

		FOR BHF USE				

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0033373

Facility Name: Bryan Manor

Address: PO Box 1205, 300 Schoonover Dr Salem 62881
 Number City Zip Code

County: Marion

Telephone Number: 618-548-4561 **Fax #** 618-548-3765

HFS ID Number: 371224606002

Date of Initial License for Current Owners: 2/12/88

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" 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 <u>501c(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other	

In the event there are further questions about this report, please contact:
Name: Stephanie Hamilton **Telephone Number:** 618-533-9633 ext 3

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/05 to 06/30/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date) _____

(Type or Print Name) Georgia Miller

(Title) Administrator

Paid Preparer

(Signed) _____ (Date) _____

(Print Name and Title) Stephanie Hamilton

(Firm Name & Address) CSI- P.O. BOX 1946, Centralia, IL 62801

(Telephone) 618-533-9633 ext 3 Fax # 618-533-6345

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

Facility Name & ID Number Bryan Manor

0033373 Report Period Beginning: 7/1/05 Ending: 06/30/06

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>93</u>	Intermediate (ICF)	<u>93</u>	<u>33,945</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>93</u>	TOTALS	<u>93</u>	<u>33,945</u>	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	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD	<u>33,384</u>			<u>33,384</u>
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>33,384</u>			<u>33,384</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.35%

D. How many bed-hold days during this year were paid by the Department?

514 (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? 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 02/12/88

J. Was the facility purchased or leased after January 1, 1978?

YES Date 02/12/88 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 07/01/05-06/30/06 Fiscal Year: 07/01/05-06/30/06

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

Facility Name & ID Number Bryan Manor # 0033373 Report Period Beginning: 7/1/05 Ending: 06/30/06

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	237,441	20,675	12,708	270,824		270,824		270,824			1
2	Food Purchase		195,508		195,508		195,508		195,508			2
3	Housekeeping	192,727	57,679		250,406		250,406		250,406			3
4	Laundry	236,852	34,007		270,859		270,859		270,859			4
5	Heat and Other Utilities			174,675	174,675		174,675		174,675			5
6	Maintenance	65,067	44,130	15,576	124,773		124,773		124,773			6
7	Other (specify):* WASTE REMOVAL											7
8	TOTAL General Services	732,087	351,999	202,959	1,287,045		1,287,045		1,287,045			8
	B. Health Care and Programs											
9	Medical Director			2,750	2,750		2,750		2,750			9
10	Nursing and Medical Records	2,806,771	320,228	52,735	3,179,734		3,179,734		3,179,734			10
10a	Therapy			48,086	48,086		48,086		48,086			10a
11	Activities	120,254	6,131		126,385		126,385		126,385			11
12	Social Services	17,997			17,997		17,997		17,997			12
13	CNA Training	258,162			258,162		258,162		258,162			13
14	Program Transportation		4,935		4,935		4,935		4,935			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,203,184	331,294	103,571	3,638,049		3,638,049		3,638,049			16
	C. General Administration											
17	Administrative	103,750			103,750	46,398	150,148		150,148			17
18	Directors Fees											18
19	Professional Services			208,459	208,459	(46,398)	162,061		162,061			19
20	Dues, Fees, Subscriptions & Promotions			56,097	56,097		56,097		56,097			20
21	Clerical & General Office Expenses	93,965	22,965	5,585	122,515		122,515		122,515			21
22	Employee Benefits & Payroll Taxes			793,633	793,633		793,633		793,633			22
23	Inservice Training & Education			3,598	3,598		3,598		3,598			23
24	Travel and Seminar			692	692		692		692			24
25	Other Admin. Staff Transportation		4,935		4,935		4,935		4,935			25
26	Insurance-Prop.Liab.Malpractice			38,437	38,437		38,437		38,437			26
27	Other (specify):*											27
28	TOTAL General Administration	197,715	27,900	1,106,501	1,332,116		1,332,116		1,332,116			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,132,986	711,193	1,413,031	6,257,210		6,257,210		6,257,210			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 Bryan Manor #0033373 Report Period Beginning: 7/1/05 Ending: 06/30/06

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			158,818	158,818		158,818		158,818			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			146,877	146,877		146,877	(25,973)	120,904			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* bond fees & amorti			61,177	61,177		61,177		61,177			36
37	TOTAL Ownership			366,872	366,872		366,872	(25,973)	340,899			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			281,932	281,932		281,932		281,932			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			281,932	281,932		281,932		281,932			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,132,986	711,193	2,061,835	6,906,014		6,906,014	(25,973)	6,880,041			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 Bryan Manor

0033373

Report Period Beginning: 7/1/05

Ending: 06/30/06

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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	25,973	32-3		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
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 25,973		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 25,973		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

BHF USE ONLY					
48		49		50	
				51	
					52

Bryan Manor

ID# 0033373
Report Period Beginning: 7/1/05
Ending: 06/30/06

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
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			34
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

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number

Bryan Manor

#

0033373

Report Period Beginning:

7/1/05

Ending:

06/30/06

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 Bryan Manor

0033373

Report Period Beginning:

7/1/05

Ending: 06/30/06

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
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
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	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	Peoples National Bank		x	Mortgage	\$17,600.00	6/24/05	\$ 1,649,834	\$ 1,520,089	06/24/2014	5.0000	\$ 146,877	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$17,600.00		\$ 1,649,834	\$ 1,520,089			\$ 146,877	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 1,649,834	\$ 1,520,089			\$ 146,877	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bryan Manor COUNTY Marion

FACILITY IDPH LICENSE NUMBER 0033373

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

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 _____ 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number Bryan Manor

0033373 Report Period Beginning:

7/1/05 Ending:

06/30/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,341 B. General Construction Type: Exterior BRICK/BLOCK Frame WOOD/BLOCK 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: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1		<u>304,920</u>		\$ <u>63,244</u>	1
2					2
3	TOTALS	<u>304,920</u>		\$ <u>63,244</u>	3

Facility Name & ID Number Bryan Manor

0033373

Report Period Beginning:

7/1/05

Ending:

06/30/06

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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	93		1988		\$ 990,822	\$ 38,668	27	\$ 38,668	\$	\$ 679,521	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BOILER		1989		2,188	81	27	81		1,384	9
10	GARAGE		1990		3,965		15			3,965	10
11	15965 SQ FT ADDITION		1993		1,588,478	58,832	27	58,832		755,020	11
12	RENOVATION OF APPROX 3000 SQ FT										12
13	ACTIVITY AREA INCLUDING DROP CEILING										13
14	INSULATION & SPRINKLERS										14
15	AND WALL CONSTRUCTION		1988		50,590	1,874	27	1,874		33,540	15
16	CENTRAL AIR RESIDENT BEDROOMS		1988		45,000	1,667	27	1,667		29,835	16
17	INSULATE RESIDENT WINGS		1989		6,967	258	27	258		4,471	17
18	FENCE		1989		572		7			572	18
19	RENOVATION OF BATHS IN RESIDENT WINGS		1989		5,856	217	27	217		3,759	19
20	SMALL BLDG ADD TO HOUSE WATER HEATERS		1989		9,900		15			9,900	20
21	SERVICE FLUSH SINK		1990		4,050	247	15	247		4,050	21
22	WATER HEATER		1991		2,290	153	15	153		2,241	22
23	UNDERGROUND WATER PIPING		1991		10,710	714	15	714		8,152	23
24	PARKING LOT		1995		5,225	292	15	292		5,225	24
25	REMODEL EAST WING		1991		36,800	2,453	15	2,453		23,714	25
26	BOILER IMPROVEMENTS		1996		3,495	233	15	233		2,155	26
27	INSTALL DRAINS AND GARBAGE DISPOSALS		1997		6,350	423	15	423		3,808	27
28	AIR CONDITIONERS		1997		1,682	112	15	112		952	28
29	PARKING LOT IMPROVEMENTS		1999		1,410	94	15	94		799	29
30	12 X 24 STORAGE SHED		1999		2,969	198	15	198		1,287	30
31	COURTYARD & SIDEWALKS		1999		13,060	871	15	871		5,661	31
32	HS29-60 A/C		2000		4,656	310	15	310		2,016	32
33	DOORS		1999		1,659	111	15	111		721	33
34	WINDOWS		2000		7,340	489	15	489		3,179	34
35	CABINETS		2000		4,196	280	15	280		1,819	35
36	BOILER & HEATING IMPROVEMENTS		1999		12,700	847	15	847		5,505	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 Bryan Manor

0033373

Report Period Beginning:

7/1/05

Ending:

06/30/06

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	AIR CONDITIONERS	2000	\$ 1,625	\$ 108	15	\$ 108	\$	\$ 594	37
38	WINDOWS	2001	4,451	297	15	297		1,633	38
39	GENERATOR	2002	45,960	3,064	15	3,064		13,788	39
40	FURNACE	2001	9,023	602	15	602		2,759	40
41	FIRE ALARM SYSTEM	2002	44,647	2,976	15	2,976		12,152	41
42	STANDBY POWER SYSTEM	2002	34,346	2,290	15	2,290		9,351	42
43	ROOF REPLACEMENT	2002	31,527	1,168	27	1,168		5,256	43
44	BASEMENT WATER SYSTEM	2002	3,000	200	15	200		700	44
45	COMPRESSOR FIRE ALARM SYSTEM	2002	3,925	262	15	262		982	45
46	ROOF REPLACEMENT	2004	7,300	487	15	487		1,015	46
47	FURNACES	2004	4,950	330	15	330		522	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)		\$ 3,013,684	\$ 121,208		\$ 121,208	\$	\$ 1,642,003	70

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

Facility Name & ID Number Bryan Manor # 0033373 Report Period Beginning: 7/1/05 Ending: 06/30/06

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	\$ 130,255	\$ 19,914	\$ 19,914	\$	avg 7	\$ 58,758	71
72	Current Year Purchases	10,052	875	875		10	875	72
73	Fully Depreciated Assets	441,200	2,896	2,896		avg 7	441,200	73
74								74
75	TOTALS	\$ 581,507	\$ 23,685	\$ 23,685	\$		\$ 500,833	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/ADMIN	95 GMC SIERRA PV 1500	1998	\$ 11,034	\$	\$	\$	5	\$ 11,034	76
77	PATIENT/ADMIN	96 DODGE VAN	2001	11,178	1,116	1,116		5	11,178	77
78	PATIENT/ADMIN	98 FORD E-150 VAN	2004	18,554	3,710	3,710		5	7,731	78
79	PATIENT/ADMIN	05 GMC SAVANA	2005	45,494	9,099	9,099		5	12,132	79
80	TOTALS			\$ 86,260	\$ 13,925	\$ 13,925	\$		\$ 42,075	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)		\$ 3,744,695	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 158,818	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 158,818	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 2,184,911	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 Bryan Manor

0033373

Report Period Beginning: 7/1/05

Ending: 06/30/06

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

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

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

* 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 checked="" type="checkbox"/> YES <input 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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>50</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></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)	13,650	68,250		81,900
4	Clinical Wages (b)	26,840	109,200		136,040
5	In-House Trainer Wages (c)	8,044	32,178		40,222
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 48,534	\$ 209,628	\$	\$ 258,162
10	SUM OF line 9, col. 1 and 2 (e)	\$ 258,162			

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	182
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	46
2. From other facilities (f)	
TOTAL TRAINED	228

- (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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	4					
					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 Bryan Manor# 0033373Report Period Beginning: 7/1/05

Ending:

06/30/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/06

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 754,472	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	828,293		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,993		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,595,758	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	10,000		13
14	Buildings, at Historical Cost	2,673,193		14
15	Leasehold Improvements, at Historical Cost	393,735		15
16	Equipment, at Historical Cost	667,769		16
17	Accumulated Depreciation (book methods)	(2,184,911)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	105,033		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,664,819	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,260,577	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 631,127	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	131,428		30
31	Accrued Taxes Payable (excluding real estate taxes)	71,207		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	UNCLAIMED FUNDS PAYABLE	3,055		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 836,817	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,520,089		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUE TO PN	105,033		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,625,122	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,461,939	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 798,638	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,260,577	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 679,053	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 679,053	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	119,585	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)	\$ 119,585	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)	\$ 798,638	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Bryan Manor# 0033373Report Period Beginning: 7/1/05Ending: 06/30/06**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	\$ 4,747,393	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,747,393	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	2,002,980	10
11	CNA Training Reimbursements	247,114	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,250,094	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	25,973	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 25,973	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Misc , Refunds, Etc.</u>	2,139	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,139	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,025,599	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,287,045	31
32	Health Care	3,638,049	32
33	General Administration	1,332,116	33
B. Capital Expense			
34	Ownership	366,872	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	281,932	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,906,014	40
41	Income before Income Taxes (line 30 minus line 40)**	119,585	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 119,585	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 Bryan Manor

0033373

Report Period Beginning: 7/1/05

Ending: 06/30/06

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	1,900	2,080	\$ 64,134	\$ 30.83	1
2	Assistant Director of Nursing	1,903	2,088	36,818	17.63	2
3	Registered Nurses	15,138	16,104	287,746	17.87	3
4	Licensed Practical Nurses	26,749	28,157	444,105	15.77	4
5	CNAs & Orderlies					5
6	CNA Trainees	29,059	29,059	217,940	7.50	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director		2,347	21,919	9.34	9
10	Activity Assistants	11,117	11,702	98,335	8.40	10
11	Social Service Workers	1,475	1,579	17,997	11.40	11
12	Dietician					12
13	Food Service Supervisor	2,117	2,301	32,123	13.96	13
14	Head Cook	6,744	7,099	68,286	9.62	14
15	Cook Helpers/Assistants	16,891	17,779	130,775	7.36	15
16	Dishwashers	864	879	6,257	7.12	16
17	Maintenance Workers	5,909	6,220	65,067	10.46	17
18	Housekeepers	22,454	23,390	192,727	8.24	18
19	Laundry	28,464	29,650	236,852	7.99	19
20	Administrator			12,500		20
21	Assistant Administrator					21
22	Other Administrative	3,806	4,160	91,250	21.94	22
23	Office Manager					23
24	Clerical	6,147	6,472	71,130	10.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)		5,538	77,892	14.07	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	234,461	246,801	1,936,298	7.85	30
31	Medical Records	1,935	2,140	22,835	10.67	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	417,133	445,545	\$ 4,132,986 *	\$ 9.28	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	254	\$ 12,708	1-3	35
36	Medical Director	28	2,750	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	21	2,100	10-3	39
40	Physical Therapy Consultant	50	5,337	10A-3	40
41	Occupational Therapy Consultant	735	36,753	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	94	4,709	10A-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	DENTIST/VISION/PODIATRIST	52	3,658	10-3	47
48	PSYCHOLOGIST	18	1,286	10A-3	48
49	TOTAL (lines 35 - 48)	1,252	\$ 69,301		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,096	\$ 46,073	10-3	50
51	Licensed Practical Nurses	25	904	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,121	\$ 46,977		53

Facility Name & ID Number Bryan Manor

0033373

Report Period Beginning: 7/1/05

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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		
C. HIESTAND	SERVICES COORD.	0	\$ 51,303	Workers' Compensation Insurance	\$ 149,746	IDPH License Fee	\$ 6,081		
S. HOTZ	HR COORD	0	39,947	Unemployment Compensation Insurance	11,563	Advertising: Employee Recruitment	5,184		
G. Miller	Admin	0	12,500	FICA Taxes	312,934	Health Care Worker Background Check	(Indicate # of checks performed <u>324</u>)		
				Employee Health Insurance	234,361	Patient Background Checks	<u>94</u> 1,504		
				Employee Meals		Dues	20,639		
				Illinois Municipal Retirement Fund (IMRF)*		License & Fees	177,962		
				Physicals, Retirement, Flowers		Subscriptions	4,927		
				Vaccines, Parties, Etc	85,029				
TOTAL (agree to Schedule V, line 17, col. 1)						Less: Public Relations Expense	()		
(List each licensed administrator separately.)			\$ 103,750			Non-allowable advertising	()		
						Yellow page advertising	()		
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			\$ 793,633		
Description			Amount	TOTAL (agree to Sch. V, line 20, col. 8)					
Penta Nascent (G Miller)			\$ 46,398	\$ 216,297					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 46,398						
(Attach a copy of any management service agreement)									
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	
CRAIN, MILLER & WERNSMAN	LEGAL		\$ 1,393				Out-of-State Travel	\$	
ACHS	LEGAL		9,532						
GLASS & SHUFFET	AUDITING		6,350				In-State Travel		
CATCHALL SERVICES INC	MGMT		131,911						
S.MILNER	CLERICAL		300				Seminar Expense	692	
S HAMILTON	ACCTG		575						
CREATIVE SYSTEMS	COMPUTERS		12,000				Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	TOTAL	\$ 692
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 162,061						

* Attach copy of IMRF notifications

**See instructions.

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. IARF-20639
- (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? 5 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 45,615 Line 10-F
- (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? _____
If YES, give effective date of lease. NO
- (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. \$ 281,932
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? 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. \$ N/A Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (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? 50
- 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? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
- 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: GLASS & SHUFFET, LTD The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. _____
- (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.

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Reclassification

\$46398 paid to Penta Nascent for administrative salaries & fringes