

		FOR BHF 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>0038570</u></p> <p>Facility Name: <u>Shelbyville Manor</u></p> <p>Address: <u>Route 128 North, P O Box 49</u> <u>Shelbyville</u> <u>62565</u> <small>Number City Zip Code</small></p> <p>County: <u>Shelby</u></p> <p>Telephone Number: <u>(217) 774-2111</u> Fax # <u>(217) 774-2209</u></p> <p>HFS ID Number: <u>37-12237450006</u></p> <p>Date of Initial License for Current Owners: <u>09/01/80</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 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 checked="" 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>Ron Wilson</u> Telephone Number: <u>(309) 344-1550</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 type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" 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>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 style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) <u>Ron Wilson</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Title) <u>Chief Financial Officer</u></td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) <u>See attached Independent Accountant's Report</u></td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Print Name and Title) <u>McGladrey & Pullen, LLP</u> <u>117 East Main Street, Suite 210</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Firm Name & Address) <u>P.O. Box 1070</u> <u>Galesburg, IL 61401</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Telephone) <u>(309)342-1175</u></td> <td style="border: none;">Fax # <u>(309)342-7816</u></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>Ron Wilson</u>			(Title) <u>Chief Financial Officer</u>		Paid Preparer	(Signed) <u>See attached Independent Accountant's Report</u>	(Date) _____		(Print Name and Title) <u>McGladrey & Pullen, LLP</u> <u>117 East Main Street, Suite 210</u>			(Firm Name & Address) <u>P.O. Box 1070</u> <u>Galesburg, IL 61401</u>			(Telephone) <u>(309)342-1175</u>	Fax # <u>(309)342-7816</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																												
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Facility Name & ID Number Shelbyville Manor

0038570 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 N/A

	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	115	Skilled (SNF)	115	41,975	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	24	Sheltered Care (SC)	24	8,760	5
6		ICF/DD 16 or Less			6
7	139	TOTALS	139	50,735	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	5,588	11,308	3,302	20,198	8
9	SNF/PED					9
10	ICF	11,175	0		11,175	10
11	ICF/DD					11
12	SC			7,997	7,997	12
13	DD 16 OR LESS					13
14	TOTALS	16,763	11,308	11,299	39,370	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.60%

D. How many bed-hold days during this year were paid by the Department? 0 (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)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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 12/01/92

J. Was the facility purchased or leased after January 1, 1978?
YES Date 08/25/92 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 115 and days of care provided 3,302

Medicare Intermediary Administar Federal Inc.

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/05 Fiscal Year: 12/31/05

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

Facility Name & ID Number Shelbyville Manor # 0038570 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	168,569	20,062	7,200	195,831		195,831		195,831		1
2	Food Purchase		205,477		205,477		205,477	(1,403)	204,074		2
3	Housekeeping	88,540	29,093	260	117,893		117,893		117,893		3
4	Laundry	31,859	11,641		43,500		43,500		43,500		4
5	Heat and Other Utilities			138,929	138,929		138,929	300	139,229		5
6	Maintenance	32,420	20,655	16,334	69,409		69,409	555	69,964		6
7	Other (specify):*										7
8	TOTAL General Services	321,388	286,928	162,723	771,039		771,039	(548)	770,491		8
	B. Health Care and Programs										
9	Medical Director			14,400	14,400		14,400		14,400		9
10	Nursing and Medical Records	1,299,368	150,093	4,111	1,453,572		1,453,572		1,453,572		10
10a	Therapy	149,975			149,975		149,975		149,975		10a
11	Activities	67,567	2,289	40	69,896		69,896	(243)	69,653		11
12	Social Services	24,411			24,411		24,411		24,411		12
13	CNA Training										13
14	Program Transportation			1,344	1,344	4,684	6,028		6,028		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,541,321	152,382	19,895	1,713,598	4,684	1,718,282	(243)	1,718,039		16
	C. General Administration										
17	Administrative	72,244			72,244		72,244	75,652	147,896		17
18	Directors Fees										18
19	Professional Services			179,769	179,769		179,769	(150,665)	29,104		19
20	Dues, Fees, Subscriptions & Promotions			45,513	45,513		45,513	(31,584)	13,929		20
21	Clerical & General Office Expenses	30,781	21,228	44,527	96,536		96,536	8,885	105,421		21
22	Employee Benefits & Payroll Taxes			389,206	389,206		389,206	16,376	405,582		22
23	Inservice Training & Education			1,614	1,614		1,614		1,614		23
24	Travel and Seminar			2,071	2,071		2,071	9,879	11,950		24
25	Other Admin. Staff Transportation			9,367	9,367	(4,684)	4,683		4,683		25
26	Insurance-Prop.Liab.Malpractice			74,649	74,649		74,649	29	74,678		26
27	Other (specify):* <u>See Att Sch VI</u>			10,317	10,317		10,317	(10,317)			27
28	TOTAL General Administration	103,025	21,228	757,033	881,286	(4,684)	876,602	(81,745)	794,857		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,965,734	460,538	939,651	3,365,923		3,365,923	(82,536)	3,283,387		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 Shelbyville Manor #0038570 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			35,325	35,325	35,325	142,608	177,933				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						95,781	95,781				32
33	Real Estate Taxes			96,918	96,918	96,918	264	97,182				33
34	Rent-Facility & Grounds			494,133	494,133	494,133	(490,849)	3,284				34
35	Rent-Equipment & Vehicles						410	410				35
36	Other (specify):*											36
37	TOTAL Ownership			626,376	626,376	626,376	(251,786)	374,590				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			22,073	22,073	22,073		22,073				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,757	63,757	63,757		63,757				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			85,830	85,830	85,830		85,830				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,965,734	460,538	1,651,857	4,078,129	4,078,129	(334,322)	3,743,807				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 Shelbyville Manor

0038570

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	(320)	V-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	(10,974)	V-30		9
10	Interest and Other Investment Income	(285)	V-32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,083)	V-2		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	(7,672)	V-27		24
25	Fund Raising, Advertising and Promotional	(31,149)	V-20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(440)	V-20		28
29	Other-Attach Schedule See Att Sch VII	(3,450)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (55,373)		\$	30

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)	(283,464)		34
35	Other- Attach Schedule See Att Sch IIIB	4,515		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (278,949)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (334,322)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

OHF USE ONLY					
48		49		50	
				51	
					52

Shelbyville Manor

ID# 0038570

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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			13
14			14
15			15
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35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Shelbyville Manor

0038570

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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

	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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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	CNA 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 Programs	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	0	(37,838)	0	0	0	0	0	0	0	0	0	(37,838)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	0	(37,838)	0	0	0	0	0	0	0	0	0	(37,838)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	(37,838)	0	0	0	0	0	0	0	0	0	(37,838)	29

STATE OF ILLINOIS

Facility Name & ID Number Shelbyville Manor

0038570

Report Period Beginning:

01/01/2005 Ending:

Summary B

12/31/2005

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(245,626)	0	0	0	0	0	0	0	0	0	(245,626)	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	0	(245,626)	0	0	0	0	0	0	0	0	0	(245,626)	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 Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	0	(283,464)	0	0	0	0	0	0	0	0	0	(283,464)	45

Facility Name & ID Number Shelbyville Manor

0038570

Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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
<u>Illini Manors, Inc.</u> <u>(100% owned by Don Fike)</u>	<u>100</u>	<u>See Attached Schedule I</u>		<u>RFMS, Inc.</u>	<u>Galesburg</u>	<u>Admin Services</u>
				<u>L B Properties, Inc.</u>	<u>Galesburg</u>	<u>Lessor</u>
				<u>Midwest Healthcare, Inc</u>		
					<u>Abingdon</u>	<u>Nursing Homoe</u>

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
<u>1</u>	<u>V</u>		\$			\$	\$	<u>1</u>
<u>2</u>	<u>V</u>	<u>34 Facility Rent</u>	<u>494,133</u>	<u>L B Properties, Inc.</u> <u>(78.2% Don Fike Owned)</u>	<u>None</u>	<u>248,507</u>	<u>(245,626)</u>	<u>2</u>
<u>3</u>	<u>V</u>							<u>3</u>
<u>4</u>	<u>V</u>							<u>4</u>
<u>5</u>	<u>V</u>	<u>19 Administrative Services</u>	<u>156,000</u>	<u>RFMS, Inc.</u> <u>(100% Don Fike Owned)</u>	<u>None</u>	<u>118,162</u>	<u>(37,838)</u>	<u>5</u>
<u>6</u>	<u>V</u>							<u>6</u>
<u>7</u>	<u>V</u>							<u>7</u>
<u>8</u>	<u>V</u>			<u>See Attached Schedules III and IV</u>				<u>8</u>
<u>9</u>	<u>V</u>							<u>9</u>
<u>10</u>	<u>V</u>							<u>10</u>
<u>11</u>	<u>V</u>							<u>11</u>
<u>12</u>	<u>V</u>							<u>12</u>
<u>13</u>	<u>V</u>							<u>13</u>
<u>14</u>	Total		\$ 650,133			\$ 366,669	\$ * (283,464)	14

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

Facility Name & ID Number Shelbyville Manor # 0038570 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	Don Fike	President	Management	100.00	See Att Sch III	>40	100.00	Salary	\$ 13,055	17-7	1
2								Benefits	686	22-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 13,741		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 Shelbyville Manor

0038570 Report Period Beginning: 01/01/2005

Ending: 2/31/2005

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 Illini Manors, Inc.
 Street Address 115 E South St
 City / State / Zip Code Galesburg, IL 61401
 Phone Number (309)343-1550
 Fax Number (309)343-2857

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1					\$	\$		\$	1	
2	See Attached Schedule III and IIIB							4,515	2	
3									3	
4									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	TOTALS				\$	\$		\$	4,515	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										1										
2	Bank One Springfield		X	Refinanced Bldg Mortgage	Varies pd Qtr	05/09/96	\$ 2,624,827	\$ 1,316,791	04/01/11	6.6600	\$ 96,065	2								
3												3								
4	Interest Income Adjustment			From page 5, line 10							(285)	4								
5												5								
Working Capital																				
6												6								
7												7								
8	Home Office allocation Adj			See Att Schedule III							1	8								
9	TOTAL Facility Related						\$ 2,624,827	\$ 1,316,791			\$ 95,781	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 2,624,827	\$ 1,316,791			\$ 95,781	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2004 report.		\$ 93,300	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.)		\$ 93,158	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (142)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 97,060	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.		\$ 96,918	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2000	112,013	8
	2001	71,913	9
	2002	72,058	10
	2003	88,863	11
	2004	93,158	12
Real estate tax accrual is based on estimated tax expense. The lessee, by terms of the lease agreement, is required to pay the applicable real estate taxes.			

	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Shelbyville Manor COUNTY Shelby

FACILITY IDPH LICENSE NUMBER 0038570

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

TELEPHONE (309) 343-1550 FAX #: (309) 343-2857

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>2013-06-17-305-001</u>	<u>LB Properties, Inc.</u>	\$ <u>93,158.00</u>	\$ <u>93,158.00</u>
2. _____	<u>S6 T11N R4E SW COR SW</u>	\$ _____	\$ _____
3. _____	<u>SW BOYS ACRES ADDN</u>	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>93,158.00</u>	\$ <u>93,158.00</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Shelbyville Manor

0038570 Report Period Beginning:

01/01/2005 Ending:

12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,041 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

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

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

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

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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	<u>Facility</u>	<u>6.87 acres</u>	<u>1991</u>	<u>\$ 20,000</u>	1
2					2
3	TOTALS	#VALUE!		\$ 20,000	3

Facility Name & ID Number Shelbyville Manor

0038570

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 Beds*	FOR BHF 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	90			1991	\$ 991,000	\$ 31,460	31	\$ 31,460		\$ 408,980	4
5	41			1992	1,138,566	36,145	31	36,145		469,885	5
6	24			2002	927,919	29,458	31	29,458		95,738	6
7											7
8											8
Improvement Type**											
9	Total improvements by year constructed:										9
10	1991			1991	45,000	3,000	15	3,000		39,000	10
11	1992			1992	2,736	1,916	15	1,916		24,908	11
12	1993			1993	2,417		10			2,417	12
13	1994			1994	47,793	1,847	7 to 40	781	(1,066)	25,603	13
14	1995			1995	2,769		7			2,769	14
15	1997			1997	10,601	626	15	707	81	5,714	15
16	1998			1998	4,912	151	5 to 7	81	(70)	4,912	16
17	1999			1999	17,500	855	40	438	(417)	2,809	17
18											18
19	Detailed improvements for the years 2001 - 2005:										19
20	Garage			2001	12,648	876	15	843	(33)	3,864	20
21	Land improvements			2002	94,574	6,305	15	6,305		20,491	21
22	Vinyl flooring			2002	10,113	259	10	1,011	752	3,454	22
23	Commercial doors			2002	2,501	288	20	125	(163)	417	23
24	Exhaust			2004	5,000	925	15	333	(592)	500	24
25	Lightning/surge protection			2004	38,372	4,775	15	2,558	(2,217)	4,050	25
26	Illuminated sign			2005	2,654	265	10	265		265	26
27	Asphalt drive			2005	1,600	229	8	117	(112)	117	27
28	Sidewalks			2005	2,600	173	15	72	(101)	72	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Shelbyville Manor

0038570

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	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 3,361,275	\$ 119,553		\$ 115,615	\$ (3,938)	\$ 1,115,965	70

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

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	\$ 1,175,981	\$ 62,815	\$ 59,460	\$ (3,355)	5 to 20	\$ 926,564	71
72	Current Year Purchases	10,079	2,613	1,718	(895)	3 to 10	1,718	72
73	Fully Depreciated Assets							73
74	Indirect Costs Allocated (See Attached Schedule III)		1,140	1,140				74
75	TOTALS	\$ 1,186,060	\$ 66,568	\$ 62,318	\$ (4,250)		\$ 928,282	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	Patient Care	Ford Enc. Bus	1995	\$ 42,500	\$	\$	\$	7	\$ 42,500	76
77	Patient Care	2000 Ford Bus	2000	48,365	2,786		(2,786)	4	48,365	77
78										78
79										79
80	TOTALS			\$ 90,865	\$ 2,786	\$	\$ (2,786)		\$ 90,865	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)	\$ 4,658,200	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 188,907	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 177,933	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (10,974)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,135,112	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		\$	92
93			93
94			94
95		\$	95

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

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

Facility Name & ID Number Shelbyville Manor

0038570

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: L B Properties, Inc.

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:				\$ <u>See Attached</u>			3
4	Additions				<u>Schedule IV-</u>			4
5					<u>Related Party</u>			5
6					<u>Lease</u>			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.

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.)

<p>1. HAVE YOU TRAINED CNAs 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 CNA _____</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 CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		3 Outside Practitioner (other than consultant)		4 Supplies (Actual or Allocated)	5 Total Units (Column 2 + 4)	6 Total Cost (Col. 3 + 5 + 6)	7 8
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$			1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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.

Facility Name & ID Number Shelbyville Manor# 0038570Report Period Beginning: 01/01/2005

Ending:

12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005

(last day of reporting year)

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	\$ 16,846	\$ 910,041	1
2	Cash-Patient Deposits	3,450	3,450	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>14,700</u>)	491,286	1,179,806	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	52,408	54,390	6
7	Other Prepaid Expenses		89,224	7
8	Accounts Receivable (owners or related parties)		1,955,505	8
9	Other(specify): <u>See Att Sch VIII</u>	2,702,108	2,710,154	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,266,098	\$ 6,902,570	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		20,000	13
14	Buildings, at Historical Cost		3,057,485	14
15	Leasehold Improvements, at Historical Cost	161,480	492,097	15
16	Equipment, at Historical Cost	392,038	1,652,426	16
17	Accumulated Depreciation (book methods)	(403,551)	(2,585,107)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 149,967	\$ 2,636,901	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,416,065	\$ 9,539,471	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 84,475	\$ 118,484	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,450	3,450	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	56,892	184,670	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,970	3,347	31
32	Accrued Real Estate Taxes(Sch.IX-B)	97,060	104,740	32
33	Accrued Interest Payable		22,046	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Interdivisional payable</u>			36
37	<u>Other current liability</u>			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 244,847	\$ 436,737	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,316,791	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Security deposits</u>	40,500	40,500	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 40,500	\$ 1,357,291	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 285,347	\$ 1,794,028	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,130,718	\$ 7,745,443	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,416,065	\$ 9,539,471	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,796,544	1
2	Restatements (describe):		2
3	<u>Year end adjustments made subsequent to the filing of</u>		3
4	<u>the prior year's Medicaid cost report (See Att Sch IX)</u>	(33,434)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,763,110	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	367,608	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)	\$ 367,608	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,130,718	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Shelbyville Manor# 0038570Report Period Beginning: 01/01/2005Ending: 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	\$ 4,373,512	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,373,512	3
B. Ancillary Revenue			
4	Day Care	400	4
5	Other Care for Outpatients		5
6	Therapy	61,362	6
7	Oxygen	4,166	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 65,928	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	3,141	13
14	Non-Patient Meals	320	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,461	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	285	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 285	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund Income	243	28
28a	See Attached Schedule X	2,308	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,551	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,445,737	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	771,039	31
32	Health Care	1,713,598	32
33	General Administration	881,286	33
B. Capital Expense			
34	Ownership	626,376	34
C. Ancillary Expense			
35	Special Cost Centers	22,073	35
36	Provider Participation Fee	63,757	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,078,129	40
41	Income before Income Taxes (line 30 minus line 40)**	367,608	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 367,608	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No 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 Shelbyville Manor

0038570

Report Period Beginning: 01/01/2005

Ending:

12/31/2005

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	1,770	1,883	\$ 49,791	\$ 26.44	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	3,624	3,855	77,108	20.00	3
4	Licensed Practical Nurses	19,944	21,217	326,313	15.38	4
5	CNAs & Orderlies	84,612	90,013	749,810	8.33	5
6	CNA Trainees					6
7	Licensed Therapist	1,524	1,604	72,190	45.01	7
8	Rehab/Therapy Aides	3,324	3,536	77,785	22.00	8
9	Activity Director	3,737	3,976	40,753	10.25	9
10	Activity Assistants	3,055	3,250	26,814	8.25	10
11	Social Service Workers	1,687	1,795	24,411	13.60	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,713	22,035	168,569	7.65	15
16	Dishwashers					16
17	Maintenance Workers	1,966	2,092	32,420	15.50	17
18	Housekeepers	11,232	11,949	88,540	7.41	18
19	Laundry	4,483	4,769	31,859	6.68	19
20	Administrator	1,955	2,080	60,606	29.14	20
21	Assistant Administrator	761	802	11,638	14.51	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,982	2,108	30,781	14.60	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,254	1,334	18,670	14.00	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	996	1,059	14,830	14.00	31
32	Other Health Care(specify)	3,580	3,809	62,846	16.50	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	172,199	183,166	\$ 1,965,734 *	\$ 10.73	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	***	\$ 7,200	1-3	35
36	Medical Director	***	14,400	9-3	36
37	Medical Records Consultant	***	1,500	10-3	37
38	Nurse Consultant	***	0	10-3	38
39	Pharmacist Consultant	***	2,611	10-3	39
40	Physical Therapy Consultant	***	0	10a-3	40
41	Occupational Therapy Consultant	***	0	10a-3	41
42	Respiratory Therapy Consultant	***	0	10a-3	42
43	Speech Therapy Consultant	***	0	10a-3	43
44	Activity Consultant	***	0	11-3	44
45	Social Service Consultant	***	0	12-3	45
46	Other(specify)	***	0	10-3	46
47					47
48	*** Monthly fee				48
49	TOTAL (lines 35 - 48)		\$ 25,711		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				52
53	TOTAL (lines 50 - 52)		\$		53

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. See Page 21, Section F
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes-IHCA Dues If YES, have these costs been properly adjusted out of the cost report? Yes
- (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? N/A
- (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? 6 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,889 Line 10
- (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. N/A
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 63,757
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? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? 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? Yes-Schedule XI 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. \$ Yes Has any meal income been offset against related costs? Yes Indicate the amount. \$ 320
- (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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: McGladrey & Pullen, LLP 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. Audit not yet completed
- (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.