PTAC Units in Resident Rooms		2014		2,591	518	5	518		950
26	Remove/Replace Entryway into Bounceback Building		2015		3,395	141	12	141		141
27										27
28										28
29	Tie to Financial Statement Depreciation					(295)			295	29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Clinton

0047134

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)		\$ 260,902	\$ 23,083		\$ 23,378	\$ 295	\$ 84,634	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	\$302,818	\$36,843	\$36,843	\$	3-20 yrs	\$174,974	71
72	Current Year Purchases	57,267	2,817	2,817		5-15 yrs	2,990	72
73	Fully Depreciated Assets	116,223					116,223	73
74								74
75	TOTALS	\$476,308	\$39,660	\$39,660	\$		\$294,187	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	2005 Ford E350	2005	\$46,919	\$	\$	\$	4	\$46,919	76
77	Patient Care	2013 Ford E350 Van	2013	51,365	12,841	12,841		4	37,450	77
78										78
79										79
80	TOTALS			\$98,284	\$12,841	\$12,841	\$		\$84,369	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)	\$835,494	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$75,584	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$75,879	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$295	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$463,190	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	2003 GMC Van - 2005	\$29,800	\$	\$29,800	86
87	2006 Toyota Corolla - 2006	14,900		14,900	87
88	1991 Ford F250 - 2007	6,159		6,159	88
89					89
90					90
91	TOTALS	\$50,859	\$	\$50,859	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$4,136	92
93			93
94			94
95		\$4,136	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: Mid-Illini Healthcare, Inc.

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:	2004	98	4/15/2006	\$ 1,367,376	10	5	3
4	Additions	2006	63					4
5	Allocated to SLF				(232,454)			5
6								6
7	TOTAL		161		\$ 1,134,922			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: X YES NO Terms: Fair Market Value *

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: \$ 10,385 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	N/A				18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning 4/14/2015

Ending 4/14/2019

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

	Fiscal Year Ending	Annual Rent
12.	3/31/2017	\$ 1,374,000
13.	3/31/2018	\$ 1,374,000
14.	3/31/2019	\$ 1,374,000

* 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 Clinton

IDPH License ID Number:

0047134

Fiscal Year End:

3/31/2016

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment Rental	9,377
Office Equipment	174
Other Equipment Rental	834
Total - Line 16	10,385

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

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.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

(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

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	

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	10A(3)	hrs	\$	7,514	\$ 541,006	\$	7,514	\$ 541,006	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,586	186,220		2,586	186,220	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		7,931	571,047		7,931	571,047	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 prescrpts				229,186		229,186	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	10A(3)			496	35,702		496	35,702	12
13	Other (specify): <u> </u>									

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	\$ 18,912	\$ 18,912	1
2	Cash-Patient Deposits	15,396	15,396	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 476,300)	1,391,912	1,391,912	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	55,067	55,067	6
7	Other Prepaid Expenses	1,986	1,986	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,483,273	\$ 1,483,273	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	250,761	260,902	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	635,592	574,592	16
17	Accumulated Depreciation (book methods)	(514,049)	(463,190)	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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 372,304	\$ 372,304	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,855,577	\$ 1,855,577	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 169,743	\$ 169,743	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,396	15,396	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	80,261	80,261	30
31	Accrued Taxes Payable (excluding real estate taxes)	100,232	100,232	31
32	Accrued Real Estate Taxes(Sch.IX-B)	271,204	271,204	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Interdivision Payable</u>	1,686,102	1,686,102	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,322,938	\$ 2,322,938	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	<u>Security Deposits</u>	67,500	67,500	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 67,500	\$ 67,500	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,390,438	\$ 2,390,438	46
47	TOTAL EQUITY(page 18, line 24)	\$ (534,861)	\$ (534,861)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,855,577	\$ 1,855,577	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (402,589)	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (402,590)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(132,271)	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)	\$ (132,271)	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)	\$ (534,861)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Clinton

0047134

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	\$ 10,101,711	1
2	Discounts and Allowances for all Levels	(145,305)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,956,406	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	646,699	6
7	Oxygen	4,776	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 651,475	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	5,280	12
13	Barber and Beauty Care	2,365	13
14	Non-Patient Meals	28	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	133	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	5,416	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 13,222	23
	D. Non-Operating Revenue		
24	Contributions	46,870	24
25	Interest and Other Investment Income***	4,924	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 51,794	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Income	9,654	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,654	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,682,551	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,691,025	31
32	Health Care	4,863,188	32
33	General Administration	1,546,526	33
	B. Capital Expense		
34	Ownership	1,670,615	34
	C. Ancillary Expense		
35	Special Cost Centers	750,181	35
36	Provider Participation Fee	293,287	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,814,822	40
41	Income before Income Taxes (line 30 minus line 40)**	(132,271)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (132,271)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,997,377	44
45	Private Pay - Net Inpatient Revenue	3,001,938	45
46	Medicare - Net Inpatient Revenue	3,014,699	46
47	Other-(specify) Medicare Replacement	74,094	47
48	Other-(specify) Managed Care	868,298	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,956,406	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	1,744	1,928	\$ 65,681	\$ 34.07	1
2	Assistant Director of Nursing	2,051	2,123	66,120	31.14	2
3	Registered Nurses	15,552	16,385	382,315	23.33	3
4	Licensed Practical Nurses	30,335	31,609	706,711	22.36	4
5	CNAs & Orderlies	134,627	140,866	1,675,818	11.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,616	11,024	110,463	10.02	10
11	Social Service Workers	4,006	4,172	59,607	14.29	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	36,271	38,036	385,456	10.13	15
16	Dishwashers					16
17	Maintenance Workers	5,375	5,772	88,054	15.26	17
18	Housekeepers	20,757	22,047	215,025	9.75	18
19	Laundry	7,171	7,513	63,608	8.47	19
20	Administrator	1,904	2,116	118,704	56.10	20
21	Assistant Administrator	756	917	13,194	14.39	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,597	10,327	126,843	12.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,000	2,080	51,218	24.62	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,998	2,114	25,895	12.25	31
32	Other Health Care MDS Coord	4,306	4,535	105,843	23.34	32
33	Other(specify) Marketing	1,996	2,080	67,082	32.25	33
34	TOTAL (lines 1 - 33)	291,062	305,644	\$ 4,327,637 *	\$ 14.16	34

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	\$ 8,858	L1, C3	35
36	Medical Director	Monthly	24,000	L9, C3	36
37	Medical Records Consultant	Monthly	1,940	L10, C3	37
38	Nurse Consultant	Monthly	120	L10, C3	38
39	Pharmacist Consultant	Monthly	9,352	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)		\$ 44,270		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

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

** See instructions.

Facility Name & ID Number

Manor Court of Clinton

STATE OF ILLINOIS

0047134

Report Period Beginning:

4/1/2015

Page 21

Ending: 3/31/2016

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	
Jennifer Westbrooks		Administrator	None	\$ 118,704	Workers' Compensation Insurance		\$ 92,346	IDPH License Fee		\$	
Andrea Goodlow		Asst. Administrator	None	9,234	Unemployment Compensation Insurance		11,458	Advertising: Employee Recruitment		1,715	
Jodi Ooms		Asst. Administrator	None	3,960	FICA Taxes		296,721	Health Care Worker Background Check		754	
					Employee Health Insurance		150,011	(Indicate # of checks performed)		300	
					Employee Meals			Patient Background Checks			
					Illinois Municipal Retirement Fund (IMRF)*						
					401 (k)		15,545	Subscriptions		555	
					Other Employee Benefits		8,120	IHCA Dues		8,787	
								Other Licenses & Fees		2,398	
								Indirect costs		10	
								Less: Public Relations Expense		()	
								Non-allowable advertising		()	
								Yellow page advertising		()	
TOTAL (agree to Schedule V, line 17, col. 1)				\$ 131,898				TOTAL (agree to Sch. V, line 20, col. 8)		\$ 14,519	
(List each licensed administrator separately.)											
B. Administrative - Other											
Description				Amount	Indirect Costs		107				
N/A				\$							
TOTAL (agree to Schedule V, line 17, col. 3)				\$	TOTAL (agree to Schedule V, line 22, col.8)		\$ 574,308				
(Attach a copy of any management service agreement)											
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		\$ 171,600	N/A				Out-of-State Travel		\$
LTC Support Services, LLC		Support Services		200,280							
McGladrey LLP		Accounting Services		33,634							
Lamkin & Lamkin, P.C.		Legal Services		1,512					In-State Travel		127
Davis & Campbell, LLC		Legal Services		16,771							
Polsinelli		Legal Services		1,715							
Duane Morris LLP		Legal Services		1,447							
									Seminar Expense		2,189
									Indirect costs		7
									Entertainment Expense		()
									(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3)				\$ 426,959	TOTAL			\$	TOTAL		\$ 2,323
(For legal fee disclosure, see page 39 of instructions)											

* Attach copy of IMRF notifications

SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

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?
If YES, give association name and amount.

Yes
8,787 IHCA
- (3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

No
N/A
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
N/A
- (5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
5-15 yrs
- (6)

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

\$ 63,411 Line 10
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
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.
This amount is to be recorded on line 42 of Schedule V.

\$ 293,287
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

- (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?
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.

No
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
Has any meal income been offset against related costs?

\$ 0
Yes Indicate the amount. \$ 28
- (16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No
N/A

c.

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

100% Line 14

d.

Have vehicle usage logs been maintained?

Yes

e.

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

Yes

f.

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

N/A

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
N/A

(17)

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

Yes
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.
Attach invoices and a summary of services for all architect and appraisal fees

Yes

SEE ACCOUNTANTS' PREPARATION REPORT