

		FOR OHF USE					

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**2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)**

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.

<p>I. IDPH Facility ID Number: <u>0027532</u></p> <p>Facility Name: <u>Manorcare at Normal</u></p> <hr/> <p>Address: <u>510 Broadway</u> <u>Normal</u> <u>61761</u> <small>Number City Zip Code</small></p> <p>County: <u>McLean</u></p> <p>Telephone Number: <u>309-452-4406</u> Fax # <u>309-454-7908</u></p> <p>IDPA ID Number: <u>520886946006</u></p> <p>Date of Initial License for Current Owners: <u>11/01/81</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input checked="" type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name <u>Craig Dekany</u> Telephone Number: <u>419-252-5740</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>06/01/99</u> to <u>05/31/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Type or Print Name) <u>Barry Lazarus</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Title) <u>Vice President - Reimbursement</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____</td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>Barry Lazarus</u>		(Title) <u>Vice President - Reimbursement</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																													
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																													
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IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																													
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	(Title) <u>Vice President - Reimbursement</u>																														
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____																														

Facility Name & ID Number Manorcare at Normal

0027532 Report Period Beginning: 06/01/99 Ending: 05/31/00

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	99	Skilled (SNF)	99	36,234	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	99	TOTALS	99	36,234	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	745	3,848	3,077	7,670	8
9	SNF/PED					9
10	ICF	10,879	14,013	340	25,232	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,624	17,861	3,417	32,902	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 90.80%)

D. How many bed-hold days during this year were paid by Public Aid? 125 (Do not include bed-hold days in Section B.)

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

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

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 11/01/81

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/01/81 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 26 and days of care provided 2821

Medicare Intermediary B/C Maryland

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/00 Fiscal Year: 05/31/99
* All facilities other than governmental must report on the accrual basis.

Print Previe

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Manorcare at Normal # 0027532 Report Period Beginning: 06/01/99 Ending: 05/31/00
 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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	152,177	11,127	11,480	174,784	632	175,416	0	175,416		1
2	Food Purchase		161,751		161,751		161,751	(48)	161,703		2
3	Housekeeping	43,250	7,345	20,071	70,666		70,666	0	70,666		3
4	Laundry	22,095	17,262	10,968	50,325		50,325	0	50,325		4
5	Heat and Other Utilities			68,253	68,253	7,505	75,758	0	75,758		5
6	Maintenance	29,868	5,277	27,999	63,144		63,144	0	63,144		6
7	Other (specify): Med. Waste			3,604	3,604		3,604	0	3,604		7
8	TOTAL General Services	247,390	202,762	142,375	592,527	8,137	600,664	(48)	600,616		8
B. Health Care and Programs											
9	Medical Director			6,850	6,850		6,850	0	6,850		9
10	Nursing and Medical Records	1,083,534	112,696	107,886	1,304,116	10,160	1,314,276	0	1,314,276		10
10a	Therapy	136,455	772	13,582	150,809		150,809	0	150,809		10a
11	Activities	50,302	3,120	2,119	55,541		55,541	0	55,541		11
12	Social Services	23,291	57	15	23,363		23,363	0	23,363		12
13	Nurse Aide Training							0			13
14	Program Transportation							0			14
15	Other (specify):*							0			15
16	TOTAL Health Care and Progra	1,293,582	116,645	130,452	1,540,679	10,160	1,550,839		1,550,839		16
C. General Administration											
17	Administrative	85,245		184,604	269,849	(53,778)	216,071	0	216,071		17
18	Directors Fees							0			18
19	Professional Services			2,084	2,084	(428)	1,656	(1,656)			19
20	Dues, Fees, Subscriptions & Promotions			63,646	63,646		63,646	(35,637)	28,009		20
21	Clerical & General Office Expense	113,457	18,897	175,292	307,646	428	308,074	(131,477)	176,597		21
22	Employee Benefits & Payroll Taxes			295,473	295,473	846	296,319	0	296,319		22
23	Inservice Training & Education			12,520	12,520		12,520	0	12,520		23
24	Travel and Seminar			22,642	22,642		22,642	0	22,642		24
25	Other Admin. Staff Transportation							0			25
26	Insurance-Prop.Liab.Malpractice			57,478	57,478		57,478	0	57,478		26
27	Other (specify):*			0				0			27
28	TOTAL General Administration	198,702	18,897	813,739	1,031,338	(52,932)	978,406	(168,770)	809,636		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,739,674	538,304	1,086,566	3,164,544	(34,635)	3,129,909	(168,818)	2,961,091		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Manorcare at Normal # 0027532 Report Period Beginning: 06/01/99 Ending: 05/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			223,142	223,142	12,958	236,100	(48,037)	188,063		30
31	Amortization of Pre-Op. & Org.							0			31
32	Interest			392	392	21,677	22,069	(10,009)	12,060		32
33	Real Estate Taxes			37,255	37,255		37,255	0	37,255		33
34	Rent-Facility & Grounds							0			34
35	Rent-Equipment & Vehicles			18,684	18,684		18,684	0	18,684		35
36	Other (specify):*							0			36
37	TOTAL Ownership			279,473	279,473	34,635	314,108	(58,046)	256,062		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation							0			38
39	Ancillary Service Centers		88,939	12,322	101,261		101,261	0	101,261		39
40	Barber and Beauty Shops		13,267		13,267		13,267	0	13,267		40
41	Coffee and Gift Shops							0			41
42	Provider Participation Fee			54,352	54,352		54,352	0	54,352		42
43	Other (specify):*		2,510	0	2,510		2,510	0	2,510		43
44	TOTAL Special Cost Centers		104,716	66,674	171,390		171,390		171,390		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,739,674	443,020	1,432,713	3,615,407	0	3,615,407	(226,864)	3,388,543		45

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

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number Manorcare at Normal

0027532

Report Period Beginning: 06/01/99

Ending: 05/31/00

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program:				3
4	Non-Patient Meals	(48)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(10,009)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(7,382)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(48,037)	30		15
16	Personal Expenses (Including Transportation)	(2,177)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(40,470)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,656)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(81,448)	21		24
25	Fund Raising, Advertising and Promotional	(35,637)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (226,864)		\$	30

OHF USE ONLY					
48		49		50	51
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (226,864)		37

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

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

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

Print Previe

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary A

Facility Name & ID Numbr Manorcare at Normal

0027532 Report Period Beginning:

06/01/99

Ending: 05/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary		Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
A. General Services														
1	Dietary		0	0	0	0	0	0	0	0	0	0	0	0 1
2	Food Purchase		(48)	0	0	0	0	0	0	0	0	0	0	(48) 2
3	Housekeeping		0	0	0	0	0	0	0	0	0	0	0	0 3
4	Laundry		0	0	0	0	0	0	0	0	0	0	0	0 4
5	Heat and Other Utilities		0	0	0	0	0	0	0	0	0	0	0	0 5
6	Maintenance		0	0	0	0	0	0	0	0	0	0	0	0 6
7	Other (specify):*		0	0	0	0	0	0	0	0	0	0	0	0 7
8	TOTAL General Services		(48)	0	0	0	0	0	0	0	0	0	0	(48) 8
B. Health Care and Programs														
9	Medical Director		0	0	0	0	0	0	0	0	0	0	0	0 9
10	Nursing and Medical Records		0	0	0	0	0	0	0	0	0	0	0	0 10
10a	Therapy		0	0	0	0	0	0	0	0	0	0	0	0 10a
11	Activities		0	0	0	0	0	0	0	0	0	0	0	0 11
12	Social Services		0	0	0	0	0	0	0	0	0	0	0	0 12
13	Nurse Aide Training		0	0	0	0	0	0	0	0	0	0	0	0 13
14	Program Transportation		0	0	0	0	0	0	0	0	0	0	0	0 14
15	Other (specify):*		0	0	0	0	0	0	0	0	0	0	0	0 15
16	TOTAL Health Care and Program		0	0	0	0	0	0	0	0	0	0	0	0 16
C. General Administration														
17	Administrative		0	0	0	0	0	0	0	0	0	0	0	0 17
18	Directors Fees		0	0	0	0	0	0	0	0	0	0	0	0 18
19	Professional Services		(1,656)	0	0	0	0	0	0	0	0	0	0	(1,656) 19
20	Fees, Subscriptions & Promotions		(35,637)	0	0	0	0	0	0	0	0	0	0	(35,637) 20
21	Clerical & General Office Expenses		(131,477)	0	0	0	0	0	0	0	0	0	0	(131,477) 21
22	Employee Benefits & Payroll Taxes		0	0	0	0	0	0	0	0	0	0	0	0 22
23	Inservice Training & Education		0	0	0	0	0	0	0	0	0	0	0	0 23
24	Travel and Seminar		0	0	0	0	0	0	0	0	0	0	0	0 24
25	Other Admin. Staff Transportation		0	0	0	0	0	0	0	0	0	0	0	0 25
26	Insurance-Prop.Liab.Malpractice		0	0	0	0	0	0	0	0	0	0	0	0 26
27	Other (specify):*		0	0	0	0	0	0	0	0	0	0	0	0 27
28	TOTAL General Administration		(168,770)	0	0	0	0	0	0	0	0	0	0	(168,770) 28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)		(168,818)	0	0	0	0	0	0	0	0	0	0	(168,818) 29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Numbr: Manorcare at Normal

0027532

Report Period Beginning:

06/01/99

Ending:

05/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES	PAGE	SUMMARY									
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	(48,037)	0	0	0	0	0	0	0	0	0	0	(48,037) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(10,009)	0	0	0	0	0	0	0	0	0	0	(10,009) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(58,046)	0	(58,046) 37									
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Cent	0	0	0	0	0	0	0	0	0	0	0	0 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(226,864)	0	(226,864) 45									

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Entity Name & ID Number: Mastercare of Normal License: 0827542 Report Period Beginning: 06/01/09 Ending: 05/31/09

VI. RELATED PARTIES (Show Pgs 6A thru 6) (Show Pgs 6A thru 6) (Hide Pgs 6A thru 6)

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

OWNERS		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MasterCare, Inc.	100	Health Care & Retirement Corporation	Elmhurst, OH			

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.

Schedule	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	B. Difference: Adjustment to Related Organization Costs (C minus E)
1	V	Supplies	184,204	H C W Manor Care, Inc	100.00%	184,204	
2	V						
3	V						
4	V						
5	V						
6	V	Therapy Management	3,873	Harvard Management Services	100.00%	3,873	
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	V						
15	V						
16	V						
17	V						
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219	V						
220	V						
221</							

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.

Line	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	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	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 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 REI

** 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

Print Previe

| the name(s)
PORTS.

Facility Name & ID Number Manorcare at Normal

0027532 Report Period Beginning: 06/01/99

Ending: 05/31/00

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

Name of Related Organization HCR ManorCare, Inc.
 Street Address 333 North Summit
 City / State / Zip Code Toledo, OH 43604
 Phone Number (419) 252-5500
 Fax Number (419) 254-5495

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Accumulated Cost	#####	357 Nurs. Fac.	\$ 388,478	\$ 221,496	162,927	\$ 632	1
2	5	Utilities	Accumulated Cost	#####	357 Nurs. Fac.	4,614,666		162,927	7,505	2
3	10	Nursing	Accumulated Cost	#####	357 Nurs. Fac.	6,247,503	4,177,723	162,927	10,160	3
4	17	General & Administrative	Accumulated Cost	#####	357 Nurs. Fac.	80,443,795	26,746,978	162,927	130,826	4
5	22	Employee Benefits	Accumulated Cost	#####	357 Nurs. Fac.	520,233		162,927	846	5
6	30	Depreciation	Accumulated Cost	#####	357 Nurs. Fac.	7,968,019		162,927	12,958	6
7	32	Interest	Direct Alloc.	1		21,677		1	21,677	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					\$ 100,204,371	\$ 31,146,197		\$ 184,604	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	Conv. Sub. Debentures		x	Facility			\$ 684,665	\$ 684,665			\$ 21,677	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7								Interest Expense			392	7								
8								Interest Income			(10,009)	8								
9	TOTAL Facility Related						\$ 684,665	\$ 684,665			\$ 12,060	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 684,665	\$ 684,665			\$ 12,060	15								

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

(See instructions.)

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

(See instructions.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	\$	37,255	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.)	\$	37,255	2
3. Under or (over) accrual (line 2 minus line 1).	\$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	37,255	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 used previously to calculate a payment rate. 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. TOTAL REFUND \$ For 19 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	\$	37,255	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1995	33,546	8
	1996	34,190	9
	1997	35,433	10
	1998	36,800	11
	1999	36,282	12
R/E Tax Payment			
1999 \$18,855.42			
2000 \$18,400.01			
	FOR OFF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 1999 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATIC \$	16

NOTES:

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

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Facility Name & ID Number: Manorcare at Normal

0027532 Report Period Beginning:

06/01/99 Ending:

05/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,117 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: _____ 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			1971	\$ 58,339	1
2			1993	42,954	2
3	TOTALS			\$ 101,293	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12

Show Pgs 12C and 12

Hide Pgs 12A thru 12

STATE OF ILLINOIS

Page 12

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Report Period Beginning:

06/01/99

Ending: 05/31/00

Facility Name & ID Number Manorcare at Normal

XI. OWNERSHIP COSTS (continued)

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

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	90		1971	1962	\$ 506,817	\$ 25,572		\$ 25,572	\$	\$ 525,497	4
5	9			1994	497,564						5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9	Building Improvement (Current Year Depreciation)					85,041		85,041		785,681	9
10				1979	60,522						10
11				1980	317,478						11
12				1981	50,351						12
13				1982	21,867						13
14				1984	16,946						14
15				1985	26,268						15
16				1986	18,155						16
17				1987	42,286						17
18				1988	207,264						18
19				1989	134,621						19
20				1990	46,332						20
21				1991	15,386						21
22				1992	57,357						22
23				1993	44,829						23
24				1994	137,130						24
25				1995	72,481						25
26	RENOVATIONS			1996	22,684						26
27	CARPET/TILE & INSTALLATION			1996	4,392						27
28	CAPITALIZED LABOR			1996	7,272						28
29	WALL/VINYL/DRYWALL			1996	5,194						29
30	SIGNS/BOARDS			1996	1,730						30
31	INSTALL GRID/PANELS			1996	4,402						31
32	CONCRETE WALK/RAMP			1996	2,850						32
33	CABINETS			1996	1,087						33
34	CARPETING			1996	9,845						34
35	ROOFING			1996	24,474						35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$ 110,613		\$ 110,613	\$	\$ 1,311,178	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.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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Page 12A

Facility Name & ID Numbe Manorcare at Normal

0027532

Report Period Beginning:

06/01/99 Ending: 05/31/00

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9		ELECTRICAL/LIGHTING		1996	2,159						9
10		WALLCOVERINGS		1996	5,910						10
11		SIGNS/CORNERGUARDS/CHAIR RAIL		1996	2,433						11
12		INSTALL SHOWER TILE		1996	2,656						12
13		REPAIR COMPRESSOR		1996	900						13
14		CONCRETE WALK		1996	1,053						14
15		PAINTING & DECORATING		1997	15,688						15
16		ROOF REPLACEMENT		1997	3,345						16
17		WALLCOVERINGS		1997	1,788						17
18		TILE & INSTALLATION		1997	2,686						18
19		RETIREMENTS		1987	(29,830)						19
20		RETIREMENTS		1992	(3,110)						20
21		CARPET		1997	1,547						21
22		INSTALL COMPRESSOR		1997	2,583						22
23		ROOF WORK		1997	51,370						23
24		WALK-IN COOLER/FREEZER		1997	9,466						24
25		ALLOC. FAC. PLAN		1997	2,758						25
26		PLUMBING/BATHROOM WORK		1997	1,226						26
27		ELECTRICAL		1997	2,416						27
28		FINISH/STUD		1998	4,865						28
29		PAINTING/WALLCOVERINGS		1998	8,175						29
30		CARPETING		1998	6,460						30
31		PLUMBING		1998	1,456						31
32		ROOFING		1998	2,170						32
33		DOORS/WINDOWS/CASEWORK		1998	9,884						33
34		ELECTRICAL		1998	5,360						34
35		FLOORING/CEILING/COVE BASE		1998	13,283						35
36		PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3			\$ #VALUE!	\$		\$	\$	\$	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.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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0027532

Report Period Beginning:

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06/01/99 Ending: 05/31/00

Facility Name & ID Numbe Manorcare at Normal

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9		GENERAL CONTRACTOR FEES		1998	1,298						9
10		CORPORATE OVERHEAD		1998	1,702						10
11		FURNISH & INSTALL STEEL DOORS		1998	2,439						11
12		MILLWORK		1998	1,166						12
13		INSTALL DUCTS		1998	327						13
14		REWORK FIRE/SMOKE DAMPERS		1998	632						14
15		RENOVATE PATIENT ROOMS		1998	5,233						15
16		WALKWAY		1998	7,267						16
17		ELECTRICAL		1998	8,111						17
18		ROOFING		1998	8,485						18
19		SIGNAGE		1998	13,529						19
20		DOORS/WINDOWS		1998	1,773						20
21		GENERAL CONTRACTOR FEES		1998	2,507						21
22		MASONRY		1998	3,700						22
23		PAINTING/WALLCOVER		1998	251						23
24		FLOORING		1998	458						24
25		RENOVATE PATIENT ROOMS		1998	(2,520)						25
26		GAZEBO		1998	2,495						26
27		FLOORS		1999	2,990						27
28		DOORS		1999	18,097						28
29		FENCING		1999	4,343						29
30		SIDEWALK		1999	3,719						30
31		FIRE SPRINKLER		1999	6,270						31
32		WATER HEATER		1999	7,717						32
33		FLOORS		2000	830						33
34		DOORS		2000	11,081						34
35		RENOVATIONS		2000	5,000						35
36		PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3			\$ #VALUE!	\$		\$	\$	\$	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.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

0027532

Report Period Beginning:

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06/01/99 Ending: 05/31/00

Facility Name & ID Numbe Manorcare at Normal

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9	DISPOSALS			2000	(361,695)						9
10											10
11											11
12											12
13											13
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17											17
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35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	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.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Page 12D

0027532

Report Period Beginning:

06/01/99 Ending: 05/31/00

Facility Name & ID Numbe Manorcare at Normal

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
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PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
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36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	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.

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Facility Name & ID Number Manorcare at Normal

0027532

Report Period Beginning: 06/01/99

Ending: 05/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componer Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 496,387	\$ 64,491	\$ 64,491	\$		\$ 266,137	37
38	Current Year Purchases	64,759						38
39	Fully Depreciated Assets	(64,669)						39
40	Home Office Allocation			12,958	12,958			40
41	TOTALS	\$ 496,477	\$ 64,491	\$ 77,449	\$ 12,958		\$ 266,137	41

D. Vehicle Depreciation (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	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 175,104	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 188,062	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 12,958	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,577,315	51

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	STEP-UP BUILDING	\$ 1,103,710	\$ 48,037	\$ 891,546	52
53					53
54					54
55					55
56					56
57	TOTALS	\$ 1,103,710	\$ 48,037	\$ 891,546	57

G. Construction-in-Progress

	Description	Cost	
58	CIP	\$ 142,239	58
59			59
60			60
61		\$ 142,239	61

* 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.

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XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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 Date of Lease	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: _____ *

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 equipm: \$ 18,684 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the curre
rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>/2001</u>	\$ _____
13.	<u>/2002</u>	\$ _____
14.	<u>/2003</u>	\$ _____

* 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.

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

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

	Facility			
	1	2	3	4
	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 Nurse Aide Competency Tests				
9 TOTALS	\$	\$	\$	\$
10 SUM OF line 9, col. 1 and 2 (e)	\$			

- (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 aide 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 aides.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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Facility Name & ID Number Manorcare at Normal# 0027532 Report Period Beginning:06/01/99 Ending: 05/31/00

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	10A	2,900	hrs	\$ 54,135	196	\$ 4,904	\$ 1,863	3,096	\$ 60,902	1	
2	Licensed Speech and Language Development Therapist	10A	1,250	hrs	23,339	26	658	(3,359)	1,276	20,638	2	
3	Licensed Recreational Therapist			hrs							3	
4	Licensed Physical Therapist	10A	3,159	hrs	58,981	321	8,020	2,268	3,480	69,269	4	
5	Physician Care			visits							5	
6	Dental Care			visits							6	
7	Work Related Program			hrs							7	
8	Habilitation			hrs							8	
9	Pharmacy	39		# of prescripts				88,939		88,939	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10	
11	Academic Education			hrs							11	
12	Exceptional Care Program										12	
13	Other (specify): X-Ray/Pharmacy	39					12,322			12,322	13	
14	TOTAL				\$ 136,455	543	\$ 25,904	\$ 89,711	7,852	\$ 252,070	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 nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name & ID Number Manorcare at Normal

0027532

Report Period Beginning: 06/01/99

Ending:

05/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/00 (last day of reporting year)

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	\$ (24,736)	1
2	Cash-Patient Deposits		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (268,352))	344,216	3
4	Supply Inventory (priced at)	9,221	4
5	Short-Term Investments		5
6	Prepaid Insurance		6
7	Other Prepaid Expenses	2,166	7
8	Accounts Receivable (owners or related parties)		8
9	Other(specify):		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 330,867	10
B. Long-Term Assets			
11	Long-Term Notes Receivable		11
12	Long-Term Investments		12
13	Land	301,354	13
14	Buildings, at Historical Cost	3,278,272	14
15	Leasehold Improvements, at Historical Cost		15
16	Equipment, at Historical Cost	497,235	16
17	Accumulated Depreciation (book methods)	(2,490,662)	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): CIP	146,613	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,732,812	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,063,679	25

	1	2	
	Operating	After	
		Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 48,050	26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits		28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	66,668	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,078	31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,255	32
33	Accrued Interest Payable		33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
Other Current Liabilities(specify):			
36	Accrued Payables	43,986	36
37			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 208,037	38
D. Long-Term Liabilities			
39	Long-Term Notes Payable		39
40	Mortgage Payable		40
41	Bonds Payable		41
42	Deferred Compensation		42
Other Long-Term Liabilities(specify):			
43			43
44			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 208,037	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,855,642	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,063,679	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,293,335	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,293,335	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	368,545	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)	\$ 368,545	17
B. Transfers (Itemize):			
18	Change in Interdivision	(3,806,238)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (3,806,238)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,855,642	24 *

* This must agree with page 17, line 47.

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Facility Name & ID Number Manorcare at Normal

0027532

Report Period Beginning: 06/01/99

Ending:

05/31/00

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,324,653	1
2	Discounts and Allowances for all Levels	(711,135)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,613,518	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	266,766	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 266,766	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,177	12
13	Barber and Beauty Care	13,065	13
14	Non-Patient Meals	48	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	59,762	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,255	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	9,352	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 93,659	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	10,009	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,009	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,983,952	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	\$ 592,527	31
32	Health Care	1,540,679	32
33	General Administration	1,031,338	33
B. Capital Expense			
34	Ownership	279,473	34
C. Ancillary Expense			
35	Special Cost Centers	171,390	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,615,407	40
41	Income before Income Taxes (line 30 minus line 40)**	368,545	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 368,545	43

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

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

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

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

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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	2,296	2,628	\$ 76,078	\$ 28.95	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,208	8,221	118,994	14.47	3
4	Licensed Practical Nurses	17,413	20,683	298,907	14.45	4
5	Nurse Aides & Orderlies	51,376	59,917	589,555	9.84	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,025	2,409	136,455	56.64	7
8	Rehab/Therapy Aides					8
9	Activity Director	4,192	4,866	50,302	10.34	9
10	Activity Assistants					10
11	Social Service Workers	1,896	2,080	23,291	11.20	11
12	Dietician	14,687	17,597	152,177	8.65	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,849	2,248	29,868	13.29	17
18	Housekeepers	5,535	6,431	43,250	6.73	18
19	Laundry	2,841	3,290	22,095	6.72	19
20	Administrator	1,728	2,198	85,245	38.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,787	10,350	113,457	10.96	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	121,833	142,918	\$ 1,739,674 *	\$ 12.17	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director	Monthly 6,850	9,3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			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) H/R Consultant	Monthly 428	21,5	46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 7,278		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	213 \$ 6,341	10,3	50
51	Licensed Practical Nurses	1,258 \$ 31,130	10,3	51
52	Nurse Aides	3,214 \$ 50,849	10,3	52
53	TOTAL (lines 50 - 52)	4,685 \$ 88,320		53

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