

		FOR OHF USE					

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2005
 STATE OF ILLINOIS
 DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
 FINANCIAL AND STATISTICAL REPORT FOR
 LONG-TERM CARE FACILITIES
 (FISCAL YEAR 2005)

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>0018150</u></p> <p>Facility Name: <u>McLean County Nursing Home</u></p> <p>Address: <u>901 North Main Street</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) 888-5380</u> Fax # <u>(309) 454-4594</u></p> <p>IDPA ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>10/1/1971</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 <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input checked="" type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Donald Lee</u> Telephone Number: <u>(309) 888-5380</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input checked="" type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input checked="" type="checkbox"/> County <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>01/01/2005</u> to <u>12/31/2005</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:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Date) _____ (Type or Print Name) <u>Donald Lee</u> (Title) <u>Administrator</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="center"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>Donald Lee</u> (Title) <u>Administrator</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) _____ Fax # _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input checked="" type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input checked="" type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>Donald Lee</u> (Title) <u>Administrator</u>							
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) _____ Fax # _____							

Facility Name & ID Number McLean County Nursing Home# 0018150 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	150	Skilled (SNF)	150	54,750	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	150	TOTALS	150	54,750	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,125	1,334	2,111	5,570	8
9	SNF/PED					9
10	ICF	32,080	14,713		46,793	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,205	16,047	2,111	52,363	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 95.64%D. How many bed-hold days during this year were paid by the Department?
_____ (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)
_____F. Does the facility maintain a daily midnight census? YesG. 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 1-Oct-71J. Was the facility purchased or leased after January 1, 1978?
YES Date 1-Oct-71 NO K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number
of beds certified 18 and days of care provided 2,111Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED
CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

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

STATE OF ILLINOIS

Page 3

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2005 Ending: 12/31/2005
 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	331,256	34,819	10,355	376,430		376,430		376,430		1
2	Food Purchase		304,272		304,272		304,272	(33,754)	270,518		2
3	Housekeeping	165,948	41,760		207,708		207,708		207,708		3
4	Laundry	129,547	35,729		165,276		165,276	(7,658)	157,618		4
5	Heat and Other Utilities			265,378	265,378		265,378		265,378		5
6	Maintenance	112,211	34,947	23,098	170,256		170,256	4,921	175,177		6
7	Other (specify):*										7
8	TOTAL General Services	738,962	451,527	298,831	1,489,320		1,489,320	(36,491)	1,452,829		8
	B. Health Care and Programs										
9	Medical Director			600	600		600		600		9
10	Nursing and Medical Records	2,327,347	5,599	98,769	2,431,715		2,431,715		2,431,715		10
10a	Therapy			111,149	111,149		111,149		111,149		10a
11	Activities	89,146	466	1,543	91,155		91,155		91,155		11
12	Social Services	92,348	79	1,513	93,940		93,940		93,940		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,508,841	6,144	213,574	2,728,559		2,728,559		2,728,559		16
	C. General Administration										
17	Administrative	96,738		64,172	160,910		160,910	(6,823)	154,087		17
18	Directors Fees							84,139	84,139		18
19	Professional Services			7,453	7,453		7,453	178,783	186,236		19
20	Dues, Fees, Subscriptions & Promotions			17,294	17,294	1,214	18,508	(1,214)	17,294		20
21	Clerical & General Office Expenses	129,047	21,058	42,681	192,786	(939)	191,847	(14,280)	177,567		21
22	Employee Benefits & Payroll Taxes			892,574	892,574		892,574		892,574		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,210	3,210	(275)	2,935		2,935		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			125,326	125,326		125,326		125,326		26
27	Other (specify):*										27
28	TOTAL General Administration	225,785	21,058	1,152,710	1,399,553		1,399,553	240,605	1,640,158		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,473,588	478,729	1,665,115	5,617,432		5,617,432	204,114	5,821,546		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.

Facility Name & ID Number McLean County Nursing Home #0018150 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			180,115	180,115		180,115	1,204	181,319			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			180,115	180,115		180,115	1,204	181,319			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		131,076		131,076		131,076		131,076			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		131,076	82,125	213,201		213,201		213,201			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,473,588	609,805	1,927,355	6,010,748		6,010,748	205,318	6,216,066			45

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

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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 Programs				3
4 Non-Patient Meals	(623)	2.2		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	(7,658)	4.2		8
9 Non-Straightline Depreciation	1,430	30.3		9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				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				24
25 Fund Raising, Advertising and Promotional				25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 CNA Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule	(48,851)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (55,702)		\$	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
Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	261,020		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 261,020		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ 205,318		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		x			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		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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	6 Lawn Service	\$ -	City of Normal		\$ 4,921	\$ 4,921	1
2	V	18 County Board	-	McLean County	100.00%	84,139	84,139	2
3	V	19 Information Services	-	McLean County	100.00%	8,201	8,201	3
4	V	17 County Administrator	64,172	McLean County	100.00%	57,349	(6,823)	4
5	V	19 County Auditor	-	McLean County	100.00%	58,605	58,605	5
6	V	19 County Treasurer	-	McLean County	100.00%	111,977	111,977	6
7	V		-			-		7
8	V		-			-		8
9	V		-			-		9
10	V		-			-		10
11	V		-			-		11
12	V		-			-		12
13	V		-			-		13
14	Total		\$ 64,172			\$ 325,192	\$ * 261,020	14

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

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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									\$		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 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 McLean County Nursing Home

0018150 Report Period Beginning: 01/01/2005

Ending: 12/31/2005

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 McLean County Government
 Street Address 104 West Front Street
 City / State / Zip Code Bloomington, IL 61702
 Phone Number (309) 888-5110
 Fax Number (309) 888-5111

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	
18	County Board	Expenditures	100,000	20 Funds	\$ 420,358	\$ 102,275	20,016	\$ 84,139	1
19	Information Services	% of Effort	100,000	20 Funds	1,759,869	801,365	466	8,201	2
17	County Administrator	FTE	100,000	20 Funds	554,849	278,180	10,336	57,349	3
19	County Auditor	Transactions	100,000	20 Funds	509,877	230,614	11,494	58,605	4
19	County Treasurer	Warrants	100,000	20 Funds	690,747	222,427	16,211	111,977	5
									6
									7
									8
									9
									10
									11
									12
									13
									14
									15
									16
									17
									18
									19
									20
									21
									22
									23
									24
25	TOTALS				\$ 3,935,700	\$ 1,634,861		\$ 320,271	25

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
	Working Capital																	
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$	\$				\$	9					
	B. Non-Facility Related*																	
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$				\$	14					
15	TOTALS (line 9+line14)						\$	\$				\$	15					

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

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

** 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

<div style="border: 1px solid black; padding: 2px; display: inline-block; color: red; font-weight: bold;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>			
1. Real Estate Tax accrual used on 2004 report.		\$	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.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	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. 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.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2000 _____	8	
	2001 _____	9	
	2002 _____	10	
	2003 _____	11	
	2004 _____	12	
			FOR OHF USE ONLY
		13 FROM R. E. TAX STATEMENT FOR 2004 \$	13
		14 PLUS APPEAL COST FROM LINE 5 \$	14
		15 LESS REFUND FROM LINE 6 \$	15
		16 AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

Facility Name & ID Number McLean County Nursing Home

0018150

Report Period Beginning:

01/01/2005 Ending:

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 58,065 B. General Construction Type: Exterior Brick Frame Steel Number of Stories One

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

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

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

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

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

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1				\$ 15,000	1
2					2
3	TOTALS			\$ 15,000	3

Facility Name & ID Number McLean County Nursing Home

0018150

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	150		Jan-74	Jan-74	\$ 2,907,918	\$ 72,695	40	\$ 72,698	\$ 3	\$ 2,272,089	4
5			Jan-75	Jan-75	66,046	1,652	40	1,651	(1)	50,494	5
6			Jan-76	Jan-76	32,940	825	40	824	(1)	24,377	6
7											7
8											8
	Improvement Type**										
9		Paging System		Dec-89	2,588	129	20	129		2,065	9
10		Smoke Detectors		Dec-89	2,418		5			2,418	10
11		Air Cond & Boiler		Nov-79	40,718		40	1,018	1,018	30,213	11
12		Roof Repairs		Jun-82	3,374		40	84	84	1,932	12
13		Smoke Damper		Jul-83	3,600		40	90	90	2,070	13
14		Various - 1984		May-84	58,471		20			58,471	14
15		Fan Coil Units		Apr-84	1,158		15			1,158	15
16		Temp Sensors		Feb-85	499		10			499	16
17		Wood shed		Jul-85	749		15			749	17
18		Sewer Machine & 100 Gal Tank		Apr-86	1,592	60	20	80	20	1,537	18
19		Rear Door - Vestibule		Jan-84	1,962	49	40	49		1,078	19
20		Various - 1987		May-87	19,471	728	20	974	246	17,975	20
21		Concrete & Asphalt		Jun-87	19,249		10			19,249	21
22		Fire Doors		Jun-88	1,070	54	20	54		971	22
23		Replace Roof		Aug-88	481,262	26,515	18	26,737	222	454,529	23
24		Boiler Repairs		Dec-89	917		10			917	24
25		Masonry Repars - Bldg		Oct-89	5,521	221	25	221		3,535	25
26		Telephone System		Jan-88	4,250	170	25	170		3,060	26
27		Courtyard Repairs		May-89	2,191	83	20	110	27	1,760	27
28		Fire Alarm Control Panel		Nov-89	5,072		10			5,072	28
29		Capital Improvements		Jul-90	21,349	644	15	4	(640)	21,349	29
30		Capital Improvements		Mar-91	2,390	120	20	120		1,800	30
31		Heat Exchanger		Mar-91	2,236		10			2,236	31
32		Door Frame & Dining Room Remodel		May-92	6,350	173	40	159	(14)	2,111	32
33		Direct Cable - 500 Ft.		Feb-92	168	7	23	7		98	33
34		Closure & Power Frame Assembly		May-92	2,545		10			2,545	34
35		Boilers (2) & Stacks		Oct-92	63,200	3,160	20	3,160		41,080	35
36		Toilet Rails & Water Booster		Jun-93	2,585	172	15	172		2,151	36

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

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

See Page 12A, Line 70 for total

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number McLean County Nursing Home

0018150

Report Period Beginning:

01/01/2005

Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Storage Tank	Nov-93	\$ 10,558	\$ 211	50	\$ 211		\$ 2,563	37	
38	Stairsteps	Nov-93	289	10	30	10		121	38	
39	Air Cond & Boiler	Nov-80	9,889		20	494	494	6,422	39	
40	Remodel Nurses Station	Apr-94	2,283	152	15	152		1,781	40	
41	Air Cond Units (2)	Jul-94	79,305	5,287	15	5,287		60,547	41	
42	IDPA Audit	Jan-92	4,243		10			4,243	42	
43	Kitchen Walk-in Freezer/Cooler	Oct-96	11,038	552	20	552		5,062	43	
44	Closed Circuit TV System-Recorder	Feb-98	3,208		5			3,208	44	
45	NT System Wiring & Switches	Dec-98	4,222		5			4,222	45	
46	Bathroom Improvements	Aug-99	9,505	951	10	951		6,092	46	
47	Four Water Coolers	Jul-99	2,089	209	10	209		1,348	47	
48	Aluminum Cubicle Track	Sep-99	7,578	379	20	379		2,390	48	
49	Roofing Repairs	May-99	29,217	1,461	20	1,461		9,667	49	
50	Cooridor Fire Doors	Dec-99	4,495	225	20	225		1,362	50	
51	Time Clock System	Jul-99	7,144	476	15	476		3,079	51	
52	Lamp Fixture Improvement	Aug-00	1,218	122	10	122		661	52	
53	Room Remodeling Project 2000	Dec-00	39,599	2,700	15	2,640	(60)	13,200	53	
54	Kitchen Disposal Unit	Jun-00	1,789	224	8	224		1,242	54	
55	Room Remodeling Project 2000	Jan-01	40,993	2,956	15	2,733	(223)	13,657	55	
56	Life Safety Project	Oct-01	12,937	866	15	862	(4)	3,552	56	
57	Door Lock Project	Mar-01	31,078	2,072	15	2,072		9,866	57	
58	Room Remodeling Project 2000	Jan-02	37,526	2,397	15	2,502	105	10,001	58	
59	Kitchen Flooring	Sep-02	16,548	1,655	10	1,655		5,441	59	
60	Generator Project	May-02	47,920	3,195	15	3,195		11,476	60	
61	Administration Remodel	Sep-02	17,510	1,174	15	1,167	(7)	3,716	61	
62	Paging System	Sep-02	3,217	210	15	214	4	707	62	
63	Nurse's Station	May-03	1,403	94	15	94		247	63	
64	Phase II Remodel - 300 Wing	Nov-03	13,354	890	15	890		1,885	64	
65	Parking Lot Repaving	Sep-04	64,698	4,313	15	4,313		5,436	65	
66	Remodel 300 Wing	Jan-04	6,770	451	15	451		869	66	
67	Parking Lot Repaving	Jul-05	57,667	1,922	15	1,927	5	1,927	67	
68	Phase III Remodel	Dec-05	35,254		15	64	64	64	68	
69	Fire Door	Aug-05	1,298	27	20	25	(2)	25	69	
70	TOTAL (lines 4 thru 69)		\$ 4,379,702	\$ 142,638		\$ 144,068	\$ 1,430	\$ 3,225,667	70	

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

Facility Name & ID Number McLean County Nursing Home

0018150

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Totals from Page 12A, Carried Forward		\$ 4,379,702	\$ 142,638		\$ 144,068	\$ 1,430	\$ 3,225,667	1
2	Air Conditioner Compressor	Nov-05	1,199	10	10	10		10	2
3	Two Security Doors	Oct-05	1,965	66	5	66		66	3
4	Door Alarm	Jun-05	1,000	50	10	50		50	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,383,866	\$ 142,764		\$ 144,194	\$ 1,430	\$ 3,225,793	34

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

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 751,851	\$ 36,624	\$ 36,624	\$	various	\$ 545,056	71
72	Current Year Purchases	10,776	501	501		various	501	72
73	Fully Depreciated Assets	192,013				various	192,013	73
74								74
75	TOTALS	\$ 954,640	\$ 37,125	\$ 37,125	\$		\$ 737,570	75

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	
76	Maintenance	Pick-up, '96 Dodge 4 x 4	Jan-96	\$ 19,549	\$ 226	\$	\$ (226)	7	\$ 19,549	76
77	Patient Transport	Bus, '81 Ford	Oct-82	26,620				9	26,620	77
78	Maintenance	Tractor, Sears	Sep-96	3,509				8	3,509	78
79										79
80	TOTALS			\$ 49,678	\$ 226	\$	\$ (226)		\$ 49,678	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)	\$ 5,403,184	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 180,115	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 181,319	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,204	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,013,041	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$	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.

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 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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2006 \$ _____

13. _____ /2007 \$ _____

14. _____ /2008 \$ _____

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 equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2005 Ending: 12/31/2005
 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? If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER CNA _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER CNA _____
---	--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	10a.3	hrs	\$	141	\$ 8,831					141	\$ 8,831	1	
2	Licensed Speech and Language Development Therapist	10a.3	hrs		104	2,838					104	2,838	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	10a.3	hrs		213	14,069					213	14,069	4	
5	Physician Care	39.3	visits										5	
6	Dental Care	39.3	visits										6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy	39.2	# of prescrpts						71,787			71,787	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Exceptional Care Program	39.2											12	
13	Other (specify): <u>Medical Supplies</u>	39.2							59,289			59,289	13	
14	TOTAL			\$	458	\$ 25,737			\$ 131,076		458	\$ 156,813	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.

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	\$ 2,627,757	\$	1
2	Cash-Patient Deposits	24,282		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	576,814		3
4	Supply Inventory (priced at FIFO)	43,168		4
5	Short-Term Investments	2,150,000		5
6	Prepaid Insurance	20,545		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Interest Receivable</u>	24,538		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,467,104	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	15,000		13
14	Buildings, at Historical Cost	4,315,252		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	825,494		16
17	Accumulated Depreciation (book methods)	(3,736,975)		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>Construction in Progress</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,418,771	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,885,875	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ (469,145)	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(21,094)		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Expenses</u>	(211,194)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (701,433)	\$	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)	\$ (701,433)	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (6,184,442)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (6,885,875)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,596,038	1
2	Restatements (describe):		2
3	Prior Period Adjustment	21,375	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,617,413	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	567,029	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)	\$ 567,029	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)	\$ 6,184,442	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	\$ 5,894,475	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,894,475	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	33,131	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	7,658	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 40,789	23
D. Non-Operating Revenue			
24	Contributions	488,485	24
25	Interest and Other Investment Income***	137,404	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 625,889	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Miscellaneous Income	16,624	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 16,624	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,577,777	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,489,320	31
32	Health Care	2,728,559	32
33	General Administration	1,399,553	33
B. Capital Expense			
34	Ownership	180,115	34
C. Ancillary Expense			
35	Special Cost Centers	131,076	35
36	Provider Participation Fee	82,125	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,010,748	40
41	Income before Income Taxes (line 30 minus line 40)**	567,029	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 567,029	43

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

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

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

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

Facility Name & ID Number McLean County Nursing Home

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	1,928	2,080	\$ 61,430	\$ 29.53	1
2	Assistant Director of Nursing	3,818	4,160	83,528	20.08	2
3	Registered Nurses	15,162	16,341	379,458	23.22	3
4	Licensed Practical Nurses	18,140	20,142	391,037	19.41	4
5	CNAs & Orderlies	117,107	127,322	1,364,845	10.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,851	2,080	30,417	14.62	9
10	Activity Assistants	5,904	6,289	58,729	9.34	10
11	Social Service Workers	6,517	7,303	92,348	12.65	11
12	Dietician					12
13	Food Service Supervisor	1,881	2,080	37,755	18.15	13
14	Head Cook	1,864	2,080	27,873	13.40	14
15	Cook Helpers/Assistants	30,182	32,191	265,628	8.25	15
16	Dishwashers					16
17	Maintenance Workers	6,584	7,112	112,211	15.78	17
18	Housekeepers	15,845	16,975	165,948	9.78	18
19	Laundry	11,507	13,058	129,547	9.92	19
20	Administrator	1,952	2,080	96,738	46.51	20
21	Assistant Administrator	1,819	2,080	34,216	16.45	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,623	6,240	94,831	15.20	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) <u>Ward Clerk</u>	3,844	4,232	47,049	11.12	33
34	TOTAL (lines 1 - 33)	251,528	273,845	\$ 3,473,588 *	\$ 12.68	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	284	\$ 10,355	1.3	35
36	Medical Director		600	9.3	36
37	Medical Records Consultant	20	1,300	10.3	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	28	1,513	11.3	44
45	Social Service Consultant	28	1,513	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	359	\$ 15,280		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	4,007	97,169	10.3	52
53	TOTAL (lines 50 - 52)	4,007	\$ 97,169		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Donald Lee	Administrator	-0-	\$ 96,738	Workers' Compensation Insurance	\$ 33,591	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	8,331	
				FICA Taxes	265,730	Health Care Worker Background Check		
				Employee Health Insurance	365,085	(Indicate # of checks performed <u>84</u>)		
				Employee Meals		Life Services Network of Illinois	6,593	
				Illinois Municipal Retirement Fund (IMRF)*	225,783	Nursing Books & Subscriptions	108	
						Other Dues	847	
						County Nursing Home Association	1,415	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 96,738	Employee Physicals	2,385			
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount			Non-allowable advertising	()	
			\$			Yellow page advertising	()	
County Administration Fee			64,172					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 64,172	TOTAL (agree to Schedule V, line 22, col.8)	\$ 892,574	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 17,294	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
Robert Rein, CPA	Consulting		7,453				In-State Travel	981
							Seminar Expense	1,954
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 7,453	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 2,935

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number McLean County Nursing Home

0018150

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network of Illinois 6,593
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 13.71
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,666 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) 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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 82,125
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
Lndry & Hskpg split on time spent.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? 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.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 623
- (16) 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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100% of Progr.
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? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: County Auditor The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not available at this time.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.