

		FOR BHF USE					

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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: 0047316

Facility Name: Manor Court of Peru

Address: 3230 Becker Drive Peru 61354

County: LaSalle

Telephone Number: (815) 220-1440 Fax # None

HFS ID Number:

Date of Initial License for Current Owners: 08/19/05

Type of Ownership:

X

VOLUNTARY,NON-PROFIT

X

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

(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 Peru # 0047316 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	130	Skilled (SNF)	130	47,450	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	130	TOTALS	130	47,450	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	2,795	6,927	2,951		18,133	5,085	2,854	38,745	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	2,795	6,927	2,951		18,133	5,085	2,854	38,745	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 81.65%

SEE ACCOUNTANTS' PREPARATION REPORT

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 02/08/05

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter certified beds.
number of certified beds 130

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.

STATE OF ILLINOIS

Facility Name & ID Number

Manor Court of Peru

0047316

Report Period Beginning:

4/1/2024

Ending:

3/31/2025

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	591,903	60,707	20,473	673,083		673,083		673,083			1
2	Food Purchase		477,847		477,847		477,847		477,847			2
3	Housekeeping	261,064	42,740	62	303,866		303,866		303,866			3
4	Laundry	83,416	26,731		110,147		110,147		110,147			4
5	Heat and Other Utilities			133,104	133,104		133,104		133,104			5
6	Maintenance	116,801	39,079	63,947	219,827		219,827		219,827			6
7	Other (specify):*											7
8	TOTAL General Services	1,053,184	647,104	217,586	1,917,874		1,917,874		1,917,874			8
	B. Health Care and Programs											
9	Medical Director			23,785	23,785		23,785		23,785			9
10	Nursing and Medical Records	4,103,224	332,652	18,698	4,454,574		4,454,574		4,454,574			10
10a	Therapy											10a
11	Activities	195,027	1,659		196,686		196,686		196,686			11
12	Social Services	57,184			57,184		57,184		57,184			12
13	CNA Training			462	462		462		462			13
14	Program Transportation			1,910	1,910		1,910		1,910			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,355,435	334,311	44,855	4,734,601		4,734,601		4,734,601			16
	C. General Administration											
17	Administrative	78,545			78,545		78,545		78,545			17
18	Directors Fees							2,795	2,795			18
19	Professional Services			355,371	355,371		355,371	5,881	361,252			19
20	Dues, Fees, Subscriptions & Promotions			47,391	47,391		47,391	(3,973)	43,418			20
21	Clerical & General Office Expenses	195,916	30,802	86,657	313,375		313,375	611	313,986			21
22	Employee Benefits & Payroll Taxes			740,531	740,531		740,531		740,531			22
23	Inservice Training & Education			1,650	1,650		1,650		1,650			23
24	Travel and Seminar			184	184		184		184			24
25	Other Admin. Staff Transportation			210	210		210		210			25
26	Insurance-Prop.Liab.Malpractice			174,965	174,965		174,965	27,273	202,238			26
27	Other (specify):*											27
28	TOTAL General Administration	274,461	30,802	1,406,959	1,712,222		1,712,222	32,587	1,744,809			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,683,080	1,012,217	1,669,400	8,364,697		8,364,697	32,587	8,397,284			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			66,455	66,455		66,455	563,976	630,431			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							291,237	291,237			32
33	Real Estate Taxes							135,923	135,923			33
34	Rent-Facility & Grounds			963,840	963,840		963,840	(963,840)				34
35	Rent-Equipment & Vehicles			12,846	12,846		12,846		12,846			35
36	Other (specify):* Mortgage Ins							57,272	57,272			36
37	TOTAL Ownership			1,043,141	1,043,141		1,043,141	84,568	1,127,709			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			8,610	8,610		8,610		8,610			38
39	Ancillary Service Centers		233,830	856,081	1,089,911		1,089,911	(3,538)	1,086,373			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			2,833	2,833		2,833	(2,833)				41
42	Provider Participation Fee			568,359	568,359		568,359		568,359			42
43	Other (specify):* Disallowed Costs	55,596		120,763	176,359		176,359	(176,359)				43
44	TOTAL Special Cost Centers	55,596	233,830	1,556,646	1,846,072		1,846,072	(182,730)	1,663,342			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,738,676	1,246,047	4,269,187	11,253,910		11,253,910	(65,575)	11,188,335			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				4
5	Telephone, TV & Radio in Resident Rooms	(13,225)	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	804	30		9
10	Interest and Other Investment Income	(1,005)	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	(313)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(49,218)	43		24
25	Fund Raising, Advertising and Promotional	(21,383)	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	(102,601)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (186,941)		\$	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)	121,366		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 121,366		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (65,575)		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	\$ (3,697)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Offset Marketing Salary	(55,596)	43	3
4	Offset Medicare Pt. A Lab	(19,932)	43	4
5	Offset Medicare Pt. A X-Ray	(17,005)	43	5
6	Offset Vending Machine revenue	(2,833)	41	6
7	Offset Miscellaneous Income	(3,538)	39	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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33				33
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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	(102,601)		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)		Peru Becker, Ltd., NFI	Galesburg	Real Estate Entity
		Residential Alternatives of Illinois, Inc. (FH is sole mem		See Page 6 Supplemental		
		Pioneer Concepts, Inc. (FH is sole member)				
		Pinnacle Opportunities, Inc. (FH is sole member)				
		See Page 6 Supplemental for specific homes				

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	18	Director Fees	\$	Residential Alternatives of Illinois, Inc.	100.00%	\$ 2,795	\$ 2,795	1
2	V	19	Professional Services		Residential Alternatives of Illinois, Inc.	100.00%	1,565	1,565	2
3	V	20	Dues, Fees & Subscriptions		Residential Alternatives of Illinois, Inc.	100.00%	37	37	3
4	V	21	Clerical & General Office		Residential Alternatives of Illinois, Inc.	100.00%	611	611	4
5	V	26	Property Insurance		Residential Alternatives of Illinois, Inc.	100.00%	1,740	1,740	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			\$			\$ 6,748	\$ * 6,748	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.

☒ 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		Peru Becker, Ltd., NFP	0.00%	\$ 4,316	\$ 4,316	15
16	V	26	Insurance		Peru Becker, Ltd., NFP	0.00%	25,533	25,533	16
17	V	30	Depreciation Expense		Peru Becker, Ltd., NFP	0.00%	563,172	563,172	17
18	V	32	Interest	65	Peru Becker, Ltd., NFP	0.00%	265,557	265,492	18
19	V	32	Amortization		Peru Becker, Ltd., NFP	0.00%	26,750	26,750	19
20	V	33	Real Estate Tax		Peru Becker, Ltd., NFP	0.00%	135,923	135,923	20
21	V	34	Facility Rent	963,840	Peru Becker, Ltd., NFP	0.00%		(963,840)	21
22	V	36	MIP Insurance		Peru Becker, Ltd., NFP	0.00%	57,272	57,272	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			\$ 963,905			\$ 1,078,523	\$ * 114,618	39

Facility Name & ID Number

Manor Court of Peru

0047316

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 Freeport	Freeport				4
5	Residential Alternatives of Illinois	100%	Manor Court of Peoria	Peoria				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 Peru

0047316

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	\$ 559	L18, C7	1
2	Jeff Shaw	Secretary & Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	559	L18, C7	2
3	William Kempiners	Director	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	559	L18, C7	3
4	Marilyn Holt	Board Member	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	559	L18, C7	4
5	Wayne Stone	Board Member	Administrative	0.00	See Att. Sch 7A	1	<1%	Director Fees	559	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	\$ 2,795		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 Peru # 0047316 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	\$	47,450	\$ 2,795	1
2	19	Professional Services	Weighted Avg BDA	382,040	20	12,600		47,450	1,565	2
3	20	Dues, Fees & Subscriptions	Weighted Avg BDA	382,040	20	300		47,450	37	3
4	21	Clerical & General Office	Weighted Avg BDA	382,040	20	4,930		47,450	611	4
5	26	Property Insurance	Weighted Avg BDA	382,040	20	14,007		47,450	1,740	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	\$		\$ 6,748	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	Refinance - w/ trade premium			\$		\$			\$	1
2	Ltd. Of Illinois - SNF			of \$315804 as of 3/31/25	\$63,289.78	6/1/2013	13,860,000	10,449,920	5/1/2043	3.8000	265,557		2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related				\$63,289.78		\$ 13,860,000	\$ 10,449,920			\$ 265,557		9
	B. Non-Facility Related*												
10	Cambridge Realty Capital						5,940,000	4,478,537	5/1/2043	3.8000	113,810		10
11	Ltd. Of Illinois - Non SNF							Offset Interest Income			(1,070)		11
12								Amortization			26,750		12
13								Offset Non SNF Interest Expense			(113,810)		13
14	TOTAL Non-Facility Related						\$ 5,940,000	\$ 4,478,537			\$ 25,680		14
15	TOTALS (line 9+line14)						\$ 19,800,000	\$ 14,928,457			\$ 291,237		15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 57,272 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.			\$	255,150	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	\$	200,649	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(54,501)	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	248,677	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.		Adjust out ALF portion of expense		(58,253)	
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.			\$	135,923	7
Assessed Value from Real Estate Tax Bill:					
2024	2,536,312	8			
Real Estate Tax Bill for Calendar Year:					
2020	202,417	9			
2021	204,143	10			
2022	201,661	11			
2023	200,649	12			
2024	197,722	13			
This facility was leased from an unrelated for-profit entity and was purchased by a related party in July 2009.					
Amount accrued includes 12 months of 2024 and 3 months of 2025. The real estate tax estimate is					
based on the 2024 tax bills. Taxes paid are for the 2023 tax bill. The related party also pays real estate taxes					
for property not operated by the SNF.					

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manor Court of Peru COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0047316

CONTACT PERSON REGARDING THIS REPORT Brian Burger

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 2024 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 2024.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 17-09-139-001	Liberty Village Second Add Lot 7	\$ 119,306.96	\$ 83,514.87
2. 17-09-124-003	Liberty Lane Village Subd Lot 1, 3	\$ 2,039.68	\$ 1,427.78
3. 17-09-124-004	Liberty Lane Village Subd Lot 1, 2	\$ 76,375.40	\$ 53,462.78
4. 17-09-414-008	Liberty Lane Village II First Addt Lot	\$ 23.40	\$
5. 17-09-417-001	Sub Lots 19A-21B Liberty Lane Villa	\$ 16.06	\$
6. 17-09-417-002	Sub Lots 19A-21B Liberty Lane Villa	\$ 16.06	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 197,777.56	\$ 138,405.43

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 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,122 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:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility - SNF	3.42 acres	2009	\$ 350,000	1
2	Facility - SNF	4 Lots	2017	75,000	2
3	TOTALS	#VALUE!		\$ 425,000	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	130		2009		\$ 13,641,000	\$	25	\$ 545,667	\$ 545,667	\$ 8,594,414
5										
6										
7										
8										
	Improvement Type**									
9	Electric Sign and Water Heater			2005	7,758		10			7,758
10	Roof			2006	5,050		10			5,050
11	Sprinkler System, Asphalt Ramp, Paved parking lot & sidewalks			2009	1,060,899		8-15 yrs	17,609	17,609	1,060,899
12	Call Light System in Therapy			2010	4,877		10			4,877
13	Wander Security Panel			2012	3,140		10			3,140
14	Vinyl Tile/Wallpaper/Paint in Dining Room			2013	11,511		10			11,511
15	Air Conditioner			2013	3,150		10			3,150
16	Mag Lock/Electromagnetic Lock			2013	2,998		10			2,998
17	Water Softener - Entire SNF Facility			2014	6,540		10			6,540
18	Fire Alarm - Manor Court Building			2014	6,830	285	10	285		6,830
19	Water Heater - Services Resident Rooms			2015	3,197	239	10	239		3,197
20	Single Faced Lighted Sign - Outside of SNF Building			2014	3,345	54	10	54		3,345
21	New PTAC units - Resident Rooms			2015	3,522		5			3,522
22	New Nurse Call System			2015	108,573	10,857	10	10,857		104,224
23	New Water Heater			2015	5,502	550	10	550		5,319
24	Amber Message Sign			2015	12,675	1,268	10	1,268		12,043
25	New Water Heater			2016	5,631	563	10	563		5,209
26	Hot Water Heater - Laundry Room/Hallway			2016	10,041	1,004	10	1,004		8,535
27	Cubicle Workstations - PT Treatment Rooms			2016	3,552	296	12	296		2,639
28	Car Port Columns			2017	15,650	1,565	10	1,565		11,607
29	New PTAC units - Resident Rooms			2018	3,566		5			3,566
30	100/200 Hall Bathrooms-Tile/Shower Walls/Grab Bars/Fixtures			2018	28,455	2,371	12	2,371		16,599
31	Office-1 Large into 2 Smaller Offices-Drywall/Paint/Lighting			2018	8,210	684	12	684		4,675
32	HVAC-2 Furnaces/2 AC UNITS-Garden Court			2018	24,150	1,610	15	1,610		10,868
33	Water Heater-Off Laundry Room			2019	12,023	1,202	10	1,202		7,514
34	Water Heater-Off Laundry Room			2019	6,931	693	10	693		4,332
35										
36										

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

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

Facility Name & ID Number Manor Court of Peru

0047316

Report Period Beginning:

4/1/2024

Ending:

3/31/2025

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Water Heater-Off Laundry Room	2019	\$ 6,930	\$ 693	10	\$ 693	\$	\$ 4,331	37
38	New Vinyl Plank Flooring-Garden Court	2019	2,793	279	10	279		1,582	38
39	Asphalt Entire Parking Lot	2019	19,540	2,443	8	2,443		13,637	39
40	New Vinyl Plank Flooring/Cove Base-Library & Garden Court	2019	2,581		10	258	258	1,419	40
41	Installed 8 High Pressure Gas Regulators in Mechanical Room	2020	2,985		10	299	299	1,644	41
42	12 New Cornice Boards in Dining Room	2020	4,184	837	5	837		4,045	42
43	Replace 22 Dry Sprinkler Heads	2020	5,581	558	10	558		2,697	43
44	New 5 Ton AC Unit	2020	2,950	590	5	590		2,655	44
45	Install New Air Handler/Air Conditioner	2022	10,197	2,040	5	2,040		6,290	45
46	Install New LVT Flooring in Conference Room	2022	11,041	1,104	10	1,104		3,496	46
47	Replace Dry Pendants Sprinkler Heads in Kitchen	2022	3,456	346	10	346		951	47
48	Installed New Countertops in Kitchen	2022	13,810	1,151	12	1,151		2,973	48
49	Replace Valve for Sprinkler System	2022	3,873	258	15	258		667	49
50	New Hot Water Heater	2023	6,420	642	10	642		1,391	50
51	PTAC Units - 4	2023	3,848	770	5	770		1,219	51
52	New 4 Ton AC Unit	2023	2,895	579	5	579		1,062	52
53	New Daikin 5 Ton AC Unit	2023	4,495	899	5	899		1,573	53
54	Replace Two Dome Light Controllers	2023	5,398	1,080	5	1,080		1,620	54
55	New Water Heater - Mechanical Room	2024	9,135	915	10	915		993	55
56	Install New 72 HD Channel Com System	2024	32,576	2,172	10	2,172		2,172	56
57	Install New Carrier 4 Ton AC Unit	2024	3,295	330	5	330		330	57
58	Install New Water Heater-Mechanical Room	2024	6,379	213	10	213		213	58
59									59
60									60
61									61
62									62
63	Additional Financial Statement Depreciation Expense			394			(394)		63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 15,173,138	\$ 41,534		\$ 604,973	\$ 563,439	\$ 9,971,321	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	\$ 184,670	\$ 20,395	\$ 21,109	\$ 714	5-15 yrs	\$ 117,860	71
72	Current Year Purchases	61,926	1,594	1,417	(177)	5-15 yrs	1,417	72
73	Fully Depreciated Assets	412,669					412,669	73
74								74
75	TOTALS	\$ 659,265	\$ 21,989	\$ 22,526	\$ 537		\$ 531,946	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2003 GMC Van	2005	\$ 29,800	\$	\$	\$	4	\$ 29,800	76
77	Patient Care	2003 Chevy Silverado	2013	14,380				4	14,380	77
78										78
79	See Attached Schedule 13A			86,121	2,932	2,932			84,582	79
80	TOTALS			\$ 130,301	\$ 2,932	\$ 2,932	\$		\$ 128,762	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)	\$ 16,387,704	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 66,455	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 630,431	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 563,976	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 10,632,029	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	2010 Toyota Corolla - 2010	\$ 16,300	\$	\$ 16,300	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 16,300	\$	\$ 16,300	91

G. Construction-in-Progress

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

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

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

Facility Name:Manor Court of Peru

IDPH License ID Number:0047316

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	2013 Ford F-150	2013	\$ 22,500	\$	\$	\$ 0	4	\$ 22,500	76
77	Facility	2020 Chevy 3500	2020	61,721	2,571	2,571	0	4	61,721	77
78	Facility	2010 Chrysler Van	2024	1,900	361	361	0	4	361	78
79							0			79
80	TOTALS			\$ 86,121	\$ 2,932	\$ 2,932	\$ 0		\$ 84,582	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
- 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?
16. Rental Amount for movable equipment: \$ 12,846
- 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 Peru

IDPH License ID Number:

0047316

Fiscal Year End:

3/31/2025

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment Rental	12,106
Other Equipment Rental	740
Total - Line 16	12,846

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
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		122		122
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		340		340
9	TOTALS	\$	\$ 462	\$	\$ 462
10	SUM OF line 9, col. 1 and 2 (e)	\$ 462			

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	\$	4,218	\$ 303,701	\$
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,434	103,237		1,434	103,237	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		6,238	449,143		6,238	449,143	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				233,830		233,830	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$	11,890	\$ 856,081	\$ 233,830	11,890	\$ 1,089,911	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

XV. BALANCE SHEET - Unrestricted Operating Fund.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 211,987	\$ 375,289	1
2	Cash-Patient Deposits	35,241	35,241	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 122,000)	1,004,636	1,392,463	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,692	27,163	6
7	Other Prepaid Expenses	660	660	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interdivision Receivable</u>	17,316,600	15,296,545	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 18,577,816	\$ 17,127,361	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	50,000	425,000	13
14	Buildings, at Historical Cost	465,380	15,173,138	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	511,389	789,566	16
17	Accumulated Depreciation (book methods)	(693,023)	(10,632,029)	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): <u>See Schedule 17A</u>		1,513,690	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 333,746	\$ 7,269,365	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 18,911,562	\$ 24,396,726	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,236,515	\$ 1,327,651	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	35,241	35,241	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	133,881	133,881	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		248,677	32
33	Accrued Interest Payable		21,736	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,405,637	\$ 1,767,186	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		14,928,457	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Security Deposits</u>	59,835	59,835	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 59,835	\$ 14,988,292	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,465,472	\$ 16,755,478	46
47	TOTAL EQUITY(page 18, line 24)	\$ 17,446,090	\$ 7,641,248	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 18,911,562	\$ 24,396,726	48

Facility Name:

Manor Court of Peru

IDPH License ID Number:

0047316

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		159,691
Insurance Escrow		5,600
MIP Insurance Escrow		59,961
Reserve for Replacement		631,490
Capitalized Loan Fee		1,309,348
Amortization Loan Fee		(652,400)
Total - Line 23	-	1,513,690

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 16,240,064	1
2	Restatements (describe):		2
3	Prior Period Adjustments - Rent Expense	(96,900)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 16,143,164	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,302,926	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,302,926	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)	\$ 17,446,090	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manor Court of Peru

0047316

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	\$ 12,276,724	1
2	Discounts and Allowances for all Levels	(57,820)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,218,904	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	314,104	6
7	Oxygen	4,652	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 318,756	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	5,789	12
13	Barber and Beauty Care	2,139	13
14	Non-Patient Meals		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	225	20
21	Other Medical Services	2,345	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 10,498	23
	D. Non-Operating Revenue		
24	Contributions	500	24
25	Interest and Other Investment Income***	1,005	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,505	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Fitness Center	1,500	28
28a	See Attached Sch 19A	5,673	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,173	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,556,836	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,917,874	31
32	Health Care	4,734,601	32
33	General Administration	1,712,222	33
	B. Capital Expense		
34	Ownership	1,043,141	34
	C. Ancillary Expense		
35	Special Cost Centers	1,277,713	35
36	Provider Participation Fee	568,359	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,253,910	40
41	Income before Income Taxes (line 30 minus line 40)**	1,302,926	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,302,926	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 808,749.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,853,064.00	45
46	MMAI-Medicaid is the Primary Payer	853,888.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	4,716,158.00	48
49	Medicare Part A	3,077,383.00	49
50	Other-(specify) Medicare Replacement/Managed Care	464,139.00	50
51	Other-(specify) Hospice	445,523.00	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)	\$ 12,218,904	56

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name:

Manor Court of Peru

IDPH License ID Number:

0047316

Fiscal Year End:

3/31/2025

Schedule 19A

XVII. Income Statement

Line 28a Other Income

Rental Description	Amount
Processing Fee	100
Miscellaneous Income	3,538
Gain/(Loss) on disposal of Asset	2,035
Total - Line 28a	5,673

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	1,832	2,080	\$ 100,166	\$ 48.16	1
2	Assistant Director of Nursing	1,880	2,056	94,862	46.14	2
3	Registered Nurses	26,140	28,282	1,093,676	38.67	3
4	Licensed Practical Nurses	17,981	19,404	615,715	31.73	4
5	CNAs & Orderlies	94,569	101,524	2,157,771	21.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,967	10,618	195,027	18.37	10
11	Social Service Workers	1,990	2,218	57,184	25.78	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	34,320	35,160	591,903	16.83	15
16	Dishwashers					16
17	Maintenance Workers	6,379	7,079	116,801	16.50	17
18	Housekeepers	14,882	15,823	261,064	16.50	18
19	Laundry	5,009	5,198	83,416	16.05	19
20	Administrator	1,816	2,080	78,545	37.76	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,600	8,395	195,916	23.34	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	1,849	2,080	41,034	19.73	31
32	Other Health Care(specify)					32
33	Other(specify)Marketing	1,840	2,080	55,596	26.73	33
34	TOTAL (lines 1 - 33)	228,054	244,077	\$ 5,738,676 *	\$ 23.51	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	\$ 20,473	L1, C3	35
36	Medical Director	Monthly	23,785	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,659	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)		\$ 54,917		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.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Lorrie Lieske	Administrator	None	\$ 78,545
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 78,545
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		\$ 156,096
RFMS, Inc.	Administrative Services		151,200
RSM US LLP	Accounting Services		38,409
Templin Healthcare Accounting	Accounting Services		4,503
Guided Care	Managed Care Consultant		1,000
Davis & Campbell, LLC	Legal Services		4,163
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 355,371
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 70,576
Unemployment Compensation Insurance			
FICA Taxes			387,070
Employee Health Insurance			234,202
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
401k			40,081
Other Employee Benefits			8,602
TOTAL (agree to Schedule V, line 22, col.8)			\$ 740,531
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			\$ 1,992
Advertising: Employee Recruitment			26,346
Health Care Worker Background Check (Indicate # of checks performed)	24		600
Patient Background Checks	531		5,307
Association Dues (total from pg 22, #4)			10,749
Subscriptions			1,880
Other Licenses & Fees			517
Indirect costs			37
Less: Public Relations Expense			(313)
PAC and Lobbying payments			(3,697)
All non-allowable advertising			()
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 43,418
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			184
Seminar Expense			
Entertainment Expense			()
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 184

*** 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

IL HEALTHCARE ASSOCIATION (IHCA)

Amount

7,052

7,052

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)

3,697

3,697

Total

(4)

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

IL HEALTHCARE ASSOCIATION (IHCA)

10,749

10,749

Total

(5)

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

\$ 68,107

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.

\$ 568,359

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?

No

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.

(11)

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

\$ N/A

Has any meal income been offset against
related costs? Indicate the amount.

\$ N/A

(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?
Indicate the amount of income earned from providing such
transportation during this reporting period.

\$ N/A

No

(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.