

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: 0047068

Facility Name: Manor Court of Peoria

Address: 6900 N Stalworth Dr Peoria 61615
Number City Zip Code

County: Peoria

Telephone Number: (309) 691-2020 Fax # (309) 683-3491

HFS ID Number:

Date of Initial License for Current Owners: 08/03/06

Type of Ownership:

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

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 4/1/2024 to 3/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

(Signed)
(Type or Print Name) Brian Burger
(Title) Chief Financial Officer

Paid
Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT
(Date)
(Print Name and Title) Larry Templin Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP
P.O. Box 326, Plainfield, IL 60544-0326
(Telephone) (630) 361-2868 Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Manor Court of Peoria # 0047068 Report Period Beginning: 4/1/2024 Ending: 3/31/2025

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>18,250</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>18,250</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	1,536	913	2,021		6,266	2,138	2,062	14,936	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	1,536	913	2,021		6,266	2,138	2,062	14,936	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 81.84%

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 certified beds.
number of certified beds 50

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: 3/31/25 Fiscal Year: 3/31/25

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number		Manor Court of Peoria		STATE OF ILLINOIS		#	0047068	Report Period Beginning:		4/1/2024	Ending:		Page 3	3/31/2025
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	265,415	27,464	8,061	300,940		300,940		300,940					1
2	Food Purchase		216,199		216,199		216,199	(285)	215,914					2
3	Housekeeping	160,469	21,567		182,036		182,036		182,036					3
4	Laundry	63,016	8,022		71,038		71,038		71,038					4
5	Heat and Other Utilities			74,448	74,448		74,448		74,448					5
6	Maintenance	85,226	14,177	103,535	202,938		202,938		202,938					6
7	Other (specify):*													7
8	TOTAL General Services	574,126	287,429	186,044	1,047,599		1,047,599	(285)	1,047,314					8
	B. Health Care and Programs													
9	Medical Director			9,000	9,000		9,000		9,000					9
10	Nursing and Medical Records	1,976,102	149,989	4,954	2,131,045		2,131,045		2,131,045					10
10a	Therapy													10a
11	Activities	108,943	2,171		111,114		111,114		111,114					11
12	Social Services	41,691			41,691		41,691		41,691					12
13	CNA Training													13
14	Program Transportation			11,961	11,961		11,961		11,961					14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	2,126,736	152,160	25,915	2,304,811		2,304,811		2,304,811					16
	C. General Administration													
17	Administrative	118,246			118,246		118,246		118,246					17
18	Directors Fees							1,075	1,075					18
19	Professional Services			181,235	181,235		181,235	2,203	183,438					19
20	Dues, Fees, Subscriptions & Promotions			51,959	51,959		51,959	(1,409)	50,550					20
21	Clerical & General Office Expenses	174,898	22,582	58,777	256,257		256,257	236	256,493					21
22	Employee Benefits & Payroll Taxes			391,756	391,756		391,756		391,756					22
23	Inservice Training & Education			2,406	2,406		2,406		2,406					23
24	Travel and Seminar			508	508		508		508					24
25	Other Admin. Staff Transportation			301	301		301		301					25
26	Insurance-Prop.Liab.Malpractice			134,495	134,495		134,495	19,266	153,761					26
27	Other (specify):*													27
28	TOTAL General Administration	293,144	22,582	821,437	1,137,163		1,137,163	21,371	1,158,534					28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,994,006	462,171	1,033,396	4,489,573		4,489,573	21,086	4,510,659					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			30,908	30,908		30,908	205,997	236,905			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							105,794	105,794			32
33	Real Estate Taxes							58,807	58,807			33
34	Rent-Facility & Grounds			441,360	441,360		441,360	(441,360)				34
35	Rent-Equipment & Vehicles			6,070	6,070		6,070		6,070			35
36	Other (specify):* Mortgage Ins							19,776	19,776			36
37	TOTAL Ownership			478,338	478,338		478,338	(50,986)	427,352			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			5,424	5,424		5,424		5,424			38
39	Ancillary Service Centers		129,396	409,268	538,664		538,664	(1,681)	536,983			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			214	214		214		214			41
42	Provider Participation Fee			100,288	100,288		100,288		100,288			42
43	Other (specify):* Disallowed Costs	66,193		141,518	207,711		207,711	(207,711)				43
44	TOTAL Special Cost Centers	66,193	129,396	656,712	852,301		852,301	(209,392)	642,909			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,060,199	591,567	2,168,446	5,820,212		5,820,212	(239,292)	5,580,920			45

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

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	(285)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,506)	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	1,027	30		9
10	Interest and Other Investment Income	(11)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(828)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(91,205)	43		24
25	Fund Raising, Advertising and Promotional	(17,939)	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	(97,165)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (210,912)		\$	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)	(28,380)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (28,380)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (239,292)		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	Political Action Committee Payments	\$ (1,423)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Offset Marketing Salary	(66,193)	43	3
4	Offset Medicare Pt. A Lab	(24,960)	43	4
5	Offset Medicare Pt. A X-Ray	(2,908)	43	5
6	Offset Miscellaneous Income	(1,681)	39	6
7				7
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48				48
49	Total	(97,165)		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
Residential Alternatives of Illinois, Inc. (Non-profit Organization)	100	Frances House, Inc. (FH)		Peoria Manor Court, I	Galesburg	Real Estate Entity
		Residential Alternatives of Illinois, Inc. (FH is sole mem		See Page 6 Supplemental		
		Pioneer Concepts, Inc. (FH is sole member)				
		Pinnacle Opportunities, Inc. (FH is sole member)				
		See Page 6 Supplemental for specific homes				

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	18	Director Fees	\$	Residential Alternatives of Illinois, Inc.	100.00%	\$ 1,075	\$ 1,075	1
2	V	19	Professional Services		Residential Alternatives of Illinois, Inc.	100.00%	602	602	2
3	V	20	Dues, Fees & Subscriptions		Residential Alternatives of Illinois, Inc.	100.00%	14	14	3
4	V	21	Clerical & General Office		Residential Alternatives of Illinois, Inc.	100.00%	236	236	4
5	V	26	Property Insurance		Residential Alternatives of Illinois, Inc.	100.00%	669	669	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			\$			\$ 2,596	\$ * 2,596	14

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

VII. RELATED PARTIES (continued)

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

☒ X

 YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees		Peoria Manor Court, Ltd., NFP	0.00%	\$ 2,429	\$ 2,429	15
16	V	26	Insurance		Peoria Manor Court, Ltd., NFP	0.00%	18,597	18,597	16
17	V	30	Depreciation Expense		Peoria Manor Court, Ltd., NFP	0.00%	204,970	204,970	17
18	V	32	Interest	35	Peoria Manor Court, Ltd., NFP	0.00%	91,035	91,000	18
19	V	32	Amortization		Peoria Manor Court, Ltd., NFP	0.00%	14,805	14,805	19
20	V	33	Real Estate Tax		Peoria Manor Court, Ltd., NFP	0.00%	58,807	58,807	20
21	V	34	Facility Rent	441,360	Peoria Manor Court, Ltd., NFP	0.00%		(441,360)	21
22	V	36	MIP Insurance		Peoria Manor Court, Ltd., NFP	0.00%	19,776	19,776	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			\$ 441,395			\$ 410,419	\$ * (30,976)	39

Ownership Listing-1

ID# 0047068

Ending: 3/31/2025

-Owners of companies must be listed instead of company names.

Place of Residence

Building Co.

Ownership

Ownership

2								1
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Facility Name & ID Number

Manor Court of Peoria

0047068

Report Period Beginning:

4/1/2024

Ending:

3/31/2025

VII. RELATED PARTIES

A. (Continued)

Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Residential Alternatives of Illinois	100%	Hawthorne Inn of Danville	Danville				1
2	Residential Alternatives of Illinois	100%	Manor Court of Princeton	Princeton				2
3	Residential Alternatives of Illinois	100%	Manor Court of Clinton-Sold in 2025	Clinton				3
4	Residential Alternatives of Illinois	100%	Manor Court of Peru	Peru				4
5	Residential Alternatives of Illinois	100%	Manor Court of Freeport	Freeport				5
6	Residential Alternatives of Illinois	100%	Manor Court of Rochelle	Rochelle				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								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Manor Court of Peoria

0047068

Report Period Beginning:

4/1/2024

Ending:

3/31/2025

VII. RELATED PARTIES

A. (Continued)

Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	Ben McMahan	President & Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	\$ 215	L18, C7	1
2	Jeff Shaw	Secretary & Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	215	L18, C7	2
3	William Kempiners	Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	215	L18, C7	3
4	Marilyn Holt	Board Member	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	215	L18, C7	4
5	Wayne Stone	Board Member	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	215	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	\$ 1,075		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

Facility Name & ID Number Manor Court of Peoria # 0047068 Report Period Beginning: 4/1/2024 Ending: 3/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	18	Director Fees	Weighted Avg BDA	382,040	20	\$ 22,500	\$	18,250	\$ 1,075	1
2	19	Professional Services	Weighted Avg BDA	382,040	20	12,600		18,250	602	2
3	20	Dues, Fees & Subscriptions	Weighted Avg BDA	382,040	20	300		18,250	14	3
4	21	Clerical & General Office	Weighted Avg BDA	382,040	20	4,930		18,250	236	4
5	26	Property Insurance	Weighted Avg BDA	382,040	20	14,007		18,250	669	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	TOTALS					\$ 54,337	\$		\$ 2,596	25

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	\$ 3,508,189	1/1/2045	3.5500	\$ 91,035	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	\$ 3,508,189			\$ 91,035	9	
	B. Non-Facility Related*												
10	Cambridge Realty Capital		X	Loan Refinance	\$28,804.47	5/29/2015	6,324,900	4,844,642	1/1/2045	3.5500	125,715	10	
11	Ltd. Of Illinois - ALC							Offset Interest Income			(46)	11	
12								Amortization			14,805	12	
13								Disallow Non-SNF Portion of Int			(125,715)	13	
14	TOTAL Non-Facility Related				\$28,804.47		\$ 6,324,900	\$ 4,844,642			\$ 14,759	14	
15	TOTALS (line 9+line14)						\$ 10,905,000	\$ 8,352,831			\$ 105,794	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 19,776 Line # 36

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2024 report.			\$	169,088	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.)		2023	\$	131,186	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(37,902)	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	177,919	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		(81,210)	
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.			\$	58,807	7
Assessed Value from Real Estate Tax Bill:					
2024	1,615,850	8			
Real Estate Tax Bill for Calendar Year:					
2020	132,733	9			
2021	131,776	10			
2022	130,633	11			
2023	131,186	12			
2024	141,866	13			
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 2024 and 3 months of 2025.					
The R/E tax estimate is based on 2024 tax bill. Taxes paid are for the 2023 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.					

FOR BHF USE ONLY		
14	FROM R. E. TAX STATEMENT FOR 2024 \$	14
15	PLUS APPEAL COST FROM LINE 5 \$	15
16	LESS REFUND FROM LINE 6 \$	16
17	AMOUNT TO USE FOR RATE CALCULATION \$	17

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' PREPARATION REPORT

FACILITY NAME	Manor Court of Peoria	COUNTY	Peoria
---------------	-----------------------	--------	--------

CONTACT PERSON REGARDING THIS REPORT Brian Burger

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u> <u>Nursing Home</u>

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,840 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (X) (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (X) (a) Own the Equipment (b) Rent equipment from a Related Organization. (X) (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

F. List the bed capacity for the building if it differs from the licensed total. N/A
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
I. Are you presently operating under a sublease agreement? No
J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO X If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES X NO
If so, please complete the following:
1. Total Amount Incurred: 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:

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	\$ 194,766	\$ 194,766	\$ 2,986,428
5										
6										
7										
8										
	Improvement Type**									
9	Sign		2007		3,100		10			3,100
10	Fire Doors, Paved Parking Lot & Sidewalks		2009		232,895		15	10,228	10,228	232,895
11	Electromagnetic Lock		2010		8,319		10			8,319
12	Water Heater		2010		4,758		10			4,758
13	Concrete-Handycap Ramp/Sidewalk Repairs		2011		4,191	280	15	280		3,841
14	Water Heater		2013		5,248		10			5,248
15	Water Heater		2014		5,502	229	10	229		5,502
16	Water Softener		2014		8,427	560	10	560		8,427
17	Vinyl Tile installed in Dining Room		2015		5,428	543	10	543		5,248
18	Water Heater-Outdoor Sprinkler Room		2016		5,632	563	10	563		5,068
19	Water Heater-Mechanical Room Near Laundry		2017		6,619	662	10	662		5,241
20	Nurse Call/Intercom/Patient Wandering System		2017		117,945	1,404	7	1,404		117,945
21	Chain Link Fence-Back of Facility		2018		3,038	203	15	203		1,453
22	Mag Locks		2018		2,694	270	10	270		1,774
23	Nurses Station - 2 Countertops / 2 Folder Cabinets		2019		5,500	550	10	550		3,208
24	Install Transfer Switch		2019		4,960	496	10	496		2,893
25	4 New PTAC Units		2019		2,729	272	10	272		1,569
26	4 New PTAC Units		2019		2,762	369	5	369		2,762
27	Parking Lot-Asphalt Patchwork		2019		4,300		10	430	430	2,365
28	Replace Condensor on AC Unit		2020		4,039	269	15	269		1,324
29	Parking Lot - Additional Patchwork/Sealcoat/Striping		2020		3,377	422	8	422		1,969
30	4 New PTAC Units		2021		2,865		5	573	573	2,006
31	New HVAC Condensor		2022		5,539	369	15	369		1,077
32	Install Door Alarm Annunciator		2022		4,520	452	10	452		1,243
33	Install Penner Cascade Contour Tub in Shower Room		2022		20,951	1,746	12	1,746		4,074
34	New Water Heater - Mechanical Room		2023		6,512	652	10	652		1,357
35	Replace North Side AC Unit Compressor/Filter/Contactor		2023		4,406	294	15	294		490
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

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	3 New PTAC Units	2023	3,887	778	5	778	\$	\$ 1,296	37
38	Repair Sewer Line in Kitchen	2024	5,500	306	15	306		306	38
39	New Dual Delayed Egress Magnetic Lock/Keypad/Door Switches	2024	4,156	312	10	312		312	39
40	Replace HVAC Compressor	2024	5,132	200	15	200		200	40
41	Install New Fire Dampers	2025	3,487	58	10	58		58	41
42	New PTAC Units - 6	2024	4,389	585	5	585		585	42
43	New PTAC Units - 8	2024	6,469	540	5	540		540	43
44	New PTAC Units - 6	2025	5,476	92	5	92		92	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)		\$ 5,393,895	\$ 13,476		\$ 219,473	\$ 205,997	\$ 3,424,973	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	\$ 138,519	\$ 11,821	\$ 11,821	\$	5-15 yrs	\$ 106,199	71
72	Current Year Purchases	23,627	394	394		5 yrs	394	72
73	Fully Depreciated Assets	262,797					262,797	73
74								74
75	TOTALS	\$ 424,943	\$ 12,215	\$ 12,215	\$		\$ 369,390	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	76
77	Facility	Chevrolet Cheyenne 1998	2014	3,230				4	3,230	77
78	Facility	2014 Braun Entervan	2016	21,865				4	21,865	78
79	See Attached Schedule 13A			25,233	5,217	5,217			5,217	79
80	TOTALS			\$ 65,616	\$ 5,217	\$ 5,217	\$		\$ 45,600	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,031,454	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 30,908	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 236,905	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 205,997	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,839,963	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	1999 Chevy Silverado 2500 - 2012	\$ 11,559	\$	\$ 11,559	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 11,559	\$	\$ 11,559	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name:Manor Court of Peoria

IDPH License ID Number:0047068

Fiscal Year End:3/31/2025

Schedule 13A

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	2018 Ford E350	2024	\$ 23,333	\$ 4,861	\$ 4,861	\$ 0	4	\$ 4,861	76
77	Facility	2010 Chrysler Van	2024	1,900	356	356	0	4	356	77
78							0			78
79							0			79
80	TOTALS			\$ 25,233	\$ 5,217	\$ 5,217	\$ 0		\$ 5,217	80

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
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: \$ 6,070
- Description: See Attached Schedule 14A
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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.

Facility Name:

Manor Court of Peoria

IDPH License ID Number:

0047068

Fiscal Year End:

3/31/2025

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment Rental	5,865
Other Equipment Rental	205
Total - Line 16	6,070

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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	\$	2,110	\$ 151,937	\$	2,110	\$ 151,937	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		653	47,031		653	47,031	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		2,921	210,300		2,921	210,300	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				129,396		129,396	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	5,684	\$ 409,268	\$ 129,396	5,684	\$ 538,664	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	\$ 16,500	\$ 55,438	1
2	Cash-Patient Deposits	2,862	2,862	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 81,000)	480,346	509,032	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,846	23,611	6
7	Other Prepaid Expenses	828	828	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 519,382	\$ 591,771	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	262,256	5,164,275	14
15	Leasehold Improvements, at Historical Cost		229,620	15
16	Equipment, at Historical Cost	273,662	490,559	16
17	Accumulated Depreciation (book methods)	(377,127)	(3,839,963)	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 Schedule 17A		583,035	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 158,791	\$ 2,774,526	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 678,173	\$ 3,366,297	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 211,363	\$ 292,003	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,862	2,862	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	64,624	64,624	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		177,919	32
33	Accrued Interest Payable		7,455	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Interdivision Payable	3,693,277	4,494,661	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,972,126	\$ 5,039,524	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,352,831	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Security Deposits	23,574	23,574	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 23,574	\$ 8,376,405	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,995,700	\$ 13,415,929	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,317,527)	\$ (10,049,632)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 678,173	\$ 3,366,297	48

Facility Name:Manor Court of Peoria

IDPH License ID Number:0047068

Fiscal Year End:3/31/2025

Schedule 17A

XV. Balance Sheet

Line 23 Long Term Assets Other (specify):

Description	Operating	After Consolidation
Real Estate Tax Escrow		40,762
Insurance Escrow		4,200
MIP Insurance Escrow		17,010
Reserve for Replacement		328,908
Capitalized Loan Fee		339,502
Amortization Loan Fee		(147,347)
Total - Line 23	-	583,035

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,329,866)	1
2	Restatements (describe):		2
3	Prior Period Adj - Rent Expense	(53,700)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,383,566)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(933,961)	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)	\$ (933,961)	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)	\$ (3,317,527)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manor Court of Peoria

0047068

Report Period Beginning: 4/1/2024

Ending: 3/31/2025

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	\$ 4,822,454	1
2	Discounts and Allowances for all Levels	(27,744)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,794,710	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	88,288	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 88,288	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		12
13	Barber and Beauty Care	276	13
14	Non-Patient Meals	285	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 561	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	1,681	28
28a	Gain on Disposal	1,000	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,681	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,886,251	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,047,599	31
32	Health Care	2,304,811	32
33	General Administration	1,137,163	33
	B. Capital Expense		
34	Ownership	478,338	34
	C. Ancillary Expense		
35	Special Cost Centers	752,013	35
36	Provider Participation Fee	100,288	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,820,212	40
41	Income before Income Taxes (line 30 minus line 40)**	(933,961)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (933,961)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 390,498.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	210,159.00	45
46	MMAI-Medicaid is the Primary Payer	513,800.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	1,788,469.00	48
49	Medicare Part A	1,151,156.00	49
50	Other-(specify) Medicare Replacement/Managed Care	633,336.00	50
51	Other-(specify) Hospice	107,292.00	51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,794,710	56

SEE ACCOUNTANTS' PREPARATION REPORT

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,933	2,080	\$ 109,234	\$ 52.52	1
2	Assistant Director of Nursing	530	541	17,582	32.50	2
3	Registered Nurses	12,148	14,249	502,167	35.24	3
4	Licensed Practical Nurses	8,838	9,830	309,243	31.46	4
5	CNAs & Orderlies	41,530	50,874	996,667	19.59	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,285	5,618	108,943	19.39	10
11	Social Service Workers	2,013	2,175	41,691	19.17	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,291	16,541	265,415	16.05	15
16	Dishwashers					16
17	Maintenance Workers	5,135	5,543	85,226	15.38	17
18	Housekeepers	9,570	10,163	160,469	15.79	18
19	Laundry	3,365	3,572	63,016	17.64	19
20	Administrator	1,948	2,080	118,246	56.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,592	8,206	174,898	21.31	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,914	2,096	41,209	19.66	31
32	Other Health Care(specify)					32
33	Other(specify)Marketing	2,134	2,297	66,193	28.82	33
34	TOTAL (lines 1 - 33)	120,226	135,865	\$ 3,060,199 *	\$ 22.52	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 8,061	L1, C3	35
36	Medical Director	Monthly	9,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,789	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)		\$ 21,850		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.

STATE OF ILLINOIS

Facility Name & ID NumberManor Court of Peoria# 0047068Report Period Beginning:4/1/2024Ending:3/31/2025Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Christina Walker

Administrator

None

\$ 118,246

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 118,246

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

\$ 72,300

RFMS, Inc.

Administrative Services

78,120

RSM US LLP

Accounting Services

19,211

Templin Healthcare Accounting

Accounting Services

4,504

Guided Care

Managed Care Consultant

1,000

Davis & Campbell, LLC

Legal Services

5,272

Saikley,Garrison,Colombo

Legal Services

828

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 181,235

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 37,992

Unemployment Compensation Insurance

28,125

FICA Taxes

229,933

Employee Health Insurance

79,012

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

401k

5,475

Other Employee Benefits

11,219

TOTAL (agree to Schedule V, line 22, col.8)

\$ 391,756

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

Description

Line #

Amount

N/A

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$ 1,990

Advertising: Employee Recruitment

35,507

Health Care Worker Background Check

(Indicate # of checks performed 22)

567

Patient Background Checks

794

Association Dues (total from pg 22, #4)

4,137

Subscriptions

1,206

Other Licenses & Fees

604

Indirect costs

14

Less: Public Relations Expense

()

PAC and Lobbying payments

(1,423)

All non-allowable advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 50,550

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

508

Seminar Expense

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 508

* Attach copy of IMRF notifications

SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
IL HEALTHCARE ASSOCIATION (IHCA)	2,714
	2,714 Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

IL HEALTHCARE ASSOCIATION (IHCA)	1,423
	1,423 Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

IL HEALTHCARE ASSOCIATION (IHCA)	4,137
	4,137 Total
- (5)

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

\$ 32,239 Line 10
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 100,288

This amount is to be recorded on line 42 of Schedule V.
- (8)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No If YES, attach an explanation of the allocation.

- (9)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes
- (10)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

No
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ Has any meal income been offset against related costs?

Yes Indicate the amount. \$ 285
- (12)

Travel and Transportation

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

No

If YES, attach a complete explanation.

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

No

If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A

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

100% Line 14

d. Have vehicle usage logs been maintained?

Yes

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

Yes

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

N/A

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

No

Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (13)

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

Firm Name: RSM US LLP

Yes
- (14)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes
- (15)

Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

Yes

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