

		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: <u>0047316</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Manor Court of Peru</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>3230 Becker Drive</u> <u>Peru</u> <u>61354</u>			
Number City Zip Code			
County: <u>La Salle</u>			
Telephone Number: <u>(815) 220-1440</u> Fax # <u>None</u>			
HFS ID Number: _____		Officer or Administrator of Provider Paid Preparer	
Date of Initial License for Current Owners: <u>08/19/05</u>			
Type of Ownership:			
☒ VOLUNTARY,NON-PROFIT ☒ Charitable Corp. ☐ Trust IRS Exemption Code <u>501 (c) 3</u> ☐ 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: <u>Ron Wilson</u> Telephone Number: <u>(309) 343-1550</u>		(Signed) _____ (Date) _____ (Type or Print Name) <u>Darcee Fanning</u> (Title) <u>Regional Director</u> (Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</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	
Email Address: _____			

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Peru

0047316 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>104</u>	Skilled (SNF)	<u>104</u>	<u>38,064</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>26</u>	Sheltered Care (SC)	<u>26</u>	<u>9,516</u>	5
6		ICF/DD 16 or Less			6
7	<u>130</u>	TOTALS	<u>130</u>	<u>47,580</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>6,449</u>	<u>16,761</u>	<u>14,373</u>	<u>37,583</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		<u>2,827</u>		<u>2,827</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>6,449</u>	<u>19,588</u>	<u>14,373</u>	<u>40,410</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.93%

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 02/08/05

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 01/01/05 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 104 and days of care provided 12,530

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 Peru # 0047316 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	280,516	22,350	11,869	314,735		314,735		314,735			1
2	Food Purchase		449,666		449,666		449,666	(7,056)	442,610			2
3	Housekeeping	260,878	57,369	115	318,362		318,362		318,362			3
4	Laundry	42,323	14,148		56,471		56,471		56,471			4
5	Heat and Other Utilities			140,496	140,496		140,496		140,496			5
6	Maintenance	65,966	42,985	44,133	153,084		153,084		153,084			6
7	Other (specify):*											7
8	TOTAL General Services	649,683	586,518	196,613	1,432,814		1,432,814	(7,056)	1,425,758			8
	B. Health Care and Programs											
9	Medical Director			20,134	20,134		20,134		20,134			9
10	Nursing and Medical Records	2,928,876	260,622	20,396	3,209,894		3,209,894		3,209,894			10
10a	Therapy			1,841,090	1,841,090		1,841,090		1,841,090			10a
11	Activities	152,972	1,894		154,866		154,866		154,866			11
12	Social Services	79,206			79,206		79,206		79,206			12
13	CNA Training											13
14	Program Transportation			4,422	4,422		4,422		4,422			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,161,054	262,516	1,886,042	5,309,612		5,309,612		5,309,612			16
	C. General Administration											
17	Administrative	80,199			80,199		80,199		80,199			17
18	Directors Fees							3,397	3,397			18
19	Professional Services			347,199	347,199		347,199	7,603	354,802			19
20	Dues, Fees, Subscriptions & Promotions			20,556	20,556		20,556	9	20,565			20
21	Clerical & General Office Expenses	127,174	44,077	49,823	221,074		221,074		221,074			21
22	Employee Benefits & Payroll Taxes			570,505	570,505		570,505	93	570,598			22
23	Inservice Training & Education			4,176	4,176		4,176		4,176			23
24	Travel and Seminar			1,139	1,139		1,139	6	1,145			24
25	Other Admin. Staff Transportation			463	463		463		463			25
26	Insurance-Prop.Liab.Malpractice			52,746	52,746		52,746	16,516	69,262			26
27	Other (specify):*											27
28	TOTAL General Administration	207,373	44,077	1,046,607	1,298,057		1,298,057	27,624	1,325,681			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,018,110	893,111	3,129,262	8,040,483		8,040,483	20,568	8,061,051			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			54,370	54,370		54,370	646,378	700,748			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			36	36		36	528,820	528,856			32
33	Real Estate Taxes							81,690	81,690			33
34	Rent-Facility & Grounds			985,800	985,800		985,800	(985,800)				34
35	Rent-Equipment & Vehicles			23,101	23,101		23,101		23,101			35
36	Other (specify):* MIP Insurance							73,161	73,161			36
37	TOTAL Ownership			1,063,307	1,063,307		1,063,307	344,249	1,407,556			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,736	2,736		2,736		2,736			38
39	Ancillary Service Centers		370,508		370,508		370,508		370,508			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			2,761	2,761		2,761		2,761			41
42	Provider Participation Fee			178,529	178,529		178,529		178,529			42
43	Other (specify):* Disallowed Costs	50,221		107,184	157,405		157,405	(157,405)				43
44	TOTAL Special Cost Centers	50,221	370,508	291,210	711,939		711,939	(157,405)	554,534			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,068,331	1,263,619	4,483,779	9,815,729		9,815,729	207,412	10,023,141			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	(39)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,694)	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				9
10	Interest and Other Investment Income	(3,469)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(49,688)	43		24
25	Fund Raising, Advertising and Promotional	(36,595)	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	(73,445)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (167,930)		\$	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)	375,342		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 375,342		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 207,412		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	Nonallowable marketing salaries	\$ (50,221)	43	1
2	Labs - Part A	(5,731)	43	2
3	X-Rays - Part A	(10,476)	43	3
4	Offset Vending Machine revenue	(7,017)	2	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	(73,445)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manor Court of Peru# 0047316

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	(7,056)	0	0	0	0	0	0	0	0	0	0	(7,056)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,056)	0	0	0	0	0	0	0	0	0	0	(7,056)	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	3,397	0	0	0	0	0	0	0	0	0	3,397	18
19	Professional Services	0	7,603	0	0	0	0	0	0	0	0	0	7,603	19
20	Fees, Subscriptions & Promotions	0	9	0	0	0	0	0	0	0	0	0	9	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	93	0	0	0	0	0	0	0	0	0	93	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6	0	0	0	0	0	0	0	0	0	6	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,630	14,886	0	0	0	0	0	0	0	0	16,516	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	12,738	14,886	0	0	0	0	0	0	0	0	27,624	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(7,056)	12,738	14,886	0	0	0	0	0	0	0	0	20,568	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manor Court of Peru # 0047316 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	0	0	646,378	0	0	0	0	0	0	0	0	646,378	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,469)	0	532,289	0	0	0	0	0	0	0	0	528,820	32
33	Real Estate Taxes	0	0	81,690	0	0	0	0	0	0	0	0	81,690	33
34	Rent-Facility & Grounds	0	0	(985,800)	0	0	0	0	0	0	0	0	(985,800)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	73,161	0	0	0	0	0	0	0	0	73,161	36
37	TOTAL Ownership	(3,469)	0	347,718	0	0	0	0	0	0	0	0	344,249	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):*	(157,405)	0	0	0	0	0	0	0	0	0	0	(157,405)	43
44	TOTAL Special Cost Centers	(157,405)	0	0	0	0	0	0	0	0	0	0	(157,405)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(167,930)	12,738	362,604	0	0	0	0	0	0	0	0	207,412	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)		Peru Becker, Ltd., NFI	Galesburg	Real Estate Entity
		Residential Alternatives of Illinois, Inc. (FH is sole mem		See Page 6 Supplemental		
		Pioneer Concepts, Inc. (FH is sole member)				
		Pinnacle Opportunities, Inc. (FH is sole member)				
		See Page 6 Supplemental for specific homes				

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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%	\$ 3,397	\$ 3,397	1
2	V	19	Professional Services		Residential Alternatives of Illinois, Inc.	100.00%	7,603	7,603	2
3	V	20	Dues, Fees & Subscriptions		Residential Alternatives of Illinois, Inc.	100.00%	9	9	3
4	V	22	Employee Benefits & PR Taxes		Residential Alternatives of Illinois, Inc.	100.00%	93	93	4
5	V	24	Travel and Seminar		Residential Alternatives of Illinois, Inc.	100.00%	6	6	5
6	V	26	Property Insurance		Residential Alternatives of Illinois, Inc.	100.00%	1,630	1,630	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 12,738	\$ * 12,738	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

☒ X

 YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	Insurance		Peru Becker, Ltd., NFP		14,886	\$	14,886
16	V	30	Depreciation Expense		Peru Becker, Ltd., NFP		646,378		646,378
17	V	32	Interest	344	Peru Becker, Ltd., NFP		505,518		505,174
18	V	32	Amortization		Peru Becker, Ltd., NFP		27,115		27,115
19	V	33	Real Estate Tax		Peru Becker, Ltd., NFP		81,690		81,690
20	V	34	Facility Rent	985,800	Peru Becker, Ltd., NFP				(985,800)
21	V	36	Property/MIP Insurance		Peru Becker, Ltd., NFP		73,161		73,161
22	V								
23	V								
24	V								
25	V								
26	V								
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ 986,144			\$ 1,348,748	\$ *	362,604

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Manor Court of Peru

0047316

Report Period Beginning:

4/1/2015

Ending:

3/31/2016

VII. RELATED PARTIES

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Manor Court of Peru

0047316

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 Peru # 0047316 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	\$ 182	L18, C7	1
2	Doug Biederstedt	Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	727	L18, C7	2
3	Jeff Shaw	Secretary & Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	727	L18, C7	3
4	William Kempiners	Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	727	L18, C7	4
5	John Kniery	Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	727	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	\$ 3,090		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 Peru # 0047316 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	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	18	Director Fees	Weighted Avg BDA	353,445	18	\$ 28,040	\$	42,822	\$ 3,397	1
2	19	Professional Services	Weighted Avg BDA	353,445	18	62,749		42,822	7,603	2
3	20	Dues, Fees & Subscriptions	Weighted Avg BDA	353,445	18	75		42,822	9	3
4	22	Employee Benefits & PR Taxes	Weighted Avg BDA	353,445	18	773		42,822	93	4
5	24	Travel and Seminar	Weighted Avg BDA	353,445	18	47		42,822	6	5
6	26	Property Insurance	Weighted Avg BDA	353,445	18	13,455		42,822	1,630	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	\$		\$ 12,738	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	Cambridge Realty Capital		X	Refinance - w/ trade premium			\$					\$	1
2	Ltd. Of Illinois - SNF			of \$542,592 as of 3/31/16	\$63,289.78	6/1/2013	13,860,000	13,728,876	5/1/2043	3.8000	505,554		2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related				\$63,289.78		\$ 13,860,000	\$ 13,728,876			\$ 505,554		9
	B. Non-Facility Related*												
10	Cambridge Realty Capital						5,940,000	5,883,804	5/1/2043	3.8000	216,651		10
11	Ltd. Of Illinois - Non SNF							Offset Interest Income			(3,813)		11
12								Amortization			27,115		12
13								Offset Non SNF Interest Expense			(216,651)		13
14	TOTAL Non-Facility Related						\$ 5,940,000	\$ 5,883,804			\$ 23,302		14
15	TOTALS (line 9+line14)						\$ 19,800,000	\$ 19,612,680			\$ 528,856		15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 73,161 Line # 36

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2015 report.			\$	132,300	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	\$	43,087	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(89,213)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	205,913	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.				(35,010)	
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	(35,010)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	81,690	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2011	_____	43,288	8	
	2012	_____	54,897	9	
	2013	_____	55,482	10	
	2014	_____	43,087	11	
	2015	_____	164,672	12	
This facility was leased from an unrelated for-profit entity and was purchased by a related party in July 2009. Amount accrued includes 12 months of 2015 and 3 months of 2016. The real estate tax estimate is based on the 2015 tax bills. Taxes paid are for the 2014 tax bill. The related party also pays real estate taxes for property not operated by the SNF.					

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

FACILITY NAME Manor Court of Peru COUNTY La Salle
FACILITY IDPH LICENSE NUMBER 0047316
CONTACT PERSON REGARDING THIS REPORT Ron Wilson
TELEPHONE (309) 343-1550 FAX #: (309) 343-2857

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.

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.

- A. Square Feet: 27,166
- B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1
- C. Does the Operating Entity? (a) Own the Facility (X) (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 (X) (b) Rent equipment from a Related Organization. (X) (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)
- E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

- F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES (X) NO
If so, please complete the following:
1. Total Amount Incurred: 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	Facility - SNF	3.42 acres	2009	\$ 350,000	1
2					2
3	TOTALS	#VALUE!		\$ 350,000	3

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	130		2009		\$ 13,641,000	\$	25	\$ 545,670	\$ 545,670	\$ 3,683,286	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Electric Sign and Water Heater			2005	7,758	104	10	104		7,758	9
10	Roof			2006	5,050	505	10	505		4,798	10
11	Sprinkler System, Asphalt Ramp, Paved parking lot & sidewalks			2009	1,060,899	1,208	8-15 yrs	71,208	70,000	480,437	11
12	Call Light System in Therapy			2010	4,877	488	10	488		3,008	12
13	Wander Security Panel			2012	3,140	314	10	314		1,099	13
14	Vinyl Tile/Wallpaper/Paint in Dining Room			2013	11,511	1,151	10	1,151		3,453	14
15	Water Heater			2013	8,877	888	10	888		2,590	15
16	Air Conditioner			2013	3,150	315	10	315		919	16
17	Mag Lock/Electromagnetic Lock			2013	2,998	300	10	300		850	17
18	Water Softener - Entire SNF Facility			2014	6,540	654	10	654		1,417	18
19											19
20	Fire Alarm - Manor Court Building			2014	6,830	683	10	683		1,081	20
21	Water Heater - Services Resident Rooms			2015	3,197	320	10	320		400	21
22	Single Faced Lighted Sign - Outside of SNF Building			2014	3,345	335	10	335		614	22
23	New PTAC units - Resident Rooms			2015	3,522	411	5	411		411	23
24	New Nurse Call System			2015	108,573	6,510	10	6,510		6,510	24
25	New Water Heater			2015	5,502	367	10	367		367	25
26	Amber Message Sign			2015	12,675	634	10	634		634	26
27	New Water Heater			2016	5,631	141	10	141		141	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Peru

0047316

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)		\$ 14,905,075	\$ 15,328		\$ 630,998	\$ 615,670	\$ 4,199,773	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	\$ 636,013	\$ 32,992	\$ 63,700	\$ 30,708	3-15 yrs	\$ 410,358	71
72	Current Year Purchases	54,373	2,455	2,455		5-10 Yrs	2,455	72
73	Fully Depreciated Assets	67,231					67,231	73
74								74
75	TOTALS	\$ 757,617	\$ 35,447	\$ 66,155	\$ 30,708		\$ 480,044	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2003 GMC Van	2005	\$ 29,800	\$	\$	\$	4	\$ 29,800	76
77	Patient Care	2003 Chevy Silverado	2013	14,380	3,595	3,595		4	8,389	77
78										78
79										79
80	TOTALS			\$ 44,180	\$ 3,595	\$ 3,595	\$		\$ 38,189	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)	\$ 16,056,872	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 54,370	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 700,748	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 646,378	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,718,006	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	2010 Toyota Corolla - 2010	\$ 16,300	\$	\$ 16,300	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 16,300	\$	\$ 16,300	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: \$ 23,101 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

Facility Name:

Manor Court of Peru

IDPH License ID Number:

0047316

Fiscal Year End:

3/31/2016

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment Rental	22,386
Office Equipment	497
Other Equipment Rental	218
Total - Line 16	23,101

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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' PREPARATION REPORT

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

		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	\$	9,190	\$ 661,679	\$	9,190	\$ 661,679	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,490	107,310		1,490	107,310	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		14,582	1,049,875		14,582	1,049,875	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				370,508		370,508	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	10A(3)			309	22,226		309	22,226	12
13	Other (specify): <u></u>									13
14	TOTAL			\$	25,571	\$ 1,841,090	\$ 370,508	25,571	\$ 2,211,598	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	\$ 26,071	\$ 80,386	1
2	Cash-Patient Deposits	13,392	13,392	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 124,000)	1,193,576	1,282,064	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	52,016	72,582	6
7	Other Prepaid Expenses	2,652	2,652	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interdivision Receivable	11,125,387	9,039,553	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 12,413,094	\$ 10,490,629	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		350,000	13
14	Buildings, at Historical Cost	210,553	14,905,075	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	513,819	801,797	16
17	Accumulated Depreciation (book methods)	(371,257)	(4,718,006)	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): See Att Sch 17A		1,804,620	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 353,115	\$ 13,143,486	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 12,766,209	\$ 23,634,115	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 281,731	\$ 300,240	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,392	13,392	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	109,594	109,594	30
31	Accrued Taxes Payable (excluding real estate taxes)	65,321	65,321	31
32	Accrued Real Estate Taxes(Sch.IX-B)		144,139	32
33	Accrued Interest Payable		41,757	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 470,038	\$ 674,443	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		19,612,680	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Security Deposits	67,500	67,500	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 67,500	\$ 19,680,180	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 537,538	\$ 20,354,623	46
47	TOTAL EQUITY(page 18, line 24)	\$ 12,228,671	\$ 3,279,492	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 12,766,209	\$ 23,634,115	48

Facility Name: Manor Court of Peru
IDPH License ID Number: 0047316
Fiscal Year End: 3/31/2016

Schedule 17A

XV. Balance Sheet
Line 22 Long Term Assets Other (specify):

Description	Operating	After Consolidation
Real Estate Tax Escrow	-	164,324
Insurance Escrow	-	5,600
MIP Insurance Escrow	-	60,586
Reserve for Replacement	-	445,388
Capitalized Loan Fee	-	1,309,348
Amortization Loan Fee	-	(180,626)
Total - Line 36	-	1,804,620

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 10,269,486	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 10,269,486	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,959,185	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,959,185	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)	\$ 12,228,671	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Peru

0047316

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	\$ 11,416,847	1
2	Discounts and Allowances for all Levels	(164,355)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,252,492	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	484,291	6
7	Oxygen	13,052	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 497,343	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	7,017	12
13	Barber and Beauty Care	8,983	13
14	Non-Patient Meals	39	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	(2,049)	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	3,343	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 17,333	23
	D. Non-Operating Revenue		
24	Contributions	1,271	24
25	Interest and Other Investment Income***	3,469	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,740	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Income</u>	2,756	28
28a	<u>Gain on Sale of Fixed Asset</u>	250	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,006	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,774,914	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,432,814	31
32	Health Care	5,309,612	32
33	General Administration	1,298,057	33
	B. Capital Expense		
34	Ownership	1,063,307	34
	C. Ancillary Expense		
35	Special Cost Centers	533,410	35
36	Provider Participation Fee	178,529	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,815,729	40
41	Income before Income Taxes (line 30 minus line 40)**	1,959,185	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,959,185	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 938,702	44
45	Private Pay - Net Inpatient Revenue	3,433,985	45
46	Medicare - Net Inpatient Revenue	6,178,181	46
47	Other-(specify) <u>Medicare Replacement</u>	162,625	47
48	Other-(specify) <u>Managed Care</u>	538,999	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,252,492	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	1,888	2,080	\$ 64,165	\$ 30.85	1
2	Assistant Director of Nursing	1,896	2,080	63,251	30.41	2
3	Registered Nurses	28,453	30,363	757,095	24.93	3
4	Licensed Practical Nurses	17,629	18,727	435,304	23.24	4
5	CNAs & Orderlies	109,770	115,682	1,459,820	12.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	12,549	13,416	152,972	11.40	10
11	Social Service Workers	4,649	4,964	79,206	15.96	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,000	24,000	280,516	11.69	15
16	Dishwashers					16
17	Maintenance Workers	6,287	6,854	65,966	9.62	17
18	Housekeepers	24,435	25,990	260,878	10.04	18
19	Laundry	3,913	4,253	42,323	9.95	19
20	Administrator	1,411	1,680	61,487	36.60	20
21	Assistant Administrator	1,052	1,120	18,712	16.71	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,178	8,584	127,174	14.82	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,129	2,264	25,590	11.30	31
32	Other Health Care MDS Coord	4,647	4,957	123,651	24.94	32
33	Other(specify) Marketing	2,220	2,454	50,221	20.46	33
34	TOTAL (lines 1 - 33)	255,106	269,468	\$ 4,068,331 *	\$ 15.10	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	\$ 11,869	L1, C3	35
36	Medical Director	Monthly	20,134	L9, C3	36
37	Medical Records Consultant	Monthly	2,020	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,417	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)		\$ 43,440		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 Peru

STATE OF ILLINOIS

0047316

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
Tiffany Green	Administrator	None	\$ 61,487	Workers' Compensation Insurance	\$	88,810	IDPH License Fee	\$
Angela Taylor	Asst. Administrator	None	18,712	Unemployment Compensation Insurance		5,419	Advertising: Employee Recruitment	1,850
				FICA Taxes		284,114	Health Care Worker Background Check	
				Employee Health Insurance		168,913	(Indicate # of checks performed 51)	513
				Employee Meals			Patient Background Checks	215 7,510
				Illinois Municipal Retirement Fund (IMRF)*				
				401 (k)		17,880	Subscriptions	86
				Other Employee Benefits		5,369	IHCA Dues	7,595
							Other Licenses & Fees	3,002
							Indirect costs	9
							Less: Public Relations Expense	()
							Non-allowable advertising	()
							Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 80,199	TOTAL (agree to Schedule V, line 22, col.8)			\$ 570,598	
(List each licensed administrator separately.)								
B. Administrative - Other				Indirect Costs			93	
Description			Amount					
N/A			\$					
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				Description			Amount	
Vendor/Payee	Type		Amount		Line #	Amount	Description	
RFMS, Inc.	Administrative Services	\$	144,000				Out-of-State Travel	
LTC Support Services, LLC	Support Services		166,395	N/A			\$	
McGladrey LLP	Accounting Services		36,017					
Duane Morris LLP	Legal Services		449				In-State Travel	
Polsinelli	Legal Services		338				147	
							Seminar Expense	
							992	
							Indirect costs	
							6	
							Entertainment Expense	
							()	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 347,199	TOTAL			\$	
(For legal fee disclosure, see page 39 of instructions)							TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 1,145	

* Attach copy of IMRF notifications

SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name & ID Number		Manor Court of Peru		STATE OF ILLINOIS	#	0047316	Report Period Beginning:	4/1/2015	Ending:	3/31/2016	Page 22
XX. GENERAL INFORMATION:											
(1)	Are nursing employees (RN,LPN,NA) represented by a union?			<u>No</u>							
(2)	Are there any dues to nursing home associations included on the cost report?			<u>Yes</u>							
	If YES, give association name and amount.			<u>7,595 IHCA</u>							
(3)	Did the nursing home make political contributions or payments to a political action organization?			<u>No</u>							
	If YES, have these costs been properly adjusted out of the cost report?			<u>N/A</u>							
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?			<u>No</u>							
	If YES, what is the capacity?			<u>N/A</u>							
(5)	Have you properly capitalized all major repairs and equipment purchases?			<u>Yes</u>							
	What was the average life used for new equipment added during this period?			<u>5-10 Yrs</u>							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$ <u>73,392</u> Line <u>10</u>							
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports?			<u>Yes</u>							
	If NO, attach a complete explanation.										
(8)	Are you presently operating under a sale and leaseback arrangement?			<u>No</u>							
	If YES, give effective date of lease.			<u>N/A</u>							
(9)	Are you presently operating under a sublease agreement?			YES <u>X</u> NO							
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?			YES <u>NO</u> <u>X</u>							
	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.			\$ <u>178,529</u>							
	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?			<u>No</u>							
	If YES, attach an explanation of the allocation.										
SEE ACCOUNTANTS' PREPARATION REPORT											
(13)	Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?			<u>Yes</u>							
(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?			<u>No</u>							
	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.			\$ <u>0</u>							
	Has any meal income been offset against related costs?			<u>Yes</u>							
	Indicate the amount.			\$ <u>39</u>							
(16)	Travel and Transportation										
	a. Are there costs included for out-of-state travel?			<u>No</u>							
	If YES, attach a complete explanation.										
	b. Do you have a separate contract with the Department to provide medical transportation for residents?			<u>No</u>							
	If YES, please indicate the amount of income earned from such a program during this reporting period.			\$ <u>N/A</u>							
	c. What percent of all travel expense relates to transportation of nurses and patients?			<u>None</u>							
	d. Have vehicle usage logs been maintained?			<u>Yes</u>							
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?			<u>Yes</u>							
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?			<u>N/A</u>							
	g. Does the facility transport residents to and from day training?			<u>No</u>							
	Indicate the amount of income earned from providing such transportation during this reporting period.			\$ <u>N/A</u>							
(17)	Has an audit been performed by an independent certified public accounting firm?			<u>Yes</u>							
	Firm Name:			<u>McGladrey & Pullen, LLP</u>							
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?			<u>Yes</u>							
(19)	Has a schedule for the legal fees reported on the cost report been provided by the facility?			<u>Yes</u>							
	See page 39 of the instructions for details.										
	Attach invoices and a summary of services for all architect and appraisal fees										