



Facility Name & ID Number Manorcare at Decatur

# 0027458 Report Period Beginning: 06/01/2005 Ending: 05/31/2006

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	<u>112</u>	Skilled (SNF)	<u>112</u>	<u>40,880</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>112</u>	TOTALS	<u>112</u>	<u>40,880</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	Total	
8	SNF	<u>365</u>	<u>19,017</u>	<u>12,832</u>	<u>32,214</u>	8
9	SNF/PED					9
10	ICF	<u>7,049</u>			<u>7,049</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,414</u>	<u>19,017</u>	<u>12,832</u>	<u>39,263</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.04%

D. How many bed-hold days during this year were paid by the Department? 53 (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)

Day Care

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 11/01/81

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

YES  Date 11/01/81 NO

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

YES  NO  If YES, enter number of beds certified 112 and days of care provided 12,087

Medicare Intermediary Highmark Medicare Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/06 Fiscal Year: 05/31/06

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

Facility Name & ID Number      Manorcare at Decatur      #      0027458      Report Period Beginning:      06/01/2005      Ending:      05/31/2006

**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	
	<b>A. General Services</b>											
1	Dietary	195,802	17,453	15,078	228,333	2,440	230,773		230,773			1
2	Food Purchase		196,775		196,775		196,775	(2,531)	194,244			2
3	Housekeeping	108,380	20,203	606	129,189		129,189		129,189			3
4	Laundry	47,267	9,684		56,951		56,951		56,951			4
5	Heat and Other Utilities			138,371	138,371	4,937	143,308	(2,125)	141,183			5
6	Maintenance	61,399	12,541	56,131	130,071		130,071		130,071			6
7	Other (specify):* <b>Medical Waste</b>			1,245	1,245		1,245		1,245			7
8	<b>TOTAL General Services</b>	<b>412,848</b>	<b>256,656</b>	<b>211,431</b>	<b>880,935</b>	<b>7,377</b>	<b>888,312</b>	<b>(4,656)</b>	<b>883,656</b>			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			33,860	33,860		33,860		33,860			9
10	Nursing and Medical Records	1,950,774	141,036	29,485	2,121,295	8,856	2,130,151	(2,656)	2,127,495			10
10a	Therapy		10,246	642,680	652,926		652,926		652,926			10a
11	Activities	74,732	3,655	4,698	83,085		83,085	(10,375)	72,710			11
12	Social Services	91,112		1,888	93,000		93,000		93,000			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	<b>2,116,618</b>	<b>154,937</b>	<b>712,611</b>	<b>2,984,166</b>	<b>8,856</b>	<b>2,993,022</b>	<b>(13,031)</b>	<b>2,979,991</b>			16
	<b>C. General Administration</b>											
17	Administrative	73,756		352,367	426,123	(122,279)	303,844		303,844			17
18	Directors Fees											18
19	Professional Services			65	65	(50)	15	(15)				19
20	Dues, Fees, Subscriptions & Promotions			55,910	55,910		55,910	(26,180)	29,730			20
21	Clerical & General Office Expenses	151,231	54,640	104,082	309,953	50	310,003	(74,655)	235,348			21
22	Employee Benefits & Payroll Taxes			571,804	571,804	36,794	608,598		608,598			22
23	Inservice Training & Education			1,192	1,192		1,192		1,192			23
24	Travel and Seminar			6,646	6,646		6,646		6,646			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			110,100	110,100		110,100		110,100			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	<b>224,987</b>	<b>54,640</b>	<b>1,202,166</b>	<b>1,481,793</b>	<b>(85,485)</b>	<b>1,396,308</b>	<b>(100,850)</b>	<b>1,295,458</b>			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,754,453</b>	<b>466,233</b>	<b>2,126,208</b>	<b>5,346,894</b>	<b>(69,252)</b>	<b>5,277,642</b>	<b>(118,537)</b>	<b>5,159,105</b>			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 Manorcare at Decatur #0027458 Report Period Beginning: 06/01/2005 Ending: 05/31/2006

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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	
	<b>D. Ownership</b>											
30	Depreciation			482,376	482,376	13,933	496,309		496,309			30
31	Amortization of Pre-Op. & Org.											31
32	Interest					55,319	55,319	(129)	55,190			32
33	Real Estate Taxes			53,949	53,949		53,949	(1,670)	52,279			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			29,955	29,955		29,955		29,955			35
36	Other (specify):*			513	513		513	(513)				36
37	<b>TOTAL Ownership</b>			566,793	566,793	69,252	636,045	(2,312)	633,733			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		300,824	20,518	321,342		321,342		321,342			39
40	Barber and Beauty Shops			23,592	23,592		23,592		23,592			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			62,460	62,460		62,460		62,460			42
43	Other (specify):* <b>IV Therapy Drugs</b>		17,618		17,618		17,618		17,618			43
44	<b>TOTAL Special Cost Centers</b>		318,442	106,570	425,012		425,012		425,012			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,754,453	784,675	2,799,571	6,338,699		6,338,699	(120,849)	6,217,850			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 Manorcare at Decatur

# 0027458

Report Period Beginning:

06/01/2005

Ending:

05/31/2006

**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	\$ (10,375)	11	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,531)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,125)	5		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	(129)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	3,581	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,546)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(941)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(15)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(75,688)	21		24
25	Fund Raising, Advertising and Promotional	(26,180)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,670)	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,230)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (120,849)		\$	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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (120,849)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Manorcare at Decatur

ID# 0027458

Report Period Beginning: 06/01/2005

Ending: 05/31/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	G/L Assets	\$ (513)	36	1
2	Customer Reimbursement	(1,607)	21	2
3	Transportation Revenue	(110)	10	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	<b>Total</b>	(2,230)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Manorcare at Decatur

# 0027458

Report Period Beginning:

06/01/2005

Ending:

05/31/2006

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,531)	0	0	0	0	0	0	0	0	0	0	(2,531)	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	(2,125)	0	0	0	0	0	0	0	0	0	0	(2,125)	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	<b>TOTAL General Services</b>	<b>(4,656)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(4,656)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(2,656)	0	0	0	0	0	0	0	0	0	0	(2,656)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(10,375)	0	0	0	0	0	0	0	0	0	0	(10,375)	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	<b>TOTAL Health Care and Programs</b>	<b>(13,031)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(13,031)</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(15)	0	0	0	0	0	0	0	0	0	0	(15)	19
20	Fees, Subscriptions & Promotions	(26,180)	0	0	0	0	0	0	0	0	0	0	(26,180)	20
21	Clerical & General Office Expenses	(74,655)	0	0	0	0	0	0	0	0	0	0	(74,655)	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	<b>TOTAL General Administration</b>	<b>(100,850)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(100,850)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(118,537)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(118,537)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Decatur

# 0027458

Report Period Beginning:

06/01/2005 Ending:

Summary B

05/31/2006

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	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	(129)	0	0	0	0	0	0	0	0	0	0	(129)	32
33	Real Estate Taxes	(1,670)	0	0	0	0	0	0	0	0	0	0	(1,670)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(513)	0	0	0	0	0	0	0	0	0	0	(513)	36
37	<b>TOTAL Ownership</b>	<b>(2,312)</b>	<b>0</b>	<b>(2,312)</b>	<b>37</b>									
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(120,849)</b>	<b>0</b>	<b>(120,849)</b>	<b>45</b>									

Facility Name & ID Number Manorcare at Decatur

# 0027458

Report Period Beginning: 06/01/2005 Ending: 05/31/2006

**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
Manor Care, Inc	100	Health Care & Retirement Corporation of America (See H.O. Cost Report)	Toledo, OH			

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

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

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	See Home Office Allocation	\$ 352,367	HCR Manor Care, Inc	100.00%	\$ 352,367	\$	1
2	V	Page						2
3	V	8						3
4	V							4
5	V							5
6	V	10a Therapy Management	10,584	Heartland Management Services	100.00%	10,584		6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 362,951			\$ 362,951	\$ *	14

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

Facility Name &amp; ID Number

Manorcare at Decatur

#

0027458

Report Period Beginning:

06/01/2005

Ending:

05/31/2006

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

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing 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 Manorcare at Decatur

# 0027458

Report Period Beginning:

06/01/2005

Ending: 5/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization HCR Manor Care, Inc  
 Street Address 333 North Summit St  
 City / State / Zip Code Toledo, OH 43604  
 Phone Number (419) 252-5500  
 Fax Number (419) 254-5494

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	\$ 1,107,111	\$ 591,572	5,512,910	\$ 2,440	1
2	1	Dietary - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac			5,512,910	0	2
3	5	Utilities - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	267,575		5,512,910	590	3
4	5	Utilities - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	2,395,925		5,512,910	4,347	4
5	10	Nursing - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	771,372	565,963	5,512,910	1,700	5
6	10	Nursing - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	3,944,092	2,235,491	5,512,910	7,156	6
7	17	General & Admin - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	24,791,565	22,717,176	5,512,910	54,629	7
8	17	General & Admin - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	96,702,974	43,044,715	5,512,910	175,459	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	6,363,513		5,512,910	14,022	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	12,550,855		5,512,910	22,772	10
11	30	Depreciation - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac			5,512,910	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	7,679,242		5,512,910	13,933	12
13										13
14	32	Interest				7,118,315			55,319	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 163,692,539	\$ 69,154,917		\$ 352,367	25

Facility Name & ID Number

Manorcare at Decatur

# 0027458

Report Period Beginning:

06/01/2005

Ending:

05/31/2006

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	<b>A. Directly Facility Related</b>																
	<b>Long-Term</b>																
1	Con Sub Debentures		X	Facility			\$ 738,560	\$ 738,560			\$ 55,319	1					
2												2					
3												3					
4												4					
5								Interest Income			(129)	5					
	<b>Working Capital</b>																
6												6					
7												7					
8												8					
9	<b>TOTAL Facility Related</b>						\$ 738,560	\$ 738,560			\$ 55,190	9					
	<b>B. Non-Facility Related*</b>																
10												10					
11												11					
12												12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 738,560	\$ 738,560			\$ 55,190	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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><b>Important</b>, 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 2005 report.		\$ 53,095	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.)		\$ 51,425	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (1,670)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 53,949	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 52,279	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	45,959	8
	2002	50,833	9
	2003	53,677	10
	2004	51,425	11
	2005	53,949	12
	<b>FOR BHF USE ONLY</b>		
	13	FROM R. E. TAX STATEMENT FOR 2005 \$	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:** 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 Manorcare at Decatur COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0027458

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 858-5495

**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. <u>04-12-03-451-010</u>	<u>See Attached</u>	\$ <u>25,723.83</u>	\$ <u>25,723.83</u>
2. <u>04-12-03-450-013</u>	<u>See Attached</u>	\$ <u>534.45</u>	\$ <u>534.45</u>
3. <u>04-12-03-451-016</u>	<u>See Attached</u>	\$ <u>716.06</u>	\$ <u>716.06</u>
4. <u>04-12-03-451-010</u>	<u>See Attached</u>	\$ <u>25,723.83</u>	\$ <u>25,723.83</u>
5. <u>04-12-03-450-013</u>	<u>See Attached</u>	\$ <u>534.45</u>	\$ <u>534.45</u>
6. <u>04-12-03-451-016</u>	<u>See Attached</u>	\$ <u>716.06</u>	\$ <u>716.06</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>53,948.68</u>	\$ <u>53,948.68</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 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 Manorcare at Decatur

# 0027458 Report Period Beginning:

06/01/2005 Ending:

05/31/2006

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 34,879 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, 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	Facility		1981, 2005	\$ 245,843	1
2	Facility		2006	140,206	2
3	TOTALS			\$ 386,049	3

Facility Name &amp; ID Number    Manorcare at Decatur

#    0027458

Report Period Beginning:

06/01/2005    Ending:    05/31/2006

**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	96			1963	\$ 659,655	\$ 117,020		\$ 117,020		\$ 1,776,072	4
5	6			2003	682,385						5
6				2003	(201,827)						6
7				2006	1,072,957						7
8											8
		<b>Improvement Type**</b>									
9		<b>BUILDING IMPROVEMENTS (Current Year Depreciation)</b>				224,969		224,969		1,263,721	9
10				1983	102,669						10
11				1984	5,247						11
12				1985	4,600						12
13				1986	9,308						13
14				1987	92,366						14
15				1988	38,377						15
16				1989	18,196						16
17				1990	6,261						17
18				1991	162,665						18
19				1992	121,887						19
20				1993	191,712						20
21				1994	75,641						21
22				1995	47,351						22
23		A/C WALL SLEEVE UNIT		1995	2,952						23
24		INSTALL FIRE BOXES		1995	513						24
25		ELECTRICAL		1995	7,058						25
26		HANDRAILS		1995	8,442						26
27		CONCRETE FLOOR		1995	884						27
28		ARCHITECT-ARCADIA / LOBBY		1995	1,439						28
29		LIGHTING		1995	4,074						29
30		FLOORING		1995	2,080						30
31		NURSE CALL SYSTEM		1995	38,400						31
32		DOOR LOCKS		1995	698						32
33		UPGRADE ARCADIA / LOBBY		1996	10,460						33
34		WALLVINYL		1996	2,759						34
35		HANDRAILS		1996	9,792						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 &amp; ID Number    Manorcare at Decatur

#    0027458

Report Period Beginning:

06/01/2005    Ending:    05/31/2006

**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	CAPITALIZED LABOR-ARCADIA / LOBBY	1996	\$ 7,272	\$		\$	\$	\$	37
38	REMODELING-ARCADIA / LOBBY	1996	2,466						38
39	INSTALL FIRE DOORS	1996	8,340						39
40	PHONE WIRING/JACKS	1996	1,486						40
41	SIGNS/BOARDS	1996	952						41
42	A/C WORK	1996	3,237						42
43	ELECTRICAL-ARCADIA / LOBBY	1996	3,479						43
44	INSTALL TILES	1996	1,825						44
45	INSTALL ASPHALT	1996	4,390						45
46	WALLCOVERINGS	1997	3,715						46
47	ROOFTOP TRANE UNITS	1997	12,448						47
48	INSTALL TILES/CEILING & WALLPANELS	1997	7,385						48
49	INSTALL WATER HEATER	1997	7,010						49
50	REPAIR ROOF LEAKS	1997	1,500						50
51	ELECTRICAL	1997	1,549						51
52	RETIREMENTS	1987	(86,079)						52
53	RETIREMENTS	1991	(3,037)						53
54	RETIREMENTS	1992	(6,084)						54
55	INSTALL DOORS	1997	12,737						55
56	WALLCOVERINGS	1997	1,623						56
57	INSTALL VINYL TILE	1997	11,728						57
58	A/C COMPRESSOR WORK	1997	2,257						58
59	FACILITY PLAN ALLOC	1997	2,759						59
60	REPAIR WATER LEAKS	1997	1,408						60
61	NURSES STATION GATE	1997	625						61
62	LANDSCAPING	1997	828						62
63	SIDEWALK	1997	4,023						63
64	INSTALL PATIO COVERS	1997	1,082						64
65	ROOFING	1998	1,992						65
66	HVAC	1998	3,794						66
67	TILE & CARPET	1998	6,771						67
68	FINISH/STUD	1998	3,333						68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,205,815	\$ 341,989		\$ 341,989	\$	\$ 3,039,793	70

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

Facility Name &amp; ID Number Manorcare at Decatur

# 0027458

Report Period Beginning:

06/01/2005 Ending: 05/31/2006

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,205,815	\$ 341,989		\$ 341,989	\$	\$ 3,039,793	1
2	MASONRY WORK	1998	1,333						2
3	PLUMBING	1998	3,172						3
4	PAINTING/WALLCOVERINGS	1998	2,182						4
5	ELECTRICAL WORK	1998	2,352						5
6	CORPORATE OVERHEAD	1998	1,702						6
7	SECURITY SYSTEM	1998	22,488						7
8	IDPU PLAN REVIEW	1998	1,362						8
9	DOORS/WINDOWS	1998	2,681						9
10	GENERAL CONTRACTOR FEES	1998	1,973						10
11	FINISH/STUD	1998	9,004						11
12	MASONRY WORK	1998	21,533						12
13	FLOORING	1998	5,943						13
14	PAINTING/WALLCOVER	1998	9,311						14
15	PLUMBING	1998	1,183						15
16	ROOFING	1998	41,500						16
17	GENERAL CONTRACTORS FEES	1998	4,278						17
18	DOORS/WINDOWS	1998	3,634						18
19	ELECTRICAL	1998	1,333						19
20	HVAC	1998	5,359						20
21	SIGNAGE	1998	11,862						21
22	FLOORING	1999	1,600						22
23	WATER HEATER	1999	1,089						23
24	CARPET	1999	2,769						24
25	LEONARD MIXING VALVE	1999	3,236						25
26	FLOOR COVERING	1999	1,552						26
27	FREIGHT CARPET TILES	1999	214						27
28	BUILDING DECORATIONS	1999	23						28
29	BATH STATION TRANSFORMER	1999	3,355						29
30	MJ ROST FREIGHT	1999	616						30
31	WALLCOVERING	1999	1,325						31
32	CORNERGUARD	1999	270						32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,376,049	\$ 341,989		\$ 341,989	\$	\$ 3,039,793	34

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

Facility Name &amp; ID Number    Manorcare at Decatur

#    0027458

Report Period Beginning:

06/01/2005    Ending:    05/31/2006

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 3,376,049	\$ 341,989		\$ 341,989	\$	\$ 3,039,793	1
2	BOILER	2000	3,076						2
3	CONCRETE & CARPENTRY	2000	30,863						3
4	PAINTING	2000	49,231						4
5	WALLCOVERING	2000	18,122						5
6	PLUMBING	2000	14,039						6
7	DEVELOPERS COST-10 BED ADDTN	2000	116,845						7
8	ADDTL COST ON CONSTRUCTION-10 BED ADDTN	2000	1,938						8
9	CARPET INSTALLATION V#3504	2000	1,805						9
10	CEILING / FLOORING	2000	25,652						10
11	AWNING FRONT ENT / SERVICE ENT	2000	2,013						11
12	CLOSET DOOR	2000	350						12
13	B G ASSEMBLY	2001	487						13
14	B G ASSEMBLY	2001	321						14
15	B G ASSEMBLY	2001	776						15
16	WATER HEATER	2001	8,452						16
17	WATER HEATER	2001	7,755						17
18	VINLY WALL COVERING	2001	433						18
19	AWNING	2001	2,013						19
20	VINLY WALL COVERING	2001	62						20
21	5/31/99 Audit Adjustment	1996	(7,272)						21
22	5/31/99 Audit Adjustment	1997	(2,758)						22
23	5/31/99 Audit Adjustment	1998	(1,702)						23
24	Border	2001	244						24
25	VWC	2001	316						25
26	Wall Coverings	2001	277						26
27	VWC	2001	200						27
28	Enterance Double Door	2001	1,305						28
29	Painting	2001	7,218						29
30	Window Treatments	2001	648						30
31	CARPET	2001	1,629						31
32	Light Fixtures	2001	3,404						32
33	Carpet	2001	870						33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,664,662	\$ 341,989		\$ 341,989	\$	\$ 3,039,793	34

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

Facility Name &amp; ID Number    Manorcare at Decatur

#    0027458

Report Period Beginning:

06/01/2005    Ending:    05/31/2006

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 3,664,662	\$ 341,989		\$ 341,989	\$	\$ 3,039,793	1
2	Handrails	2001	1,865						2
3	Add'l Cost Smoke Shelter	2001	3,960						3
4	Smoke Shelter	2001	2,015						4
5	Painting	2001	7,200						5
6	Painting	2001	2,602						6
7	Add'l Cost Smoke Shelter	2001	600						7
8	Double Glass Doors	2001	4,050						8
9	Vinyl Tile & Sheets	2001	7,759						9
10	Wallpaper & Painting Retainage	2001	500						10
11	Wallpaper & Painting	2001	4,500						11
12	Doors	2001	4,935						12
13	Smoking Shelter	2001	5,400						13
14	VWC	2001	823						14
15	Smoke Shelter	2001	3,492						15
16	Artwork	2001	2,068						16
17	Smoke Shelter	2001	388						17
18	Carpet	2001	8,821						18
19	Smoke Shelter	2001	400						19
20	Smoke Shelter	2001	988						20
21	Window treatments	2001	593						21
22	Kitchen store room door	2001	1,380						22
23	Sidewalk & Parking Lot	2001	8,555						23
24	Shower Room Renovation	2002	655						24
25	Window treatments	2002	3,459						25
26	Carpet and Installation	2002	1,190						26
27	Artwork	2002	2,199						27
28	Renovation - OH & Int.	2002	1,905						28
29	Reno - Flooring, Painting	2002	29,775						29
30	Reno - Plumbing & Electrical	2002	37,536						30
31	Arch & Engineering Costs	2002	2,240						31
32	Arch & Engineering Costs	2002	619						32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,817,136	\$ 341,989		\$ 341,989	\$	\$ 3,039,793	34

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

Facility Name &amp; ID Number    Manorcare at Decatur

#    0027458

Report Period Beginning:

06/01/2005    Ending:    05/31/2006

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12D, Carried Forward</b>		\$ 3,817,136	\$ 341,989		\$ 341,989	\$	\$ 3,039,793	1
2	<u>Adjust asset #1680 - (Reno-Plumbing &amp; Electrical)</u>	2003	(4,164)						2
3	<u>Exterior Renovations - Soffitt &amp; Gutters</u>	2002	9,112						3
4	<u>Exterior Renovations - Soffitt &amp; Gutters</u>	2002	1,013						4
5	<u>Vent Work</u>	2002	331						5
6	<u>Baseboard</u>	2002	4,164						6
7	<u>Addtn. - Carpet, VWC &amp; Sig</u>	2002	9,213						7
8	<u>Addtn - Concrete test &amp; L</u>	2002	3,599						8
9	<u>Addtn - Permits</u>	2002	8,834						9
10	<u>PLUMBING - 2003 Audit Adjustment</u>	2003	(6,909)						10
11	<u>DEVELOPERS COST-10 BED ADDTN - 2003 Audit Adj.</u>	2000	(116,845)						11
12	<u>WATER HEATER - 2003 Audit Adjustment</u>	2001	(497)						12
13	<u>Artwork - 2003 Audit Adjustment</u>	2001	(2,068)						13
14	<u>Artwork -2003 Audit Adjustment</u>	2002	(2,199)						14
15	<u>Renovation - O/H &amp; Int. - 2003 Audit Adjustment</u>	2002	(1,905)						15
16	<u>Renovation-Roofing &amp; Sheet Metal</u>	2003	67,148						16
17	<u>Renovation-General Overhead</u>	2003	1,031						17
18	<u>Renovation-Interest</u>	2003	581						18
19	<u>AWNING</u>	2003	2,470						19
20	<u>CREDIT ON VWC</u>	2002	(142)						20
21	<u>Renovation-Engineering</u>	2004	4,880						21
22	<u>Renovation-General Overhead</u>	2004	10,453						22
23	<u>Renovation-Interest</u>	2004	138						23
24	<u>Landscaping-Install Facade Materials</u>	2003	23,983						24
25	<u>GAZEBO</u>	2003	6,215						25
26	<u>ADD'L COST GAZEBO</u>	2003	2,611						26
27	<u>Doors and Downspouts</u>	2004	7,110						27
28	<u>Doors Retainage</u>	2004	790						28
29	<u>Vinyl Tile and Cove Base</u>	2004	17,910						29
30	<u>Vinyl Tile and Base</u>	2005	2,974						30
31	<u>Vinyl Tile</u>	2005	2,974						31
32	<u>Vinyl Tile and Cove Base</u>	2005	10,985						32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,880,925	\$ 341,989		\$ 341,989	\$	\$ 3,039,793	34

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

Facility Name &amp; ID Number    Manorcare at Decatur

#    0027458

Report Period Beginning:

06/01/2005    Ending:    05/31/2006

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12E, Carried Forward</b>		\$ 3,880,925	\$ 341,989		\$ 341,989	\$	\$ 3,039,793	1
2	Water/Sewer/Utilities	2005	76,296						2
3	Paving/Parking	2005	45,064						3
4	Site Concrete	2005	20,963						4
5	Site Preparation	2005	50,580						5
6	Fencing/Gazebo/Courtyard	2005	13,234						6
7	Landscaping	2005	30,808						7
8	Site Demolition	2005	25,400						8
9	Water/Sewer Testing	2005	9,025						9
10	Landscaping	2005	10,269						10
11	Landscaping	2005	1,838						11
12	Nursing Station Carpentry	2005	3,360						12
13	Vinyl Wall Covering	2005	1,344						13
14	Architect & Engineering Fees	2005	150,302						14
15	General Overhead & Interest	2005	221,331						15
16	Permit Fees, Plan Reviews	2005	15,128						16
17	Vinyl Wall Covering, Flooring	2005	34,343						17
18	Vinyl Wall Covering	2005	1,551						18
19	Carpet	2005	3,680						19
20	Canopy Sprinklers	2005	3,950						20
21	Blinds	2005	2,375						21
22	Vinyl Wall Covering	2005	(676)						22
23	Fabrics	2005	499						23
24	Flooring	2005	14,253						24
25	Overhead & Interest	2005	1,641						25
26	Carpentry	2005	26,507						26
27	Wallcovering	2006	624						27
28	Doors	2006	5,715						28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,650,327	\$ 341,989		\$ 341,989	\$	\$ 3,039,793	34

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

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/2005 Ending: 05/31/2006

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	\$ 1,125,394	\$ 140,386	\$ 140,386	\$		\$ 856,527	71
72	Current Year Purchases	289,393						72
73	Fully Depreciated Assets			13,933	13,933			73
74	Home Office							74
75	TOTALS	\$ 1,414,787	\$ 140,386	\$ 154,319	\$ 13,933		\$ 856,527	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 6,451,163	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 482,375	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 496,308	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 13,933	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,896,320	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 Manorcare at Decatur

# 0027458

Report Period Beginning: 06/01/2005

Ending: 05/31/2006

**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:	<u>N/A</u>			\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	<b>TOTAL</b>				\$ _____			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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 29,955

Description: O2 Concentrators, Wheelchairs, Gerichairs, Elect Beds, Etc.

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	<b>TOTAL</b>		\$ _____	\$ _____	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)	
<b>TOTAL TRAINED</b>	

- (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	Units	Cost				
1	Licensed Occupational Therapist	10a	hrs	\$	5,248	\$ 272,901	\$ 4,593	5,248	\$ 277,494	1
2	Licensed Speech and Language Development Therapist	10a	hrs		2,196	114,197	2,341	2,196	116,538	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs		4,906	255,123	3,312	4,906	258,435	4
5	Physician Care		visits							5
6	Dental Care	39	visits			1,000			1,000	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				300,824		300,824	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): P/S-Lab, X-Ray	10,Col3, 39				19,977			19,977	13
14	TOTAL			\$	12,350	\$ 663,198	\$ 311,070	12,350	\$ 974,268	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 Manorcare at Decatur# 0027458Report Period Beginning: 06/01/2005

Ending:

05/31/2006**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 05/31/2006

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (44,892)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (176,483) )	1,131,687		3
4	Supply Inventory (priced at )	32,515		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,340		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,121,650	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	386,049		13
14	Buildings, at Historical Cost	4,650,327		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,414,788		16
17	Accumulated Depreciation (book methods)	(3,896,319)		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	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 2,554,845	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 3,676,495	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 36,251	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	324,937		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	80,923		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Other Accrued Expenses</u>	77,623		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 519,734	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 519,734	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 3,156,761	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 3,676,495	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,360,825	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,360,825	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	1,177,759	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,177,759	17
<b>B. Transfers (Itemize):</b>			
18	Change in Interdivision	(1,381,823)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (1,381,823)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,156,761	24 *

\* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare at Decatur# 0027458Report Period Beginning: 06/01/2005Ending: 05/31/2006**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,768,008	1
2	Discounts and Allowances for all Levels	(274,074)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 5,493,934</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care	10,375	4
5	Other Care for Outpatients		5
6	Therapy	1,595,345	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,605,720</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,486	12
13	Barber and Beauty Care	25,495	13
14	Non-Patient Meals	1,045	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	369,059	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,774	19
20	Radiology and X-Ray	6,425	20
21	Other Medical Services	422	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 416,706</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	129	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 129</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Purchase Discounts</b>	(31)	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ (31)</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 7,516,458</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	880,935	31
32	Health Care	2,984,166	32
33	General Administration	1,481,793	33
<b>B. Capital Expense</b>			
34	Ownership	566,793	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	425,012	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 6,338,699</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>1,177,759</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 1,177,759</b>	<b>43</b>

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

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

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

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

Facility Name & ID Number Manorcare at Decatur

# 0027458

Report Period Beginning:

06/01/2005

Ending:

05/31/2006

**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	1,408	1,535	\$ 42,928	\$ 27.97	1
2	Assistant Director of Nursing	5,488	5,982	138,105	23.09	2
3	Registered Nurses	14,627	15,943	356,698	22.37	3
4	Licensed Practical Nurses	24,942	27,186	498,060	18.32	4
5	CNAs & Orderlies	77,163	84,106	895,509	10.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,962	7,605	74,732	9.83	10
11	Social Service Workers	4,996	5,398	91,112	16.88	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,417	21,217	195,802	9.23	15
16	Dishwashers					16
17	Maintenance Workers	3,959	4,320	61,399	14.21	17
18	Housekeepers	10,660	11,649	108,380	9.30	18
19	Laundry	4,976	5,433	47,267	8.70	19
20	Administrator	2,280	2,280	73,756	32.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,498	11,112	151,231	13.61	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,736	1,898	19,474	10.26	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	188,112	205,664	\$ 2,754,453 *	\$ 13.39	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	33,860	Ln 9, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 33,860		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. IHCA \$ 5,945
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes \$1,903
- (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? 5-10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 56,812 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. \_\_\_\_\_
- (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. \$ 62,460  
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? Yes Indicate the amount. \$ (1,045)
- (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? N/A  
d. Have vehicle usage logs been maintained? N/A  
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? 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. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? \_\_\_\_\_  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ 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? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.