

		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>0047324</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Manor Court of Princeton</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>140 North Sixth St</u> <u>Princeton</u> <u>61356</u>																									
Number City Zip Code																									
County: <u>Bureau</u>																									
Telephone Number: <u>(815) 875-6600</u> Fax # <u>(815) 875-6005</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>12/21/04</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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	☐ 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 Princeton

0047324 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>125</u>	Skilled (SNF)	<u>125</u>	<u>45,750</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>125</u>	TOTALS	<u>125</u>	<u>45,750</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>18,913</u>	<u>11,675</u>	<u>4,548</u>	<u>35,136</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>18,913</u>	<u>11,675</u>	<u>4,548</u>	<u>35,136</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.80 %

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 01/03/05

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 01/03/05 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 125 and days of care provided 3,557

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCUAL ☒ 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 Princeton # 0047324 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	432,760	31,607	9,805	474,172		474,172	(98,440)	375,732			1
2	Food Purchase		384,133		384,133		384,133	(82,190)	301,943			2
3	Housekeeping	182,414	56,786		239,200		239,200	(29,269)	209,931			3
4	Laundry	78,482	13,545		92,027		92,027	(11,260)	80,767			4
5	Heat and Other Utilities			233,062	233,062		233,062	(51,274)	181,788			5
6	Maintenance	142,913	37,493	44,416	224,822		224,822	(27,429)	197,393			6
7	Other (specify):*											7
8	TOTAL General Services	836,569	523,564	287,283	1,647,416		1,647,416	(299,862)	1,347,554			8
	B. Health Care and Programs											
9	Medical Director			23,500	23,500		23,500		23,500			9
10	Nursing and Medical Records	2,466,844	130,485	14,703	2,612,032		2,612,032	(357,298)	2,254,734			10
10a	Therapy											10a
11	Activities	116,975	8,378		125,353		125,353	(1,025)	124,328			11
12	Social Services	68,449			68,449		68,449		68,449			12
13	CNA Training			8,787	8,787		8,787		8,787			13
14	Program Transportation			5,292	5,292		5,292	(630)	4,662			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,652,268	138,863	52,282	2,843,413		2,843,413	(358,953)	2,484,460			16
	C. General Administration											
17	Administrative	247,668			247,668		247,668	(30,305)	217,363			17
18	Directors Fees							2,332	2,332			18
19	Professional Services			374,378	374,378		374,378	(45,700)	328,678			19
20	Dues, Fees, Subscriptions & Promotions			25,966	25,966		25,966	(4,463)	21,503			20
21	Clerical & General Office Expenses	131,959	30,024	56,421	218,404		218,404	(24,870)	193,534			21
22	Employee Benefits & Payroll Taxes			608,318	608,318		608,318	(83,977)	524,341			22
23	Inservice Training & Education			4,517	4,517		4,517		4,517			23
24	Travel and Seminar			474	474		474		474			24
25	Other Admin. Staff Transportation			786	786		786		786			25
26	Insurance-Prop.Liab.Malpractice			151,321	151,321		151,321	(19,446)	131,875			26
27	Other (specify):*											27
28	TOTAL General Administration	379,627	30,024	1,222,181	1,631,832		1,631,832	(206,429)	1,425,403			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,868,464	692,451	1,561,746	6,122,661		6,122,661	(865,244)	5,257,417			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			58,286	58,286		58,286	455,574	513,860			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			93,800	93,800		93,800	(21,552)	72,248			33
34	Rent-Facility & Grounds			885,798	885,798		885,798	(885,798)				34
35	Rent-Equipment & Vehicles			25,532	25,532		25,532		25,532			35
36	Other (specify):*											36
37	TOTAL Ownership			1,063,416	1,063,416		1,063,416	(451,776)	611,640			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			7,248	7,248		7,248		7,248			38
39	Ancillary Service Centers		221,062	1,245,965	1,467,027		1,467,027		1,467,027			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			2,314	2,314		2,314	(2,314)				41
42	Provider Participation Fee			255,517	255,517		255,517		255,517			42
43	Other (specify):* Disallowed Costs	52,595		241,130	293,725		293,725	(293,725)				43
44	TOTAL Special Cost Centers	52,595	221,062	1,752,174	2,025,831		2,025,831	(296,039)	1,729,792			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,921,059	913,513	4,377,336	9,211,908		9,211,908	(1,613,059)	7,598,849			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	(759)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,413)	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	1,925	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,126)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(63)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(60)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(105,358)	43		24
25	Fund Raising, Advertising and Promotional	(108,854)	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	(1,153,765)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,379,473)		\$	30

BHF USE ONLY							
48		49		50		51	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(233,586)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (233,586)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,613,059)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Vending Machine Income	\$ (2,314)	41	1
2	Adjust out Hawthorne Inn SLF expenses	(98,440)	1	2
3	Adjust out Hawthorne Inn SLF expenses	(81,431)	2	3
4	Adjust out Hawthorne Inn SLF expenses	(29,269)	3	4
5	Adjust out Hawthorne Inn SLF expenses	(11,260)	4	5
6	Adjust out Hawthorne Inn SLF expenses	(51,274)	5	6
7	Adjust out Hawthorne Inn SLF expenses	(27,429)	6	7
8	Adjust out Hawthorne Inn SLF expenses	(357,298)	10	8
9	Adjust out Hawthorne Inn SLF expenses	(1,025)	11	9
10	Adjust out Hawthorne Inn SLF expenses	(630)	14	10
11	Adjust out Hawthorne Inn SLF expenses	(30,305)	17	11
12	Adjust out Hawthorne Inn SLF expenses	(45,781)	19	12
13	Adjust out Hawthorne Inn SLF expenses	(1,404)	20	13
14	Adjust out Hawthorne Inn SLF expenses	(24,976)	21	14
15	Adjust out Hawthorne Inn SLF expenses	(83,977)	22	15
16	Adjust out Hawthorne Inn SLF expenses	(20,487)	26	16
17	Adjust out Hawthorne Inn SLF expenses	(20,636)	33	17
18	Adjust out Hawthorne Inn SLF expenses	(194,876)	34	18
19	Adjust out Hawthorne Inn SLF expenses	(7,748)	43	19
20	Labs - Part A	(14,385)	43	20
21	X-Rays - Part A	(1,745)	43	21
22	Marketing Wages	(46,159)	43	22
23	Disallow Property Taxes	(916)	33	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	(1,153,765)		49

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
<u>Residential Alternatives of Illinois, Inc.</u>	<u>100</u>	<u>Frances House, Inc. (FH)</u>		<u>Danville Independence</u>	<u>Danville</u>	<u>Real Estate Entity</u>
<u>(Non-profit Organization)</u>		<u>Residential Alternatives of Illinois, Inc. (FH is sole mem</u>		<u>See Page 6 Supplemental</u>		
		<u>Pioneer Concepts, Inc. (FH is sole member)</u>				
		<u>Pinnacle Opportunities, Inc. (FH is sole member)</u>				
		<u>See Page 6 Supplemental for specific homes</u>				

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	<u>Director Fees</u>	\$	<u>Residential Alternatives of Illinois, Inc.</u>	<u>100.00%</u>	<u>\$ 2,332</u>	<u>\$ 2,332</u>	1
2	V	19	<u>Professional Services</u>		<u>Residential Alternatives of Illinois, Inc.</u>	<u>100.00%</u>	<u>141</u>	<u>141</u>	2
3	V	20	<u>Dues, Fees & Subscriptions</u>		<u>Residential Alternatives of Illinois, Inc.</u>	<u>100.00%</u>	<u>67</u>	<u>67</u>	3
4	V	21	<u>Clerical & General Office</u>		<u>Residential Alternatives of Illinois, Inc.</u>	<u>100.00%</u>	<u>106</u>	<u>106</u>	4
5	V	26	<u>Property Insurance</u>		<u>Residential Alternatives of Illinois, Inc.</u>	<u>100.00%</u>	<u>1,041</u>	<u>1,041</u>	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			\$			<u>\$ 3,687</u>	<u>\$ *</u>	<u>3,687</u> 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	34	Facility Rent	690,922	Hawthorne Inn of Princeton, LLC	0.00%	\$	\$(690,922)	15
16	V	30	Depreciation Expense		Hawthorne Inn of Princeton, LLC	0.00%	453,649	453,649	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								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			\$ 690,922			\$ 453,649	\$ * (237,273)	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 Princeton

0047324

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 Princeton

0047324

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 Princeton # 0047324 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	\$ 583	L18, C7	1
2	Doug Biederstedt	Director	Administrative	0.00	See Att. Sch 7A	1	<1 %	Director Fees	389	L18, C7	2
3	Jeff Shaw	Secretary & Director	Administrative	0.00	See Att. Sch 7A	1	<1 %	Director Fees	583	L18, C7	3
4	William Kempiners	Director	Administrative	0.00	See Att. Sch 7A	1	<1 %	Director Fees	583	L18, C7	4
5	Ben McMahan	President & Director	Administrative	0.00	See Att. Sch 7A	1	<1 %	Director Fees	194	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	\$ 2,332		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												1	
2	N/A											2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	15	

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

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

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

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.		\$	126,948	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		\$	94,764	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(32,184)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	125,068	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 SLF Portion of Expense		(20,636)	
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	(20,636)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	72,248	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2015	106,063	8	FOR BHF USE ONLY	
		2016	94,060	9		
		2017	96,401	10		
		2018	94,764	11		
		2019	96,549	12		
This facility is leased from a related not-for-profit entity. The lease agreement requires the lessee to pay the real estate taxes. Amount accrued includes the estimated expense for 12 months of 2019 and 3 months of 2020.				13	FROM R. E. TAX STATEMENT FOR 2019 \$	13
Taxes paid were for the 2018 tax bill.				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 Princeton COUNTY Bureau

FACILITY IDPH LICENSE NUMBER 0047324

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) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>16-16-226-010</u>	<u>140 N. Sixth St.</u>	\$ <u>96,548.80</u>	\$ <u>75,308.00</u>
2. <u></u>	<u>Princeton</u>	\$ <u></u>	\$ <u></u>
3. <u></u>	<u>E SI OF NE COR OF PT L 98</u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u><u>96,548.80</u></u>	\$ <u><u>75,308.00</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach 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:

38,703

B. General Construction Type:

Exterior

Brick

Frame

Wood

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

N/A

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility SNF		2009	\$ 50,700	1
2					2
3	TOTALS			\$ 50,700	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Princeton

0047324

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	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	98		2009		\$ 5,371,483	\$	25	\$ 214,860	\$ 214,860	\$ 2,218,233	4
5	27		2013		2,946,720		25	117,869	117,869	756,325	5
6											6
7											7
8											8
	Improvement Type**										
9	Electric Signs			2005	4,098		10			4,098	9
10	Electrical Lighting - Landscaping, Fiberglass Insulation			2006	12,540	608	10-15 yrs	608		11,628	10
11	Sign			2007	2,600		10			2,600	11
12	New Roof			2008	144,175		10			144,175	12
13	Paved Parking Lot and Sidewalks			2009	174,779		15	11,651	11,651	120,403	13
14	AC Unit Kitchen			2010	5,429	543	10	543		5,203	14
15	Dry Valve for Sprinkler System			2011	7,258	726	10	726		6,715	15
16	Dining Room Wallpaper/Paint/Carpet/Desk/Countertops			2011	14,230	1,423	10	1,423		13,044	16
17	3x6 Single Face Lighted Sign			2010	2,620	262	10	262		2,598	17
18	Shower Remodels (concrete shower stalls, sealer, paint)			2011	7,350	735	10	735		6,676	18
19	Office Partitions			2011	2,893	289	10	289		2,628	19
20	Phys Ther Addition:wood frame/drywall/roof/landscaping/cabinets/paint			2010	526,495		12	43,874	43,874	420,464	20
21	Air Conditioner - 5 Ton			2011	4,400	440	10	440		3,850	21
22	Lake Patio and Shelter: Roof/Footings/Gutters/Sidewalk/Washouts Aroun			2012	23,098		12	1,925	1,925	14,117	22
23	Theatre Room-electrical wiring/install screen & speakers			2013	15,158	1,516	10	1,516		10,485	23
24	New Water Heater			2013	10,277	1,028	10	1,028		6,510	24
25	New Furnace			2014	4,145	276	15	276		1,681	25
26											26
27	Dining Room: Drywall/Beams/Trim/Paint/Wallpaper			2014	5,315	443	12	443		2,621	27
28	East Wing/Kitchen Doors			2014	9,000	900	10	900		5,250	28
29	Water Heater			2014	10,194	1,019	10	1,019		5,947	29
30	New Workstations - Activity to Offices- Cubicles / Cabinets			2016	12,510	1,251	10	1,251		4,587	30
31	VCT Tile - Resident Rooms			2017	24,148	2,415	10	2,415		6,239	31
32	Sidewalk			2017	10,602	707	15	707		1,826	32
33	Wallpaer-Library/TV Room/Nurses Station			2018	9,452	1,890	5	1,890		4,253	33
34	Small Asphalt Parking Area			2018	4,495	562	8	562		796	34
35	Nurse Call System			2018	104,793	10,479	10	10,479		13,972	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 Princeton

0047324

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	2 Carrier (4 and 5 Ton) AC Units -200 Hallway/200 Dining Room	2018	6,785	1,357	5	1,357	\$	\$ 2,601	37
38	Asphalt Entire Parking Lot	2019	16,824	1,052	8	1,052		1,052	38
39	4 PTAC Units	2019	3,067	256	5	256		256	39
40	Hall 100 Shower Privacy Curtains	2019	5,100	340	5	340		340	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)		\$ 9,502,033	\$ 30,517		\$ 420,696	\$ 390,179	\$ 3,801,173	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	\$ 1,085,514	\$ 26,861	\$ 92,256	\$ 65,395	3-15 yrs	\$ 875,482	71
72	Current Year Purchases	12,986	908	908		5-7 yrs	908	72
73	Fully Depreciated Assets	155,734					155,734	73
74								74
75	TOTALS	\$ 1,254,234	\$ 27,769	\$ 93,164	\$ 65,395		\$ 1,032,124	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76	Patient Care	2005 Ford E350 Van	2005	\$ 46,919	\$	\$	\$	4	\$ 46,919
77									77
78									78
79									79
80	TOTALS			\$ 46,919	\$	\$	\$		\$ 46,919

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)			\$	10,853,886
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	58,286
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	513,860
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	455,574
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	4,880,216

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	Truck - 2004	\$ 3,500	\$	\$ 3,500
87	2003 GMC Van - 2005	29,800		29,800
88	2000 Ford F250 - 2006	8,425		8,425
89	See Sch 13A	1,942,951	90,650	982,810
90	2010 Toyota Corolla	16,300		16,300
91	TOTALS	\$ 2,000,976	\$ 90,650	\$ 1,040,835

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

Schedule 13A

Fixed Asset Summary

<u>FIXED ASSETS</u>	<i>Fr prior year</i>		<i>Agrees w/</i>
	MCD CR		MCD CR
	03/31/19	Additions	03/31/20
Land "A"	14,300	-	14,300
Buildings	1,663,532	-	1,663,532
Building Improvements	85,359	-	85,359
Equipment	179,760	-	179,760
	1,942,951	-	1,942,951

<u>Accum Depreciation</u>	<i>Fr prior year</i>		<i>Agrees w/</i>
	MCD CR	MCD	MCD CR
	03/31/19	Depreciation	03/31/20
Buildings	671,272	72,976	744,248
Building Improvements	53,112	5,690	58,802
Non-care Assets	-	-	-
Equipment	167,776	11,984	179,760
	892,160	90,650	982,810

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: \$ 25,532 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 Princeton

IDPH License ID Number:

0047324

Fiscal Year End:

3/31/20

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment Rental	23,809
Other Equipment Rental	1,723
Total - Line 16	25,532

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	\$	\$ 2,334	\$	\$ 2,334
2	Books and Supplies		6,453		6,453
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	\$	\$ 8,787	\$	\$ 8,787
10	SUM OF line 9, col. 1 and 2 (e)	\$ 8,787			

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	\$	6,154	\$ 443,064	\$	6,154	\$ 443,064	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,914	137,827		1,914	137,827	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		9,237	665,074		9,237	665,074	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				221,062		221,062	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	17,305	\$ 1,245,965	\$ 221,062	17,305	\$ 1,467,027	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	\$ 296,568	\$ 296,568	1
2	Cash-Patient Deposits	26,249	26,249	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 315,000)	367,567	367,567	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	50,630	50,630	6
7	Other Prepaid Expenses	2,320	2,320	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interdivision Receivable</u>	2,725,540	2,725,540	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,468,874	\$ 3,468,874	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,700	13
14	Buildings, at Historical Cost	474,389	9,327,254	14
15	Leasehold Improvements, at Historical Cost		174,779	15
16	Equipment, at Historical Cost	548,202	1,301,153	16
17	Accumulated Depreciation (book methods)	(728,571)	(4,880,216)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 294,020	\$ 5,973,670	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,762,894	\$ 9,442,544	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 144,322	\$ 144,322	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,249	26,249	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	119,665	119,665	30
31	Accrued Taxes Payable (excluding real estate taxes)	73,391	73,391	31
32	Accrued Real Estate Taxes(Sch.IX-B)	125,068	125,068	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Interdivision Payable</u>		3,748,649	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 488,695	\$ 4,237,344	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Security Deposits</u>	55,500	55,500	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 55,500	\$ 55,500	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 544,195	\$ 4,292,844	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,218,699	\$ 5,149,700	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,762,894	\$ 9,442,544	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,615,046	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,615,046	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	603,653	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)	\$ 603,653	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,218,699	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Princeton

0047324

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	\$ 8,526,072	1
2	Discounts and Allowances for all Levels	25,614	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,551,686	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,103,751	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,103,751	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	2,893	12
13	Barber and Beauty Care	7,398	13
14	Non-Patient Meals	759	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	104,630	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,385	19
20	Radiology and X-Ray	1,745	20
21	Other Medical Services	2,241	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 134,051	23
	D. Non-Operating Revenue		
24	Contributions	600	24
25	Interest and Other Investment Income***	2,383	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,983	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Income	167	28
28a	See Attached Schedule 19A	22,923	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 23,090	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,815,561	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,647,416	31
32	Health Care	2,843,413	32
33	General Administration	1,631,832	33
	B. Capital Expense		
34	Ownership	1,063,416	34
	C. Ancillary Expense		
35	Special Cost Centers	1,770,314	35
36	Provider Participation Fee	255,517	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,211,908	40
41	Income before Income Taxes (line 30 minus line 40)**	603,653	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 603,653	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,958,956	44
45	Private Pay - Net Inpatient Revenue	3,312,585	45
46	Medicare - Net Inpatient Revenue	1,510,327	46
47	Other-(specify) Medicare Replacement	85,733	47
48	Other-(specify) Managed Care	1,684,085	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,551,686	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 Princeton

IDPH License ID Number:

0047324

Fiscal Year End:

3/31/20

Schedule 19A

XVII. Income Statement

Line 28a Other Income

Rental Description	Amount
Late Fees	(2,737)
Maintenance Fee Income	25,660
Total - Line 16	22,923

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	1,789	1,953	\$ 74,380	\$ 38.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	16,340	17,682	470,533	26.61	3
4	Licensed Practical Nurses	21,233	23,019	534,793	23.23	4
5	CNAs & Orderlies	84,148	90,597	1,361,435	15.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,246	10,826	116,975	10.81	10
11	Social Service Workers	3,895	4,196	68,449	16.31	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	32,014	34,926	432,760	12.39	15
16	Dishwashers					16
17	Maintenance Workers	6,792	7,299	142,913	19.58	17
18	Housekeepers	15,575	16,609	182,414	10.98	18
19	Laundry	7,055	7,604	78,482	10.32	19
20	Administrator	1,937	2,165	166,651	76.98	20
21	Assistant Administrator	1,932	2,080	81,017	38.95	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,934	8,593	131,959	15.36	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	2,004	2,108	25,703	12.19	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	1,872	1,980	52,595	26.56	33
34	TOTAL (lines 1 - 33)	214,766	231,637	\$ 3,921,059 *	\$ 16.93	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	\$ 9,805	L1, C3	35
36	Medical Director	Monthly	23,500	L9, C3	36
37	Medical Records Consultant	Monthly	2,114	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,868	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)		\$ 45,287		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	N/A			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 Princeton

STATE OF ILLINOIS

0047324

Report Period Beginning:

4/1/2019

Page 21

Ending: 3/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Peggy Holt	Administrator	None	\$ 110,054
Glenda Olds	Administrator	None	56,597
Glenda Olds	Asst Admin	None	81,017
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 247,668

B. Administrative - Other

Description	Amount
N/A	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$

C. Professional Services

Vendor/Payee	Type	Amount
LTC Support Services, LLC	Support Services	\$ 196,512
RFMS, Inc.	Administrative Services	144,000
RSM US LLP	Accounting Services	29,057
Templin Healthcare Accounting	Accounting Services	4,229
Digital River Pacific	Computer Services	345
James G. Ahlberg	Legal Services	175
Angel, Isaacson & Tracy	Legal Services	60
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 374,378

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 43,434
Unemployment Compensation Insurance	9,196
FICA Taxes	260,311
Employee Health Insurance	179,221
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401k	21,245
Other Employee Benefits	10,934
TOTAL (agree to Schedule V, line 22, col.8)	\$ 524,341

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 1,990
Advertising: Employee Recruitment	7,244
Health Care Worker Background Check (Indicate # of checks performed 4)	108
Patient Background Checks	274
Subscriptions	2,639
IHCA Dues	8,960
Other Licenses & Fees	877
Indirect costs	67
Less: Public Relations Expense	(3,126)
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 21,503

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	474
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 474

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number		Manor Court of Princeton		STATE OF ILLINOIS	#	0047324	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>8,960 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>5-7 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>46,804</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>255,517</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>759</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?			<u>Yes</u>							
	See page 39 of the instructions for details.										
	Attach invoices and a summary of services for all architect and appraisal fees.										

SEE ACCOUNTANTS' PREPARATION REPORT