

		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: 0027532

Facility Name: Manorcare at Normal

Address: 510 Broadway Normal 61761
 Number City Zip Code

County: McLean

Telephone Number: (309) - 452-4406 **Fax #** (309) - 454-7908

HFS ID Number: 520886946006

Date of Initial License for Current Owners: 11/01/81

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Craig Dekany, CPA **Telephone Number:** (419) - 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/05 to 05/31/06 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) <u>Barry Lazarus</u>	
	(Title) <u>Vice President of Reimbursement</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (____) _____ Fax # (____) _____	

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 Manorcare at Normal

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

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	<u>109</u>	Skilled (SNF)	<u>109</u>	<u>39,785</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>109</u>	TOTALS	<u>109</u>	<u>39,785</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>1,300</u>	<u>9,284</u>	<u>15,055</u>	<u>25,639</u>	8
9	SNF/PED					9
10	ICF	<u>6,561</u>	<u>3,917</u>	<u>360</u>	<u>10,838</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,861</u>	<u>13,201</u>	<u>15,415</u>	<u>36,477</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.69%

D. How many bed-hold days during this year were paid by the Department? 7 (Do not include bed-hold days in Section B.)

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

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

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

YES NO

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

YES NO

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

Date started 11/01/81

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 97 and days of care provided 11,586

Medicare Intermediary HighMark Medicare Services

IV. ACCOUNTING BASIS

ACCURAL 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 Normal # 0027532 Report Period Beginning: 06/01/05 Ending: 05/31/06

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	167,509	18,179	59,939	245,627	2,587	248,214		248,214			1
2	Food Purchase		222,950		222,950		222,950	(2,076)	220,874			2
3	Housekeeping	114,711	29,709	1,598	146,018		146,018		146,018			3
4	Laundry	31,991	15,706	1,164	48,861		48,861		48,861			4
5	Heat and Other Utilities			145,964	145,964	5,235	151,199	(6,440)	144,759			5
6	Maintenance	41,179	15,753	65,526	122,458		122,458		122,458			6
7	Other (specify):* Medical Waste			1,435	1,435		1,435		1,435			7
8	TOTAL General Services	355,390	302,297	275,626	933,313	7,822	941,135	(8,516)	932,619			8
	B. Health Care and Programs											
9	Medical Director			15,775	15,775		15,775		15,775			9
10	Nursing and Medical Records	2,003,586	190,145	47,680	2,241,411	9,390	2,250,801	(22,726)	2,228,075			10
10a	Therapy		10,465	828,958	839,423		839,423		839,423			10a
11	Activities	66,070	4,019	2,793	72,882		72,882		72,882			11
12	Social Services	123,606	288	1,411	125,305		125,305		125,305			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,193,262	204,917	896,617	3,294,796	9,390	3,304,186	(22,726)	3,281,460			16
	C. General Administration											
17	Administrative	118,333		366,259	484,592	(122,283)	362,309		362,309			17
18	Directors Fees											18
19	Professional Services			9,636	9,636	(777)	8,859	(8,859)				19
20	Dues, Fees, Subscriptions & Promotions			77,841	77,841		77,841	(45,423)	32,418			20
21	Clerical & General Office Expenses	197,293	53,648	(184,141)	66,800	777	67,577	234,004	301,581			21
22	Employee Benefits & Payroll Taxes			641,927	641,927	39,015	680,942		680,942			22
23	Inservice Training & Education			854	854		854		854			23
24	Travel and Seminar			30,624	30,624		30,624		30,624			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			117,892	117,892		117,892		117,892			26
27	Other (specify):* Personal Purchase			14	14		14		14			27
28	TOTAL General Administration	315,626	53,648	1,060,906	1,430,180	(83,268)	1,346,912	179,722	1,526,634			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,864,278	560,862	2,233,149	5,658,289	(66,056)	5,592,233	148,480	5,740,713			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 Normal #0027532 Report Period Beginning: 06/01/05 Ending: 05/31/06

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			270,743	270,743	14,774	285,517		285,517		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			61,476	61,476	51,282	112,758	(2,764)	109,994		32
33	Real Estate Taxes			55,750	55,750		55,750	(48,267)	7,483		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			61,344	61,344		61,344		61,344		35
36	Other (specify):*			3,192	3,192		3,192	(3,192)			36
37	TOTAL Ownership			452,505	452,505	66,056	518,561	(54,223)	464,338		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		390,596	89,165	479,761		479,761		479,761		39
40	Barber and Beauty Shops			14,436	14,436		14,436		14,436		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			59,678	59,678		59,678		59,678		42
43	Other (specify):* IV Therapy Drugs		34,018		34,018		34,018		34,018		43
44	TOTAL Special Cost Centers		424,614	163,279	587,893		587,893		587,893		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,864,278	985,476	2,848,933	6,698,687		6,698,687	94,257	6,792,944		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 Normal

0027532

Report Period Beginning:

06/01/05

Ending:

05/31/06

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	(2,076)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,440)	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	(2,764)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	2,490	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(22,726)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(11,570)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(8,859)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	247,830	21		24
25	Fund Raising, Advertising and Promotional	(45,423)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(48,267)	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(7,938)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 94,257		\$	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))	\$ 94,257		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Manorcare at Normal

ID# 0027532

Report Period Beginning: 06/01/05

Ending: 05/31/06

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	G/L Assets	\$ (3,192)	36
2	Customer Reimbursement	(4,746)	21
3			
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48	Total	(7,938)	
49			

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Normal

0027532

Report Period Beginning:

06/01/05

Ending:

05/31/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,076)	0	0	0	0	0	0	0	0	0	0	(2,076)	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	(6,440)	0	0	0	0	0	0	0	0	0	0	(6,440)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(8,516)	0	0	0	0	0	0	0	0	0	0	(8,516)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(22,726)	0	0	0	0	0	0	0	0	0	0	(22,726)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(22,726)	0	0	0	0	0	0	0	0	0	0	(22,726)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,859)	0	0	0	0	0	0	0	0	0	0	(8,859)	19
20	Fees, Subscriptions & Promotions	(45,423)	0	0	0	0	0	0	0	0	0	0	(45,423)	20
21	Clerical & General Office Expenses	234,004	0	0	0	0	0	0	0	0	0	0	234,004	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	179,722	0	0	0	0	0	0	0	0	0	0	179,722	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	148,480	0	0	0	0	0	0	0	0	0	0	148,480	29

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Normal

0027532

Report Period Beginning:

06/01/05 Ending:

Summary B

05/31/06

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	(2,764)	0	0	0	0	0	0	0	0	0	0	(2,764)	32
33	Real Estate Taxes	(48,267)	0	0	0	0	0	0	0	0	0	0	(48,267)	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):*	(3,192)	0	0	0	0	0	0	0	0	0	0	(3,192)	36
37	TOTAL Ownership	(54,223)	0	(54,223)	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	94,257	0	94,257	45									

Facility Name & ID Number Manorcare at Normal

0027532

Report Period Beginning:

06/01/05

Ending:

05/31/06

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	\$ 366,259	HCR Manor Care, Inc	100.00%	\$ 366,259	\$	1
2	V	Page						2
3	V	8						3
4	V							4
5	V							5
6	V	10a Therapy Management	18,015	Heartland Management Services	100.00%	18,015		6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 384,274			\$ 384,274	\$ *	14

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

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

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	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 Normal

0027532

Report Period Beginning:

06/01/05

Ending: 05/31/06

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 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) 254-5495

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	\$ 1,107,111	\$ 591,572	5,845,655	\$ 2,587	1
2	1	Dietary - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac			5,845,655	0	2
3	5	Utilities - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	267,575		5,845,655	625	3
4	5	Utilities - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	2,395,925		5,845,655	4,610	4
5	10	Nursing - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	771,372	565,963	5,845,655	1,802	5
6	10	Nursing - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	3,944,092	2,235,491	5,845,655	7,588	6
7	17	General & Admin - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	24,791,965	22,717,176	5,845,655	57,927	7
8	17	General & Admin - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	96,702,974	43,044,715	5,845,655	186,049	8
9	22	Employees Benefits - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	6,363,513		5,845,655	14,868	9
10	22	Employees Benefits - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	12,550,855		5,845,655	24,147	10
11	30	Depreciation - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac			5,845,655	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	7,679,242		5,845,655	14,774	12
13										13
14	32	Interest				7,118,315			51,282	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 163,692,939	\$ 69,154,917		\$ 366,259	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	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			
A. Directly Facility Related																	
Long-Term																	
1	Conv Sub Debentures		X	Facility			\$ 684,665	\$ 684,665			\$ 51,282	1					
2	National City Bank, Trustee						983,699	983,699			61,476	2					
3												3					
4												4					
5												5					
Working Capital																	
6												6					
7								Interest Income			(2,764)	7					
8												8					
9	TOTAL Facility Related						\$ 1,668,364	\$ 1,668,364			\$ 109,994	9					
B. Non-Facility Related*																	
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 1,668,364	\$ 1,668,364			\$ 109,994	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

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.	\$	103,360	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.)	\$	55,093	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(48,267)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	55,750	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	7,483	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	41,693	8
	2002	60,358	9
	2003	42,658	10
	2004	54,436	11
	2005	55,750	12

FOR BHF USE ONLY			
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 Normal COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0027532

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

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>14-28-479-009</u>	<u>See Attached</u>	\$ <u>27,874.84</u>	\$ <u>27,874.84</u>
2. <u>14-28-479-009</u>	<u>See Attached</u>	\$ <u>27,874.84</u>	\$ <u>27,874.84</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>55,749.68</u>	\$ <u>55,749.68</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 Normal

0027532 Report Period Beginning:

06/01/05 Ending:

05/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,362 B. General Construction Type: Exterior Masonry Frame Steel, Fire Resistant 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).

N/A

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>Facility</u>		<u>1971</u>	<u>\$ 58,339</u>	<u>1</u>
2			<u>1993 & 2001</u>	<u>115,287</u>	<u>2</u>
3	TOTALS			\$ 173,626	3

Facility Name & ID Number Manorcare at Normal

0027532

Report Period Beginning:

06/01/05

Ending:

05/31/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	90		1971	1962	\$ 506,817	\$ (438)		\$ (438)	\$	\$ 1,154,597	4
5	9			1994	497,564						5
6	10			2001	588,325						6
7											7
8											8
Improvement Type**											
9	Building Improvements (Current Year Depreciation)					151,767		151,767		1,830,636	9
10				1979	60,522						10
11				1980	317,478						11
12				1981	50,351						12
13				1982	21,867						13
14				1984	16,946						14
15				1985	26,268						15
16				1986	18,155						16
17				1987	42,286						17
18		RETIREMENTS		1987	(29,830)						18
19				1988	207,264						19
20				1989	134,621						20
21				1990	46,332						21
22				1991	15,386						22
23				1992	57,357						23
24		RETIREMENTS		1992	(3,110)						24
25				1993	44,829						25
26				1994	137,130						26
27				1995	72,481						27
28		RENOVATIONS-PATIENT ROOMS		1996	22,684						28
29		CARPET/TILE & INSTALLATION		1996	4,392						29
30		CAPITALIZED LABOR		1996	7,272						30
31		WALL VINYL/DRYWALL		1996	5,194						31
32		SIGNS/BOARDS		1996	1,730						32
33		INSTALL GRID/PANELS		1996	4,402						33
34		CONCRETE WALK/RAMP		1996	2,850						34
35		CABINETS		1996	1,087						35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare at Normal

0027532

Report Period Beginning:

06/01/05

Ending:

05/31/06

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	CARPETING	1996	\$ 9,845	\$		\$	\$	\$	37
38	ROOFING	1996	24,474						38
39	ELECTRICAL/LIGHTING	1996	2,159						39
40	WALLCOVERINGS	1996	5,910						40
41	SIGNS/CORNERGUARDS/CHAIR RAIL	1996	2,433						41
42	INSTALL SHOWER TILE	1996	2,656						42
43	REPAIR COMPRESSOR	1996	900						43
44	CONCRETE WALK	1996	1,053						44
45	CR5/31/99 AUDIT ADJ - CAPITAL	1996	(7,272)						45
46	PAINTING & DECORATING	1997	15,688						46
47	ROOF REPLACEMENT	1997	3,345						47
48	WALLCOVERINGS	1997	1,788						48
49	TILE & INSTALLATION	1997	2,686						49
50	CARPET	1997	1,547						50
51	INSTALL COMPRESSOR	1997	2,583						51
52	ROOF WORK	1997	51,370						52
53	WALK-IN COOLER/FREEZER	1997	9,466						53
54	ALLOC. FAC. PLAN	1997	2,758						54
55	PLUMBING/BATHROOM WORK	1997	1,226						55
56	ELECTRICAL	1997	2,416						56
57	CR5/31/99 AUDIT ADJ - CAPITAL	1997	(2,758)						57
58	CR5/31/99 AUDIT ADJ - CAPITAL	1998	(1,702)						58
59	FINISH/STUD	1998	4,865						59
60	PAINTING/WALLCOVERINGS	1998	8,175						60
61	CARPETING	1998	6,460						61
62	PLUMBING	1998	1,456						62
63	ROOFING	1998	2,170						63
64	DOORS/WINDOWS/CASEWORK	1998	9,884						64
65	ELECTRICAL	1998	5,360						65
66	FLOORING/CEILING/COVE BASE	1998	13,283						66
67	GENERAL CONTRACTOR FEES-PATIENT ROOMS	1998	1,298						67
68	CORPORATE OVERHEAD-PATIENT ROOMS	1998	1,702						68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,065,874	\$ 151,329		\$ 151,329	\$	\$ 2,985,233	70

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

Facility Name & ID Number Manorcare at Normal

0027532

Report Period Beginning:

06/01/05

Ending:

05/31/06

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	
1	Totals from Page 12A, Carried Forward		\$ 3,065,874	\$ 151,329		\$ 151,329	\$	\$ 2,985,233	1
2	FURNISH & INSTALL STEEL DOORS	1998	2,439						2
3	MILLWORK	1998	1,166						3
4	INSTALL DUCTS	1998	327						4
5	REWORK FIRE/SMOKE DAMPERS	1998	632						5
6	RENOVATE PATIENT ROOMS	1998	5,233						6
7	WALKWAY	1998	7,267						7
8	ELECTRICAL	1998	8,111						8
9	ROOFING	1998	8,485						9
10	SIGNAGE	1998	13,529						10
11	DOORS/WINDOWS	1998	1,773						11
12	GENERAL CONTRACTOR FEES-PATIENT ROOMS	1998	2,507						12
13	MASONRY	1998	3,700						13
14	PAINTING/WALLCOVER	1998	251						14
15	FLOORING	1998	458						15
16	RENOVATE PATIENT ROOMS	1998	(2,520)						16
17	GAZEBO	1998	2,495						17
18	FLOORS	1999	2,990						18
19	DOORS	1999	18,097						19
20	FENCING	1999	4,343						20
21	SIDEWALK	1999	3,719						21
22	FIRE SPRINKLER	1999	6,270						22
23	WATER HEATER	1999	7,717						23
24	FLOORS	2000	830						24
25	DOORS	2000	11,081						25
26	RENOVATION-ARCADIA ADDTN	2000	5,000						26
27	CONCRETE	2000	1,685						27
28	CARPENTRY	2000	3,179						28
29	DRYWALL / FINISHES	2000	15,397						29
30	CEILING / FLOORING	2000	5,680						30
31	CARPETING & PADS	2000	7,167						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,214,881	\$ 151,329		\$ 151,329	\$	\$ 2,985,233	34

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

Facility Name & ID Number Manorcare at Normal

0027532

Report Period Beginning:

06/01/05

Ending:

05/31/06

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	
1	Totals from Page 12B, Carried Forward		\$ 3,214,881	\$ 151,329		\$ 151,329	\$	\$ 2,985,233	1
2	<u>PAINTING</u>	2000	28,868						2
3	<u>WALLCOVERING</u>	2000	7,060						3
4	<u>ELECTRICAL</u>	2000	12,505						4
5	<u>GENERAL OVERHEAD & MISC-ARCADIA ADDTN</u>	2000	25,528						5
6	<u>5/31/03 Audit Adjustment (See IDPH Pg.12 Schedule)</u>	2000	(25,528)						6
7	<u>INTEREST ON CONSTRUCTION-ARCADIA ADDITION</u>	2000	5,447						7
8	<u>5/31/03 Audit Adjustment (See IDPH Pg.12 Schedule)</u>	2000	(5,447)						8
9	<u>OVERHEAD COST-ARCADIA ADDITION</u>	2000	43,193						9
10	<u>5/31/03 Audit Adjustment (See IDPH Pg.12 Schedule)</u>	2000	(43,193)						10
11	<u>WATER HEATER</u>	2001	9,350						11
12	<u>8 REPLACEMENT WINDOWS</u>	2001	5,812						12
13	<u>MIXING VALVE</u>	2001	3,397						13
14	<u>CARPET & VWC</u>	2001	24,531						14
15	<u>SOIL & CONCRETE TESTING</u>	2001	2,905						15
16	<u>WATER & SEWER, PERMIT FEES</u>	2001	14,582						16
17	<u>SITWORK</u>	2001	74,254						17
18	<u>LANDSCAPING</u>	2001	2,270						18
19	<u>ADDITIONAL COST SITWORK</u>	2001	371						19
20	<u>FLOORING BY GREASE TRAP</u>	2002	753						20
21	<u>FLOORING</u>	2002	5,415						21
22	<u>ADDITIONAL ARCHITECTURE ENG.</u>	2002	65						22
23	<u>ARCHITECTURE ENGINEERING</u>	2002	350						23
24	<u>ARCHITECTURE ENGINEERING</u>	2002	2,993						24
25	<u>FRONT HALL & OFFICE WALLS/FLOORS</u>	2002	7,395						25
26	<u>FRONT HALL & OFFICE WALLS/FLOORS</u>	2002	39,302						26
27	<u>FRONT HALL & OFFICE WALLS/FLOORS</u>	2002	13,311						27
28	<u>DIETARY HVAC</u>	2002	82,214						28
29	<u>SMOKE SHELTER</u>	2002	3,540						29
30	<u>ALUMINUM SHELTER</u>	2002	5,225						30
31	<u>SIDEWALK</u>	2002	2,375						31
32	<u>FENCE</u>	2002	975						32
33	<u>RETROACTIVE ADDITION</u>	2002	(10)						33
34	TOTAL (lines 1 thru 33)		\$ 3,564,690	\$ 151,329		\$ 151,329	\$	\$ 2,985,233	34

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

Facility Name & ID Number Manorcare at Normal

0027532

Report Period Beginning:

06/01/05

Ending:

05/31/06

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	
1	Totals from Page 12C, Carried Forward		\$ 3,564,690	\$ 151,329		\$ 151,329	\$	\$ 2,985,233	1
2	LANDSCAPING	2003	7,887						2
3	DEVELOPERS COST - OVERHEAD	2003	10,184						3
4	INTEREST ON CONSTRUCTION	2003	722						4
5	CARPENTRY	2003	3,460						5
6	FLOORING	2003	7,040						6
7	PAINTING	2003	33,211						7
8	WALLCOVERING	2003	6,434						8
9	HVAC	2003	3,587						9
10	VWC	2003	754						10
11	HANDRAILS & INSTALLATION	2003	2,300						11
12	VWC	2004	922						12
13	BORDER	2004	56						13
14	PAINT, VWC & BORDER	2004	1,300						14
15	CABINETS AND COUNTERTOPS	2004	5,671						15
16	FLOORING	2004	2,288						16
17	FLOORING	2004	7,170						17
18	PAINT & VWC	2004	7,200						18
19	CARPET	2004	868						19
20	OVERLAY ASPHALT PARKING LOT	2004	9,662						20
21	PARKING LOT CONSTRUCTION AND PAVING	2005	55,622						21
22	PAINT & VINYL WALL COVERING	2004	1,189						22
23	PAINT & VINYL WALL COVERING	2004	3,497						23
24	VINYL WALL COVERING	2004	219						24
25	DOOR WITH LOCK	2004	3,461						25
26	EXIT PANEL	2003	1,995						26
27	VINYL COVERED TILE	2004	640						27
28	PAINTING	2004	1,450						28
29	VINYL WALL COVERING	2004	432						29
30	ENGINEERING, OVERHEAD & INTEREST	2004	43,667						30
31	ELECTRICAL WORK	2004	30,627						31
32	VINYL WALL COVERING	2004	56						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,818,261	\$ 151,329		\$ 151,329	\$	\$ 2,985,233	34

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

Facility Name & ID Number Manorcare at Normal

0027532

Report Period Beginning:

06/01/05

Ending:

05/31/06

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	
1	Totals from Page 12D, Carried Forward		\$ 3,818,261	\$ 151,329		\$ 151,329	\$	\$ 2,985,233	1
2	VINYL COVERED TILE AND COVE BASE	2004	2,175						2
3	ADJUST ASSET #1851 (VINYL WALL COVERING)	2004	(56)						3
4	ELECTRICAL WORK	2004	4,342						4
5	ELECTRICAL WORK	2004	8,455						5
6	ENGINEERING COST, OVERHEAD & INTEREST	2005	9,557						6
7	VINYL WALL COVERING	2005	1,279						7
8	VINYL WALL COVERING	2005	1,279						8
9	13 PHONE LINES & JACKS	2005	3,520						9
10	VINYL WALL COVERING	2005	506						10
11	VINYL WALL COVERING	2005	526						11
12	VINYL WALL COVERING	2005	159						12
13	VINYL WALL COVERING	2005	257						13
14	VINYL WALL COVERING	2005	7,268						14
15	VINYL WALL COVERING	2005	2,749						15
16	VINYL WALL COVERING	2005	2,670						16
17	VINYL WALL COVERING	2005	2,510						17
18	FLOORING VINYL	2005	1,980						18
19	KICK RAIL	2005	2,354						19
20	WINDOW TREATMENTS	2005	5,098						20
21	VINYL COVERED TILE AND CARPET	2005	9,340						21
22	DOOR	2005	1,580						22
23	CEILING TILE	2005	29,500						23
24	OVERHEAD & INTEREST	2005	18,308						24
25	ROOFING & SHEET METAL	2005	237,310						25
26	DUCT WORK	2005	6,803						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,177,729	\$ 151,329		\$ 151,329	\$	\$ 2,985,233	34

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

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

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	\$ 1,377,980	\$ 119,414	\$ 119,414	\$		\$ 867,062	71
72	Current Year Purchases	54,200						72
73	Fully Depreciated Assets							73
74	Home Office Allocation			14,774	14,774			74
75	TOTALS	\$ 1,432,180	\$ 119,414	\$ 134,188	\$ 14,774		\$ 867,062	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)	\$ 5,783,535	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 270,743	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 285,517	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 14,774	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,852,295	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	CIP	\$ 717,956	92
93			93
94			94
95		\$ 717,956	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 Normal

0027532

Report Period Beginning: 06/01/05

Ending: 05/31/06

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:	<u>N/A</u>			\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	TOTAL				\$ _____			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /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: \$ 61,344 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	TOTAL		\$ _____	\$ _____	21

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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	\$	10,885	\$ 272,129	\$ 4,314	10,885	\$ 276,443	1
2	Licensed Speech and Language Development Therapist	10a	hrs		2,964	74,090	31	2,964	74,121	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs		19,271	481,786	6,120	19,271	487,906	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				390,596		390,596	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>Inhalation,X-Ray,Lab</u>	<u>10,Col3, 39</u>				90,118			90,118	13
14	TOTAL			\$	33,120	\$ 918,123	\$ 401,061	33,120	\$ 1,319,184	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 Normal# 0027532Report Period Beginning: 06/01/05

Ending:

05/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/06

(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	\$ (29,765)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (148,628))	732,834		3
4	Supply Inventory (priced at)	40,608		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,277		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 745,954	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	173,626		13
14	Buildings, at Historical Cost	4,177,729		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,432,180		16
17	Accumulated Depreciation (book methods)	(3,852,295)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>CIP</u>	717,956		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,649,196	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,395,150	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 41,606	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	247,741		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	55,750		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Accrued Expenses</u>	140,427		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 485,524	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	983,699		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 983,699	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,469,223	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,925,927	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,395,150	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,681,669	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,681,669	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,618,569	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)	\$ 1,618,569	17
B. Transfers (Itemize):			
18	Change in Interdivision	(1,374,311)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (1,374,311)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,925,927	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare at Normal# 0027532Report Period Beginning: 06/01/05Ending: 05/31/06**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	\$ 6,901,673	1
2	Discounts and Allowances for all Levels	(1,116,295)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,785,378	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,034,636	6
7	Oxygen	11,900	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,046,536	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	3,493	12
13	Barber and Beauty Care	16,103	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	440,875	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,930	19
20	Radiology and X-Ray	1,848	20
21	Other Medical Services	329	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 482,578	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,226	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,226	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	1,538	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,538	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,317,256	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	933,313	31
32	Health Care	3,294,796	32
33	General Administration	1,430,180	33
B. Capital Expense			
34	Ownership	452,505	34
C. Ancillary Expense			
35	Special Cost Centers	587,893	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,698,687	40
41	Income before Income Taxes (line 30 minus line 40)**	1,618,569	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,618,569	43

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

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

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

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

Facility Name & ID Number Manorcare at Normal

0027532

Report Period Beginning:

06/01/05

Ending:

05/31/06

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	2,071	2,237	\$ 65,405	\$ 29.24	1
2	Assistant Director of Nursing	2,957	3,194	62,946	19.71	2
3	Registered Nurses	12,315	13,301	316,197	23.77	3
4	Licensed Practical Nurses	26,968	29,128	618,374	21.23	4
5	CNAs & Orderlies	77,011	83,179	917,767	11.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,820	6,298	66,070	10.49	10
11	Social Service Workers	6,152	6,619	123,606	18.67	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,430	18,863	167,509	8.88	15
16	Dishwashers					16
17	Maintenance Workers	2,117	2,291	41,179	17.97	17
18	Housekeepers	11,991	12,982	114,711	8.84	18
19	Laundry	3,794	4,102	31,991	7.80	19
20	Administrator	2,355	2,355	76,966	32.68	20
21	Assistant Administrator	1,947	1,947	41,367	21.25	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,634	14,093	197,289	14.00	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	2,008	2,173	22,901	10.54	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	187,570	202,762	\$ 2,864,278 *	\$ 14.13	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	15,775	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)		\$ 15,775		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 \$6,135
- (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, \$1,963
- (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. \$ 53,625 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. \$ 59,678
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? No 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? 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? No
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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.