

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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 License ID Number: 0046839

Facility Name: Manor Court of Freeport

Address: 2170 West Navajo Drive Freeport 61032
 Number City Zip Code

County: Stephenson

Telephone Number: (815)233-2400 **Fax #** (815) 297-0767

HFS ID Number: 37-1223846009

Date of Initial License for Current Owners: 12/06/05

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Ron Wilson **Telephone Number:** (309) 343-1550

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2007 to 12/31/2007 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) Tim Bledsoe

(Title) Director of Operations

Paid Preparer

(Signed) See Attached Independent Accountant's Report (Date) _____

(Print Name and Title) McGladrey & Pullen, LLP
117 E. Main St., Suite 210

(Firm Name & Address) P.O. Box 1070
Galesburg, IL 61401

(Telephone) (309) 342-1175 Fax # (309) 342-7816

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 Manor Court of Freeport# 0046839 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>45</u>	Skilled (SNF)	<u>45</u>	<u>16,425</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>33</u>	Sheltered Care (SC)	<u>33</u>	<u>12,045</u>	5
6		ICF/DD 16 or Less			6
7	<u>78</u>	TOTALS	<u>78</u>	<u>28,470</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>1,063</u>	<u>8,158</u>	<u>3,555</u>	<u>12,776</u>	8
9	SNF/PED					9
10	ICF		<u>0</u>			10
11	ICF/DD					11
12	SC		<u>6,506</u>		<u>6,506</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>1,063</u>	<u>14,664</u>	<u>3,555</u>	<u>19,282</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 67.73%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES NO

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

YES NO

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

Date started 1/9/06

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

YES Date 1/1/06 NO

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

YES NO If YES, enter number
of beds certified 45 and days of care provided 3,555Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED
CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Manor Court of Freeport # 0046839 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	128,785	27,784	4,278	160,847		160,847	(26,867)	133,980		1
2	Food Purchase		126,860		126,860		126,860	(24,609)	102,251		2
3	Housekeeping	94,550	36,964		131,514		131,514	(14,806)	116,708		3
4	Laundry	33,386	25,690		59,076		59,076	(6,651)	52,425		4
5	Heat and Other Utilities			143,433	143,433		143,433	(32,413)	111,020		5
6	Maintenance	31,351	27,491	38,204	97,046		97,046	(8,152)	88,894		6
7	Other (specify):*										7
8	TOTAL General Services	288,072	244,789	185,915	718,776		718,776	(113,498)	605,278		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,137,833	201,801	1,500	1,341,134		1,341,134	(242,454)	1,098,680		10
10a	Therapy			241,034	241,034		241,034		241,034		10a
11	Activities	61,172	1,615		62,787		62,787	(182)	62,605		11
12	Social Services	26,416			26,416		26,416		26,416		12
13	CNA Training										13
14	Program Transportation			638	638	4,019	4,657		4,657		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,225,421	203,416	249,172	1,678,009	4,019	1,682,028	(242,636)	1,439,392		16
	C. General Administration										
17	Administrative	73,220			73,220		73,220	(7,492)	65,728		17
18	Directors Fees							2,027	2,027		18
19	Professional Services			147,587	147,587		147,587	(8,370)	139,217		19
20	Dues, Fees, Subscriptions & Promotions			38,919	38,919		38,919	(23,124)	15,795		20
21	Clerical & General Office Expenses	59,008	26,023	20,721	105,752		105,752	(9,797)	95,955		21
22	Employee Benefits & Payroll Taxes			278,661	278,661		278,661	(48,744)	229,917		22
23	Inservice Training & Education			447	447		447	115	562		23
24	Travel and Seminar			795	795		795	567	1,362		24
25	Other Admin. Staff Transportation			8,037	8,037	(4,019)	4,018	(607)	3,411		25
26	Insurance-Prop.Liab.Malpractice			45,523	45,523		45,523	(5,934)	39,589		26
27	Other (specify):* See Att Sch V	37,498		736	38,234		38,234	(38,234)			27
28	TOTAL General Administration	169,726	26,023	541,426	737,175	(4,019)	733,156	(139,593)	593,563		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,683,219	474,228	976,513	3,133,960		3,133,960	(495,727)	2,638,233		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 Manor Court of Freeport #0046839 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			273,405	273,405	273,405	(54,564)	218,841			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			501,768	501,768	501,768	(106,721)	395,047			32
33	Real Estate Taxes			109,000	109,000	109,000	(25,070)	83,930			33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			3,614	3,614	3,614		3,614			35
36	Other (specify):*										36
37	TOTAL Ownership			887,787	887,787	887,787	(186,355)	701,432			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops			2,015	2,015	2,015		2,015			41
42	Provider Participation Fee			24,638	24,638	24,638		24,638			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			26,653	26,653	26,653		26,653			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,683,219	474,228	1,890,953	4,048,400	4,048,400	(682,082)	3,366,318			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 Manor Court of Freeport

0046839

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(460)	V-32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		V-27		24
25	Fund Raising, Advertising and Promotional	(21,790)	V-20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Att Sch VI	(682,627)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (704,877)		\$	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 See Att Sch III	22,795		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 22,795		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (682,082)		37

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

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

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

BHF USE ONLY					
48		49		50	51
					52

Manor Court of Freeport

ID# 0046839

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Facility Name & ID Number Manor Court of Freeport

0046839

Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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
Residential Alternatives of Illinois, Inc. (Non-Profit Organization)	100	See Attached Schedule I		Residential Alternatives of Iowa (Common Board of Directors)	Coralville, Iowa	Long-term care

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

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

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

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

Facility Name & ID Number

Manor Court of Freeport

#

0046839

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	See Attached Schedules III								\$ 2,027	18-7	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	\$ 2,027		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 Manor Court of Freeport

0046839 Report Period Beginning: 01/01/2007

Ending: 2/31/2007

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 Residential Alternatives of Illinois, Inc.
 Street Address 285 S. Farnham
 City / State / Zip Code Galesburg, IL 61401
 Phone Number (309) 343-1550
 Fax Number (309) 343-2857

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	See Attached Schedule II & III							29,480	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 29,480	25

Facility Name & ID Number

Manor Court of Freeport

0046839

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1	Edwin Enterprises, LLC		X	Purchase facility -	See Att Sch XII	01/01/06	\$ 6,389,163	\$ 6,179,570	11/30/2015	6.0000	\$ 386,361	1						
2				SNF & SC portion								2						
3												3						
4												4						
5												5						
	Working Capital																	
6	Home office Allocation Adj	X		See Attached Schedule III							9,146	6						
7	Less Interest Income			from page 5, line 10							(460)	7						
8												8						
9	TOTAL Facility Related						\$ 6,389,163	\$ 6,179,570			\$ 395,047	9						
	B. Non-Facility Related*																	
10												10						
11	Edwin Enterprises, LLC		X	Facility purchase	See Att Sch XII	01/01/06	1,901,337	1,845,845	11/30/2015	6.0000	115,407	11						
12				ALC portion								12						
13												13						
14	TOTAL Non-Facility Related						\$ 1,901,337	\$ 1,845,845			\$ 115,407	14						
15	TOTALS (line 9+line14)						\$ 8,290,500	\$ 8,025,415			\$ 510,454	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # _____* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

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 2006 report.		\$	111,606	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.)		\$	108,939	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,667)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	111,667	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.		\$	109,000	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2002	<u>N/A</u>	<u>8</u>	
	2003	<u>N/A</u>	<u>9</u>	
	2004	<u>N/A</u>	<u>10</u>	
	2005	<u>N/A</u>	<u>11</u>	
	2006	<u>154,939</u>	<u>12</u>	
R.E. tax accrual estimate is based on estimated real estate tax expense for the SNF bldg.				
This facility is leased from an unrelated for-profit third party. The lease agreement requires the lessee to pay the real estate taxes.				
		FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2006	\$	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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manor Court of Freeport COUNTY Stephenson

FACILITY IDPH LICENSE NUMBER 0046839

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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>18-13-35-332-006</u>	<u>Lot 71 Deer Creek Section 3</u>	\$ <u>154,939.00</u>	\$ <u>154,939.00</u>
2. _____	<u>2170 Navajo Dr Freeport, IL</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>154,939.00</u>	\$ <u>154,939.00</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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 Manor Court of Freeport

0046839 Report Period Beginning:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,906 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

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

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

None

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

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility- SNF, SC</u>	<u>36,814</u>	<u>2006</u>	<u>\$ 115,320</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	36,814		\$ 115,320	3

Facility Name & ID Number Manor Court of Freeport

0046839

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	45		2006		\$ 2,347,908	\$ 58,698	40	\$ 58,698	\$	\$ 117,396	4
5	33		2006		3,330,573	83,264	40	83,264		166,528	5
6											6
7											7
8											8
Improvement Type**											
9	Security Fence		2006		4,940	618	8	618		721	9
10	Parking lot, Sidewalks and Grading SNF		2006		77,240	3,862	20	3,862		7,724	10
11	Parking lot, sidewalks, and Grading, SC		2006		108,329	5,416	20	5,416		10,832	11
12	Sign		2007		5,200	173	10	173		173	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

*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 Manor Court of Freeport

0046839

Report Period Beginning:

01/01/2007

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12/31/2007

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 5,874,190	\$ 152,031		\$ 152,031	\$	\$ 303,374	70

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

Facility Name & ID Number Manor Court of Freeport # 0046839 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	\$ 548,389	\$ 62,272	\$ 62,272	\$	3-15 yrs	\$ 128,579	71
72	Current Year Purchases	6,000	550	550		10 yrs	550	72
73	Fully Depreciated Assets							73
74	Indirect costs		263	263				74
75	TOTALS	\$ 554,389	\$ 63,085	\$ 63,085	\$		\$ 129,129	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2006 Toyota Corolla	2006	\$ 14,900	\$ 3,725	\$ 3,725	\$	4	\$ 5,898	76
77										77
78										78
79										79
80	TOTALS			\$ 14,900	\$ 3,725	\$ 3,725	\$		\$ 5,898	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)	\$ 6,558,799	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 218,841	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 218,841	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 438,401	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	Land ALC- 2006	\$ 34,680	\$	\$	86
87	Land Impr ALC 2006	55,806	2,790	5,580	87
88	Facility ALC- 2006	1,720,644	43,016	86,032	88
89	Equipment ALC 2006	90,207	9,021	18,042	89
90					90
91	TOTALS	\$ 1,901,337	\$ 54,827	\$ 109,654	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 Manor Court of Freeport

0046839

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	<u>/2008</u>	\$	<u>N/A</u>
13.	<u>/2009</u>	\$	<u>N/A</u>
14.	<u>/2010</u>	\$	<u>N/A</u>

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 N/A.

N/A
N/A

9. Option to Buy: YES NO Terms: N/A*

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: \$ N/A Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

Facility Name & ID Number Manor Court of Freeport# 0046839

Report Period Beginning:

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12/31/2007

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

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

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Manor Court of Freeport# 0046839Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 644,196	\$	1
2	Cash-Patient Deposits	485		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	293,562		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,711		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interdivision Recble</u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 987,954	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	150,000		13
14	Buildings, at Historical Cost	7,399,125		14
15	Leasehold Improvements, at Historical Cost	251,515		15
16	Equipment, at Historical Cost	659,496		16
17	Accumulated Depreciation (book methods)	(548,055)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,912,081	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,900,035	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,348	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	485		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	40,922		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,077		31
32	Accrued Real Estate Taxes(Sch.IX-B)	111,667		32
33	Accrued Interest Payable	40,844		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Interdivision Payable</u>	2,253,378		36
37	<u>Accrued fines and penalties</u>	10,000		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,462,721	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	8,025,415		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	<u>Security deposits</u>	93,000		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 8,118,415	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 10,581,136	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,681,101)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,900,035	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,334,793)	1
2	Restatements (describe):		2
3	See Attached Schedule X	(51,253)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,386,046)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(295,055)	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)	\$ (295,055)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,681,101)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manor Court of Freeport# 0046839Report Period Beginning: 01/01/2007Ending: 12/31/2007**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	\$ 3,720,369	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,720,369	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	(150)	6
7	Oxygen	19,835	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 19,685	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,049	13
14	Non-Patient Meals	687	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,736	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	460	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 460	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached Schedule VII</u>	2,410	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,410	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,746,660	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	718,776	31
32	Health Care	1,678,009	32
33	General Administration	730,490	33
B. Capital Expense			
34	Ownership	887,787	34
C. Ancillary Expense			
35	Special Cost Centers	2,015	35
36	Provider Participation Fee	24,638	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,041,715	40
41	Income before Income Taxes (line 30 minus line 40)**	(295,055)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (295,055)	43

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

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

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

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

Facility Name & ID Number Manor Court of Freeport

0046839

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

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	1,961	2,086	\$ 54,365	\$ 26.06	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	4,820	5,128	116,041	22.63	3
4	Licensed Practical Nurses	10,948	11,647	212,550	18.25	4
5	CNAs & Orderlies	67,684	72,005	672,524	9.34	5
6	CNA Trainees					6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides			0		8
9	Activity Director	6,765	7,197	61,172	8.50	9
10	Activity Assistants			0		10
11	Social Service Workers	1,812	1,928	26,416	13.70	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,851	13,671	128,785	9.42	15
16	Dishwashers					16
17	Maintenance Workers	3,228	3,434	31,351	9.13	17
18	Housekeepers	10,275	10,931	94,550	8.65	18
19	Laundry	3,649	3,882	33,386	8.60	19
20	Administrator	1,082	1,151	35,965	31.25	20
21	Assistant Administrator	1,707	1,816	30,570	16.83	21
22	Other Administrative	1,686	1,793	37,498	20.91	22
23	Office Manager					23
24	Clerical	4,484	4,770	59,008	12.37	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	352	374	7,018	18.76	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	627	667	6,665	9.99	31
32	Other Health Care(specify)	3,948	4,200	68,670	16.35	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	137,879	146,680	\$ 1,676,534 *	\$ 11.43	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	***	\$ 4,278	1-3	35
36	Medical Director	***	6,000	9-3	36
37	Medical Records Consultant	***	0	10-3	37
38	Nurse Consultant	***	0	10-3	38
39	Pharmacist Consultant	***	1,500	10-3	39
40	Physical Therapy Consultant	***	122,063	10a-3	40
41	Occupational Therapy Consultant	***	111,316	10a-3	41
42	Respiratory Therapy Consultant	***	0	10a-3	42
43	Speech Therapy Consultant	***	7,655	10a-3	43
44	Activity Consultant	***	0	11-3	44
45	Social Service Consultant	***	0	12-3	45
46	Other(specify) <u>Dental Consultant</u>	***	0	10-3	46
47					47
48	<u>*** Monthly fee</u>				48
49	TOTAL (lines 35 - 48)		\$ 252,812		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Andres Barbelas	Administrator	None	\$ 35,965	Workers' Compensation Insurance	\$ 81,269	IDPH License Fee	\$ 0		
Lori Enzler	Asst Admin	None	30,570	Unemployment Compensation Insurance	8,350	Advertising: Employee Recruitment	6,634		
				FICA Taxes	128,273	Health Care Worker Background Check	0		
				Employee Health Insurance	52,261	(Indicate # of checks performed <u>100</u>)	1,000		
				Employee Meals	0	Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*	0	Advertising - Promotion & Yellow pgs	21,790		
See Attached Schedule III	Indirect Costs	N/A	6,685	401(k)	5,827	Subscriptions	3,145		
TOTAL (agree to Schedule V, line 17, col. 1)				Other Employee Benefits	2,681	IHCA Dues	1,776		
(List each licensed administrator separately.)			\$ 73,220			Other Licenses and Fees	4,574		
B. Administrative - Other						Indirect Costs- See Att Sch III & Sch VI	(1,334)		
Description			Amount	Less allocation for ALC portion	(49,773)	Less: Public Relations Expense	()		
			\$	Indirect Costs - See Att Schedule III	1,029	Non-allowable advertising	(21,790)		
						Yellow page advertising	()		
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 229,917	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 15,795		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount	
C. Professional Services							Out-of-State Travel	\$	
Vendor/Payee	Type		Amount						
RFMS, Inc.	Administrative Services		\$ 72,000				In-State Travel		
McGladrey & Pullen, LLP	Accounting Services		9,140				Staff use of personal vehicle on facility		
Duane Morris LLP	Legal Services		47,788				business and meals (under \$250 per		
DrinkerBiddleGardner Car	Legal Services		1,306				travel voucher	0	
Crain Miller	Legal Services		16,682				Seminar Expense	795	
Foley & Lardner LLP	Legal Services		671				Less: non-allowable out-of-statetravel	0	
							Indirect costs - See Att Sch III	567	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 147,587				TOTAL	\$ 1,362	

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. See Page 21 Section F
- (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
- (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? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 8,732 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 24,638
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. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 687
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: McGladrey & Pullen, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit not yet completed
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, 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.