

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

I. IDPH License ID Number: <u>0047068</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Manor Court of Peoria</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>4/1/2019</u> to <u>3/31/20</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>6900 N Stalworth Dr</u> <u>Peoria</u> <u>61615</u>																									
Number City Zip Code																									
County: <u>Peoria</u>																									
Telephone Number: <u>(309) 691-2020</u> Fax # <u>(309) 683-3491</u>																									
HFS ID Number: _____		<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>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Larry Templin</u> <u>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></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	(Date) _____	(Print Name and Title) <u>Larry Templin</u> <u>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 # ()												
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	(Telephone) <u>(630) 361-2868</u> Fax # ()																								
Date of Initial License for Current Owners: <u>08/03/06</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:		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																							
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 Peoria

0047068 Report Period Beginning: 4/1/2019 Ending: 3/31/20

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>50</u>	Skilled (SNF)	<u>50</u>	<u>18,300</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>50</u>	TOTALS	<u>50</u>	<u>18,300</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>2,694</u>	<u>8,934</u>	<u>3,835</u>	<u>15,463</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>2,694</u>	<u>8,934</u>	<u>3,835</u>	<u>15,463</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.50 %

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒ Non-allowable costs have been eliminated in Schedule V, Column 7

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 50 and days of care provided 2,358

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 3/31/20 Fiscal Year: 3/31/20
* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Peoria # 0047068 Report Period Beginning: 4/1/2019 Ending: 3/31/20

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	161,698	25,784	6,400	193,882		193,882		193,882			1
2	Food Purchase		152,157		152,157		152,157	(1,273)	150,884			2
3	Housekeeping	116,048	29,156		145,204		145,204		145,204			3
4	Laundry	23,776	6,899		30,675		30,675		30,675			4
5	Heat and Other Utilities			67,231	67,231		67,231		67,231			5
6	Maintenance	54,420	27,320	30,712	112,452		112,452	(4,300)	108,152			6
7	Other (specify):*											7
8	TOTAL General Services	355,942	241,316	104,343	701,601		701,601	(5,573)	696,028			8
	B. Health Care and Programs											
9	Medical Director			17,250	17,250		17,250		17,250			9
10	Nursing and Medical Records	1,409,218	87,327	9,410	1,505,955		1,505,955		1,505,955			10
10a	Therapy											10a
11	Activities	78,542	3,085		81,627		81,627		81,627			11
12	Social Services	23,817			23,817		23,817		23,817			12
13	CNA Training											13
14	Program Transportation			4,884	4,884		4,884		4,884			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,511,577	90,412	31,544	1,633,533		1,633,533		1,633,533			16
	C. General Administration											
17	Administrative	103,152			103,152		103,152		103,152			17
18	Directors Fees							933	933			18
19	Professional Services			176,571	176,571		176,571	56	176,627			19
20	Dues, Fees, Subscriptions & Promotions			20,980	20,980		20,980	(1,031)	19,949			20
21	Clerical & General Office Expenses	119,777	31,402	42,551	193,730		193,730	42	193,772			21
22	Employee Benefits & Payroll Taxes			294,322	294,322		294,322		294,322			22
23	Inservice Training & Education			2,101	2,101		2,101		2,101			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			255	255		255		255			25
26	Insurance-Prop.Liab.Malpractice			52,440	52,440		52,440	11,795	64,235			26
27	Other (specify):*											27
28	TOTAL General Administration	222,929	31,402	589,220	843,551		843,551	11,795	855,346			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,090,448	363,130	725,107	3,178,685		3,178,685	6,222	3,184,907			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			43,277	43,277		43,277	227,236	270,513			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							163,067	163,067			32
33	Real Estate Taxes							62,824	62,824			33
34	Rent-Facility & Grounds			462,000	462,000		462,000	(462,000)				34
35	Rent-Equipment & Vehicles			38,101	38,101		38,101		38,101			35
36	Other (specify):* MIP Insurance							22,866	22,866			36
37	TOTAL Ownership			543,378	543,378		543,378	13,993	557,371			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			5,865	5,865		5,865		5,865			38
39	Ancillary Service Centers		170,866	425,320	596,186		596,186		596,186			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			1,187	1,187		1,187	(1,187)				41
42	Provider Participation Fee			99,124	99,124		99,124		99,124			42
43	Other (specify):* Disallowed Costs	36,602		243,528	280,130		280,130	(280,130)				43
44	TOTAL Special Cost Centers	36,602	170,866	775,024	982,492		982,492	(281,317)	701,175			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,127,050	533,996	2,043,509	4,704,555		4,704,555	(261,102)	4,443,453			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,273)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,927)	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	215	30		9
10	Interest and Other Investment Income	(407)	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	(1,058)	20		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	(178,374)	43		24
25	Fund Raising, Advertising and Promotional	(40,604)	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	(60,712)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (288,140)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	27,038		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 27,038		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (261,102)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Nonallowable marketing salaries	\$ (36,602)	43	1
2	Labs - Part A	(17,547)	43	2
3	X-Rays - Part A	(1,076)	43	3
4	Offset Vending Machine revenue	(1,187)	41	4
5	Capitalized Repairs over \$2,500	(4,300)	6	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	(60,712)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manor Court of Peoria# 0047068

Report Period Beginning:

4/1/2019

Ending:

3/31/20

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	(1,273)	0	0	0	0	0	0	0	0	0	0	(1,273)	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	(4,300)	0	0	0	0	0	0	0	0	0	0	(4,300)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,573)	0	0	0	0	0	0	0	0	0	0	(5,573)	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	933	0	0	0	0	0	0	0	0	0	933	18
19	Professional Services	0	56	0	0	0	0	0	0	0	0	0	56	19
20	Fees, Subscriptions & Promotions	(1,058)	27	0	0	0	0	0	0	0	0	0	(1,031)	20
21	Clerical & General Office Expenses	0	42	0	0	0	0	0	0	0	0	0	42	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	417	11,378	0	0	0	0	0	0	0	0	11,795	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(1,058)	1,475	11,378	0	0	0	0	0	0	0	0	11,795	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(6,631)	1,475	11,378	0	0	0	0	0	0	0	0	6,222	29

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)		Danville Independence	Danville	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%	\$ 933	\$ 933	1
2	V	19	Professional Services		Residential Alternatives of Illinois, Inc.	100.00%	56	56	2
3	V	20	Dues, Fees & Subscriptions		Residential Alternatives of Illinois, Inc.	100.00%	27	27	3
4	V	21	Clerical & General Office		Residential Alternatives of Illinois, Inc.	100.00%	42	42	4
5	V	26	Property Insurance		Residential Alternatives of Illinois, Inc.	100.00%	417	417	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 1,475	\$ * 1,475	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	Insurance		Peoria Manor Court, Ltd., NFP		\$ 11,378	\$ 11,378	15
16	V	30	Depreciation Expense		Peoria Manor Court, Ltd., NFP		227,021	227,021	16
17	V	32	Interest	210	Peoria Manor Court, Ltd., NFP		148,478	148,268	17
18	V	32	Amortization		Peoria Manor Court, Ltd., NFP		15,206	15,206	18
19	V	33	Real Estate Tax		Peoria Manor Court, Ltd., NFP		62,824	62,824	19
20	V	34	Facility Rent	462,000	Peoria Manor Court, Ltd., NFP			(462,000)	20
21	V	36	MIP Insurance		Peoria Manor Court, Ltd., NFP		22,866	22,866	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 462,210			\$ 487,773	\$ * 25,563	39

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Manor Court of Peoria

0047068

Report Period Beginning:

4/1/2019

Ending:

3/31/20

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Manor Court of Peoria

0047068

Report Period Beginning:

4/1/2019

Ending:

3/31/20

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Peoria # 0047068 Report Period Beginning: 4/1/2019 Ending: 3/31/20

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	John Kniery	President & Director	Administrative	0.00	See Att. Sch 7A	1	<1 %	Director Fees	\$ 234	L18, C7	1
2	Doug Biederstedt	Director	Administrative	0.00	See Att. Sch 7A	1	<1 %	Director Fees	155	L18, C7	2
3	Jeff Shaw	Secretary & Director	Administrative	0.00	See Att. Sch 7A	1	<1 %	Director Fees	233	L18, C7	3
4	William Kempiners	Director	Administrative	0.00	See Att. Sch 7A	1	<1 %	Director Fees	233	L18, C7	4
5	Ben McMahan	President & Director	Administrative	0.00	See Att. Sch 7A	1	<1 %	Director Fees	78	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	\$ 933		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

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	Loan Refinance	\$20,858.41	5/29/2015	\$ 4,580,100	\$ 4,127,032	1/1/2045	3.5500	\$ 148,478	1	
2	Ltd. Of Illinois - SNF											2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$20,858.41		\$ 4,580,100	\$ 4,127,032			\$ 148,478	9	
	B. Non-Facility Related*												
10	Cambridge Realty Capital		X	Loan Refinance	\$28,804.47	5/29/2015	6,324,900	5,699,235	1/1/2045	3.5500	205,042	10	
11	Ltd. Of Illinois - ALC							Offset Interest Income			(617)	11	
12								Amortization			15,206	12	
13								Disallow Non-SNF Portion of Int			(205,042)	13	
14	TOTAL Non-Facility Related				\$28,804.47		\$ 6,324,900	\$ 5,699,235			\$ 14,589	14	
15	TOTALS (line 9+line14)						\$ 10,905,000	\$ 9,826,267			\$ 163,067	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 22,866 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 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	148,367	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.)		2018	\$	129,067	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(19,300)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	168,880	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.		Less Non-SNF portion of taxes		(86,756)	
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	62,824	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	128,559	8	
		2016	130,982	9	
		2017	130,703	10	
		2018	129,067	11	
		2019	135,050	12	
This facility was leased from an unrelated for-profit entity and was purchased by a related party in December 2009. The lease agreement requires the lessee to pay the R/E taxes. Amount accrued includes 12 months of 2019 and 3 months of 2020.				13	FROM R. E. TAX STATEMENT FOR 2019 \$ 13
The R/E tax estimate is based on 2018 tax bill. Taxes paid are for the 2018 tax bill. The related party also pays real estate taxes for property not operated by the SNF. See Att Sch for the allocation of SNF portion.				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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manor Court of Peoria COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0047068

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 13-11-352-005	Fieldstone Estates SW 1/4 Sec 11-9N-	\$ 129,613.28	\$ 54,437.57
2.		\$	\$
3. 13-11-352-025	Fieldstone Estates Extn 1 SW 1/4 Sec	\$ 1,359.24	\$ 570.88
4.		\$	\$
5. 13-11-352-026	Fieldstone Estates Extn 1 SW 1/4 Sec	\$ 1,359.24	\$ 570.88
6.		\$	\$
7. 13-11-355-011	Fieldstone Estates Extn 1 SW 1/4 Sec	\$ 1,359.24	\$ 570.88
8.		\$	\$
9. 13-11-355-012	Fieldstone Estates Extn 1 SW 1/4 Sec	\$ 1,359.24	\$ 570.88
10.		\$	\$
TOTALS		\$ 135,050.24	\$ 56,721.09

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,840

B. General Construction Type: Exterior BrickFrame WoodNumber 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	Facility - SNF	62,400	2009	\$ 147,000	1
2					2
3	TOTALS	62,400		\$ 147,000	3

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	50		2009		\$ 4,869,143	\$	25	\$ 194,767	\$ 194,767	\$ 2,012,610
5										
6										
7										
8										
	Improvement Type**									
9	Sign		2007		3,100		10			3,100
10	Fire Doors, Paved Parking Lot & Sidewalks		2009		232,895	218	15	15,525	15,307	160,547
11	Electromagnetic Lock		2010		8,319	832	10	832		8,111
12	Water Heater		2010		4,758	475	10	475		4,520
13	Concrete-Handycap Ramp/Sidewalk Repairs		2011		4,191	279	15	279		2,444
14	Water Heater		2013		5,248	525	10	525		3,718
15	Water Heater		2014		5,502	550	10	550		3,072
16	Water Softener		2014		8,427	843	10	843		4,495
17	Vinyl Tile installed in Dining Room		2015		5,428	543	10	543		2,534
18	Water Heater-Outdoor Sprinkler Room		2016		5,632	563	10	563		2,252
19	Water Heater-Mechanical Room Near Laundry		2017		6,619	662	10	662		1,931
20	Nurse Call/Intercom/Patient Wandering System		2017		117,945	16,849	7	16,849		49,144
21	Chain Link Fence-Back of Facility		2018		3,038	202	15	202		439
22	Mag Locks		2018		2,694	269	10	269		426
23	Nurses Station - 2 Countertops / 2 Folder Cabinets		2019		5,500	458	10	458		458
24	Install Transfer Switch		2019		4,960	413	10	413		413
25	4 New PTAC Units		2019		2,729	205	10	205		205
26	4 New PTAC Units		2019		2,762	184	5	184		184
27	Parking Lot-Asphalt Patchwork		2019		4,300		10	215	215	215
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

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

Facility Name & ID Number Manor Court of Peoria

0047068

Report Period Beginning:

4/1/2019

Ending:

3/31/20

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)		\$ 5,303,190	\$ 24,070		\$ 234,359	\$ 210,289	\$ 2,260,818	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	\$ 377,788	\$ 12,615	\$ 29,562	\$ 16,947	3-15 yrs	\$ 336,757	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	124,356					124,356	73
74								74
75	TOTALS	\$ 502,144	\$ 12,615	\$ 29,562	\$ 16,947		\$ 461,113	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76	Patient Care	Toyota Corolla 2006	2006	\$ 15,288	\$	\$	\$	4	\$ 15,288
77	Facility	Chevrolet Cheyenne 1998	2014	3,230				4	3,230
78	Facility	2014 Braun Entervan	2016	21,865	5,467	5,467		4	21,865
79	Facility	2005 Ford E 350 Van	2019	6,000	1,125	1,125		4	1,125
80	TOTALS			\$ 46,383	\$ 6,592	\$ 6,592	\$		\$ 41,508

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)			\$	5,998,717
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	43,277
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	270,513
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	227,236
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	2,763,439

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86	1999 Chevy Silverado 2500 - 2012	\$ 11,559	\$	\$ 11,559
87				
88				
89				
90				
91	TOTALS	\$ 11,559	\$	\$ 11,559

G. Construction-in-Progress		
	Description	Cost
92	N/A	\$
93		
94		
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.

		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
9. Option to Buy:

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ 38,101 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					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: Manor Court of Peoria
IDPH License ID Number: 0047068
Fiscal Year End: 3/31/20

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment Rental	34,184
Other Equipment Rental	3,917
Total - Line 16	38,101

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

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	39(3)	hrs	\$	1,657	\$ 119,299	\$	1,657	\$ 119,299	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		842	60,608		842	60,608	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		3,399	244,750		3,399	244,750	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				170,866		170,866	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	39(3)				663			663	12
13	Other (specify): <u></u>									13
14	TOTAL			\$	5,898	\$ 425,320	\$ 170,866	5,898	\$ 596,186	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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 63,734	\$ 80,011	1
2	Cash-Patient Deposits	4,237	4,237	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 241,000)	762,893	762,893	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,569	25,466	6
7	Other Prepaid Expenses	3,868	5,799	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interdivision Receivable	1,312,632	513,188	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,170,933	\$ 1,391,594	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		147,000	13
14	Buildings, at Historical Cost	194,637	5,073,570	14
15	Leasehold Improvements, at Historical Cost		229,620	15
16	Equipment, at Historical Cost	311,409	548,527	16
17	Accumulated Depreciation (book methods)	(349,791)	(2,763,439)	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		577,544	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 156,255	\$ 3,812,822	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,327,188	\$ 5,204,416	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 181,691	\$ 191,771	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,237	4,237	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	35,836	35,836	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,449	1,449	31
32	Accrued Real Estate Taxes(Sch.IX-B)		168,880	32
33	Accrued Interest Payable		12,209	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)	\$ 223,213	\$ 414,382	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,826,267	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Security Deposits	27,000	27,000	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 27,000	\$ 9,853,267	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 250,213	\$ 10,267,649	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,076,975	\$ (5,063,233)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,327,188	\$ 5,204,416	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Facility Name:Manor Court of Peoria

IDPH License ID Number:0047068

Fiscal Year End:3/31/20

Schedule 17A

XV. Balance Sheet

Line 23 Long Term Assets Other (specify):

Description	Operating	After Consolidation
Real Estate Tax Escrow		34,016
Insurance Escrow		4,200
MIP Insurance Escrow		15,580
Reserve for Replacement		256,483
Capitalized Loan Fee		339,502
Amortization Loan Fee		(72,237)
Total - Line 36	-	577,544

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,410,877	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)	\$ 2,410,876	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(333,901)	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)	\$ (333,901)	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)	\$ 2,076,975	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Peoria

0047068

Report Period Beginning: 4/1/2019

Ending:

3/31/20

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,189,354	1
2	Discounts and Allowances for all Levels	(72,796)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,116,558	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	71,527	6
7	Oxygen	493	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 72,020	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	4,924	12
13	Barber and Beauty Care	1,149	13
14	Non-Patient Meals	1,273	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	163,766	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	4,073	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 175,185	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	407	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 407	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Income	2,860	28
28a	See Attached Schedule 19A	3,624	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,484	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,370,654	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	701,601	31
32	Health Care	1,633,533	32
33	General Administration	843,551	33
	B. Capital Expense		
34	Ownership	543,378	34
	C. Ancillary Expense		
35	Special Cost Centers	883,368	35
36	Provider Participation Fee	99,124	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,704,555	40
41	Income before Income Taxes (line 30 minus line 40)**	(333,901)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (333,901)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 347,589	44
45	Private Pay - Net Inpatient Revenue	2,078,770	45
46	Medicare - Net Inpatient Revenue	976,412	46
47	Other-(specify) Medicare Replacement	91,458	47
48	Other-(specify) Managed Care	622,329	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,116,558	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name:

Manor Court of Peoria

IDPH License ID Number:

0047068

Fiscal Year End:

3/31/20

Schedule 19A

XVII. Income Statement

Line 28a Other Income

Rental Description	Amount
Late Fees	3,464
Processing Fee	160
Total - Line 16	3,624

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	1,726	1,814	\$ 66,678	\$ 36.76	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,735	11,768	356,083	30.26	3
4	Licensed Practical Nurses	12,458	13,238	341,740	25.82	4
5	CNAs & Orderlies	39,180	41,551	612,111	14.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,349	6,651	78,542	11.81	10
11	Social Service Workers	1,328	1,356	23,817	17.56	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	9,088	10,502	161,698	15.40	15
16	Dishwashers					16
17	Maintenance Workers	4,130	4,258	54,420	12.78	17
18	Housekeepers	10,034	10,551	116,048	11.00	18
19	Laundry	2,143	2,239	23,776	10.62	19
20	Administrator	1,957	2,101	103,152	49.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,706	7,130	119,777	16.80	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	2,280	2,457	32,606	13.27	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	1,544	1,688	36,602	21.68	33
34	TOTAL (lines 1 - 33)	109,658	117,304	\$ 2,127,050 *	\$ 18.13	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 6,400	L1, C3	35
36	Medical Director	Monthly	17,250	L9, C3	36
37	Medical Records Consultant	Monthly	2,034	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,534	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)		\$ 30,218		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	44	1,175	L10, C3	52
53	TOTAL (lines 50 - 52)	44	\$ 1,175		53

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Manor Court of Peoria

STATE OF ILLINOIS

0047068

Report Period Beginning:

4/1/2019

Page 21

Ending: 3/31/20

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	
Terri Edens		Administrator	None	\$ 2,083	Workers' Compensation Insurance		\$ 27,323	IDPH License Fee		\$ 1,990	
Bekime Feezor-Branch		Administrator	None	40,054	Unemployment Compensation Insurance		17,512	Advertising: Employee Recruitment		12,366	
Michelle Urnikis		Administrator	None	61,015	FICA Taxes		166,535	Health Care Worker Background Check			
					Employee Health Insurance		69,615	(Indicate # of checks performed 13)		325	
					Employee Meals			Patient Background Checks		120 1,205	
					Illinois Municipal Retirement Fund (IMRF)*						
					401k		3,029	Subscriptions		307	
					Other Employee Benefits		10,308	IHCA Dues		3,207	
TOTAL (agree to Schedule V, line 17, col. 1)								Other Licenses & Fees		1,580	
(List each licensed administrator separately.)				\$ 103,152				Indirect costs		27	
B. Administrative - Other								Less: Public Relations Expense		(1,058)	
Description			Amount					Non-allowable advertising		()	
N/A			\$					Yellow page advertising		()	
					TOTAL (agree to Schedule V,		\$ 294,322	TOTAL (agree to Sch. V,		\$ 19,949	
					line 22, col.8)			line 20, col. 8)			
TOTAL (agree to Schedule V, line 17, col. 3)				\$	E. Schedule of Non-Cash Compensation Paid				G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)					to Owners or Employees						
C. Professional Services					Description				Line #	Amount	
Vendor/Payee		Type	Amount								
LTC Support Services, LLC		Support Services	\$ 76,104								
RFMS, Inc.		Administrative Services	74,400								
RSM US LLP		Accounting Services	18,139								
Templin Healthcare Accounting		Accounting Services	4,228								
Digital River Pacific		Computer Services	345								
Davis & Campbell, LLC		Legal Services	3,355								
TOTAL (agree to Schedule V, line 19, column 3)					TOTAL						
(For legal fee disclosure, see page 39 of instructions)				\$ 176,571					\$		

* Attach copy of IMRF notifications

SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name & ID Number		Manor Court of Peoria		STATE OF ILLINOIS	#	0047068	Report Period Beginning:	4/1/2019	Ending:	3/31/20	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>3,207 IHCA</u>							
(3)	Did the nursing home make political contributions or payments to a political action organization?			<u>Yes</u>							
	If YES, have these costs been properly adjusted out of the cost report?			<u>Yes</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?										
(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>N/A</u>							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$ <u>25,387</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 NO <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>99,124</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.										
(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 benefits on Schedule V.			\$ <u>0</u>							
	Has any meal income been offset against related costs?			<u>Yes</u>							
	Indicate the amount.			\$ <u>1,273</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>100% Line 14</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>RSM US LLP</u>							
(18)	Have all costs which do not relate to the provision of long term care been adjusted out 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?										
	See page 39 of the instructions for details.			<u>Yes</u>							
	Attach invoices and a summary of services for all architect and appraisal fees.										

SEE ACCOUNTANTS' PREPARATION REPORT