

		FOR BHF USE					

LL1

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: 0027581

Facility Name: Manorcare at Champaign

Address: 309 East Springfield Champaign 61820
 Number City Zip Code

County: Champaign

Telephone Number: (217) 352-5135 **Fax #** (217) 352-9139

HFS ID Number: 520886946008

Date of Initial License for Current Owners: 11/01/1981

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 06/01/2006 to 05/31/2007 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) <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 Champaign

0027581 Report Period Beginning: 06/01/2006 Ending: 05/31/2007

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 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	102	Skilled (SNF)	102	37,230	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	102	TOTALS	102	37,230	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	0	13,971	15,754	29,725	8
9	SNF/PED					9
10	ICF	4,350			4,350	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,350	13,971	15,754	34,075	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.53%

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)

Not Applicable

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 11/01/1981

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

YES Date 11/01/1981 NO

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

YES NO If YES, enter number of beds certified 102 and days of care provided 11,032

Medicare Intermediary HighMark Medicare Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 05/31/07

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

Facility Name & ID Number Manorcare at Champaign # 0027581 Report Period Beginning: 06/01/2006 Ending: 05/31/2007

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	242,419	20,320	44,304	307,043	2,670	309,713		309,713			1
2	Food Purchase		215,333		215,333		215,333	(13,287)	202,046			2
3	Housekeeping	105,199	17,148	555	122,902		122,902		122,902			3
4	Laundry	60,086	14,708	11,169	85,963		85,963		85,963			4
5	Heat and Other Utilities			138,102	138,102	6,257	144,359	(8,577)	135,782			5
6	Maintenance	64,472	44,492	60,359	169,323		169,323		169,323			6
7	Other (specify):* Med Waste			1,400	1,400		1,400		1,400			7
8	TOTAL General Services	472,176	312,001	255,889	1,040,066	8,927	1,048,993	(21,864)	1,027,129			8
	B. Health Care and Programs											
9	Medical Director			25,000	25,000		25,000		25,000			9
10	Nursing and Medical Records	2,250,382	208,189	81,665	2,540,236	4,229	2,544,465	(10,188)	2,534,277			10
10a	Therapy	368,042	9,712	693,631	1,071,385		1,071,385		1,071,385			10a
11	Activities	66,708	3,483	2,253	72,444		72,444		72,444			11
12	Social Services	122,222	135	740	123,097		123,097		123,097			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,807,354	221,519	803,289	3,832,162	4,229	3,836,391	(10,188)	3,826,203			16
	C. General Administration											
17	Administrative	90,643		404,209	494,852	(100,667)	394,185		394,185			17
18	Directors Fees											18
19	Professional Services			3,316	3,316	(3,032)	284	(284)				19
20	Dues, Fees, Subscriptions & Promotions			80,687	80,687		80,687	(47,720)	32,967			20
21	Clerical & General Office Expenses	214,373	56,459	446,970	717,802	3,032	720,834	(387,474)	333,360			21
22	Employee Benefits & Payroll Taxes			698,332	698,332	46,138	744,470		744,470			22
23	Inservice Training & Education			5,149	5,149		5,149		5,149			23
24	Travel and Seminar			13,845	13,845		13,845		13,845			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			99,236	99,236		99,236		99,236			26
27	Other (specify):* Pers Purch			8	8		8	(8)				27
28	TOTAL General Administration	305,016	56,459	1,751,752	2,113,227	(54,529)	2,058,698	(435,486)	1,623,212			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,584,546	589,979	2,810,930	6,985,455	(41,373)	6,944,082	(467,538)	6,476,544			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 Champaign #0027581 Report Period Beginning: 06/01/2006 Ending: 05/31/2007

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			212,672	212,672	15,760	228,432		228,432		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			219,318	219,318	25,613	244,931		244,931		32
33	Real Estate Taxes			50,018	50,018		50,018	1,026	51,044		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			186,335	186,335		186,335		186,335		35
36	Other (specify):* G/L Assets			1,472	1,472		1,472	(1,472)			36
37	TOTAL Ownership			669,815	669,815	41,373	711,188	(446)	710,742		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		381,941	62,489	444,430		444,430		444,430		39
40	Barber and Beauty Shops			12,417	12,417		12,417		12,417		40
41	Coffee and Gift Shops	80,888			80,888		80,888		80,888		41
42	Provider Participation Fee			55,845	55,845		55,845		55,845		42
43	Other (specify):* IV Therapy		53,754		53,754		53,754		53,754		43
44	TOTAL Special Cost Centers	80,888	435,695	130,751	647,334		647,334		647,334		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,665,434	1,025,674	3,611,496	8,302,604		8,302,604	(467,984)	7,834,620		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 Champaign

0027581

Report Period Beginning:

06/01/2006

Ending:

05/31/2007

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	(13,287)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,577)	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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	2,952	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(5,945)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(90,781)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(284)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(295,921)	21		24
25	Fund Raising, Advertising and Promotional	(47,720)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	1,026	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(9,447)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (467,984)		\$	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))	\$ (467,984)		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		52

Manorcare at Champaign

ID# 0027581

Report Period Beginning: 06/01/2006

Ending: 05/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Phone	\$ (186)	21	1
2	G/L Assets	(1,472)	36	2
3	Customer Reimbursement	(3,222)	21	3
4	Transportation Revenue	(4,148)	10	4
5	Purchase Svc-Phys Care	(95)	10	5
6	Personal Purchases	(8)	27	6
7	Donations	(66)	21	7
8	Hospitality Income	(250)	21	8
9			41	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	(9,447)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Champaign# 0027581

Report Period Beginning:

06/01/2006

Ending:

05/31/2007**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	(13,287)	0	0	0	0	0	0	0	0	0	0	(13,287)	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	(8,577)	0	0	0	0	0	0	0	0	0	0	(8,577)	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	(21,864)	0	0	0	0	0	0	0	0	0	0	(21,864)	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	(10,188)	0	0	0	0	0	0	0	0	0	0	(10,188)	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	(10,188)	0	0	0	0	0	0	0	0	0	0	(10,188)	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	(284)	0	0	0	0	0	0	0	0	0	0	(284)	19
20	Fees, Subscriptions & Promotions	(47,720)	0	0	0	0	0	0	0	0	0	0	(47,720)	20
21	Clerical & General Office Expenses	(387,474)	0	0	0	0	0	0	0	0	0	0	(387,474)	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):*	(8)	0	0	0	0	0	0	0	0	0	0	(8)	27
28	TOTAL General Administration	(435,486)	0	0	0	0	0	0	0	0	0	0	(435,486)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(467,538)	0	0	0	0	0	0	0	0	0	0	(467,538)	29

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Champaign

0027581

Report Period Beginning:

06/01/2006 Ending:

Summary B

05/31/2007

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	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	1,026	0	0	0	0	0	0	0	0	0	0	1,026	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):*	(1,472)	0	0	0	0	0	0	0	0	0	0	(1,472)	36
37	TOTAL Ownership	(446)	0	(446)	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)	(467,984)	0	(467,984)	45									

Facility Name & ID Number Manorcare at Champaign

0027581

Report Period Beginning: 06/01/2006 Ending: 05/31/2007

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
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	\$ 404,209	HCR Manor Care, Inc	100.00%	\$ 404,209	\$	1
2	V	Page						2
3	V	8						3
4	V							4
5	V							5
6	V	10a Therapy Management	31,610	Heartland Management Services	100.00%	31,610		6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 435,819			\$ 435,819	\$ *	14

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

Facility Name & ID Number

Manorcare at Champaign

0027581

Report Period Beginning: 06/01/2006

Ending:

05/31/2007

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	Not Applicable								\$	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 Champaign

0027581

Report Period Beginning: 06/01/2006

Ending: 5/31/2007

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac	\$	\$	7,461,734	\$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	1,156,548	625,878	7,461,734	2,670	2
3	5	Utilities - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac	500,452		7,461,734	1,433	3
4	5	Utilities - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	2,089,736		7,461,734	4,824	4
5	10	Nursing - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac			7,461,734	0	5
6	10	Nursing - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	1,831,963	1,296,078	7,461,734	4,229	6
7	17	General & Admin - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac	41,206,110	32,327,667	7,461,734	118,031	7
8	17	General & Admin - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	80,368,229	42,462,992	7,461,734	185,511	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac	8,458,198		7,461,734	24,228	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	9,492,178		7,461,734	21,910	10
11	30	Depreciation - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac			7,461,734	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	6,827,559		7,461,734	15,760	12
13										13
14	32	Interest							25,613	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 151,930,973	\$ 76,712,615		\$ 404,209	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Conv Sub Debentures		X	Facility			\$ 522,057	\$ 522,057		\$ 25,613	1									
2	City of Champaign						619,571			49,159	2									
3	National City Bank, Trustee						280,211	280,211		17,508	3									
4	City of Champaign - Debt Discount						(152,652)			152,651	4									
5											5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related						\$ 1,269,187	\$ 802,268		\$ 244,931	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$	14									
15	TOTALS (line 9+line14)						\$ 1,269,187	\$ 802,268		\$ 244,931	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2006 report.		\$ 48,445	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.)		\$ 49,471	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 1,026	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 50,018	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.		\$ 51,044	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	42,434	8
	2003	45,094	9
	2004	48,050	10
	2005	48,924	11
	2006	50,018	12
	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 Manorcare at Champaign COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0027581

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 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>46-21-18-103-003</u>	<u>See Attached</u>	\$ <u>20,961.85</u>	\$ <u>20,961.85</u>
2. <u>46-21-18-103-011</u>	<u>See Attached</u>	\$ <u>765.04</u>	\$ <u>765.04</u>
3. <u>46-21-18-103-012</u>	<u>See Attached</u>	\$ <u>1,326.14</u>	\$ <u>1,326.14</u>
4. <u>46-21-18-103-020</u>	<u>See Attached</u>	\$ <u>951.34</u>	\$ <u>951.34</u>
5. <u>46-21-18-103-021</u>	<u>See Attached</u>	\$ <u>1,004.62</u>	\$ <u>1,004.62</u>
6. <u>46-21-18-103-003</u>	<u>See Attached</u>	\$ <u>20,961.85</u>	\$ <u>20,961.85</u>
7. <u>46-21-18-103-011</u>	<u>See Attached</u>	\$ <u>765.04</u>	\$ <u>765.04</u>
8. <u>46-21-18-103-012</u>	<u>See Attached</u>	\$ <u>1,326.14</u>	\$ <u>1,326.14</u>
9. <u>46-21-18-103-020</u>	<u>See Attached</u>	\$ <u>951.34</u>	\$ <u>951.34</u>
10. <u>46-21-18-103-021</u>	<u>See Attached</u>	\$ <u>1,004.62</u>	\$ <u>1,004.62</u>
	TOTALS	\$ <u>50,017.98</u>	\$ <u>50,017.98</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 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 Manorcare at Champaign

0027581

Report Period Beginning:

06/01/2006 Ending:

05/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,745 B. General Construction Type: Exterior Masonry Frame Steel, Fire Resistant Number of Stories 3

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).

Not Applicable

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1968</u>	<u>\$ 54,050</u>	1
2			<u>2007</u>	<u>227,000</u>	2
3	TOTALS			\$ 281,050	3

Facility Name & ID Number Manorcare at Champaign

0027581

Report Period Beginning:

06/01/2006 Ending: 05/31/2007

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	102			1968	\$ 1,201,229	\$ (11,217)		\$ (11,217)	\$	\$ 1,356,262	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements (Current Year Depreciation)					107,315		107,315		1,589,333	9
10				1985	3,107						10
11				1986	8,851						11
12				1987	74,516						12
13				1987	(55,068)						13
14				1988	41,139						14
15				1989	1,297						15
16				1990	20,319						16
17				1991	50,575						17
18				1992	374,174						18
19		RETIREMENTS		1992	(6,784)						19
20				1993	51,354						20
21				1994	48,400						21
22				1995	229,982						22
23		ELECTRICAL WORK		1996	17,102						23
24		WALLVINYL		1996	10,548						24
25		VINYL FLOORING		1996	14,858						25
26		INSTALL CAMERA SYSTEM		1996	1,453						26
27		REMODEL 13 ROOMS AND LOBBY		1996	35,665						27
28		HVAC		1996	21,101						28
29		ROOF WORK		1996	1,365						29
30		CORPORATE OVERHEAD-13 ROOMS/LOBBY		1996	7,272						30
31		CONCRETE WORK		1996	3,880						31
32		CARPET		1996	5,900						32
33		DIGITAL KEYPAD		1996	1,915						33
34		INSTALL EMERGENCY GENERATOR		1996	44,791						34
35		INSTALL CIRCUIT BREAKER		1996	3,289						35
36		HVAC		1996	1,867						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 Champaign

0027581

Report Period Beginning:

06/01/2006 Ending: 05/31/2007

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	INSTALL COVE BASE/SIGNS	1996	\$ 2,612	\$		\$	\$	\$	37
38	C/R 5/31/99 AUDIT ADJ. - CAPITAL LABOR	1996	(7,272)						38
39	WALLCOVERINGS	1997	12,165						39
40	CARPET	1997	1,639						40
41	INSTALL HYDROLIC CYLINDER	1997	14,249						41
42	UNIT PROTECTION SWITCH	1997	6,354						42
43	FURNISH/INSTALL TILES	1997	16,476						43
44	HANDRAILS	1997	5,661						44
45	PLUMBING	1997	7,610						45
46	VINYL TILE	1997	1,643						46
47	HAND RAILS	1997	1,450						47
48	FACILITY PLAN ALLOC	1997	2,759						48
49	INSTALL GATES	1997	1,226						49
50	CORNER GUARDS	1997	314						50
51	C/R 5/31/99 AUDIT ADJ. - ALLOC. FAC. PLAN	1997	(2,758)						51
52	ELECTRICAL	1998	2,598						52
53	REPLACE WINDOWS	1998	2,763						53
54	INSTALL QUARRY TILE	1998	1,640						54
55	INSTALL DUCTWORK	1998	2,350						55
56	CORPORATE OVERHEAD	1998	1,702						56
57	SECURITY SYSTEM	1998	33,542						57
58	ENTRYWAY/PARKING LOT WORK	1998	2,209						58
59	ELEVATOR EQP EVAL	1998	700						59
60	CARPENTRY	1998	355						60
61	WALLPAPER	1998	400						61
62	CARPETING/FLOORING	1998	2,471						62
63	PLUMBING	1998	9,690						63
64	ELECTRICAL	1998	1,367						64
65	HVAC	1998	565						65
66	PAINTING/WALLCOVERING	1998	10,552						66
67	GENERAL REQ	1998	1,500						67
68	CONTRACTORS	1998	2,507						68
69	ROOFING	1998	500						69
70	TOTAL (lines 4 thru 69)		\$ 2,355,636	\$ 96,098		\$ 96,098	\$	\$ 2,945,595	70

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

Facility Name & ID Number Manorcare at Champaign

0027581

Report Period Beginning:

06/01/2006 Ending: 05/31/2007

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		\$ 2,355,636	\$ 96,098		\$ 96,098	\$	\$ 2,945,595	1
2	C/R 5/31/99 AUDIT ADJ. - CORPORATE O/H	1998	(1,702)						2
3	DOOR/WINDOW	1998	2,456						3
4	ELEVATORS	1998	3,433						4
5	SIGNAGE	1998	11,862						5
6	CARPETING	1999	5,993						6
7	CALL LIGHT SYSTEM	1999	42,342						7
8	1997 BILLING FOR CONSTRUCTION	1999	20,476						8
9	INSTALL SECURE DOOR KIT	1999	3,753						9
10	FABRIC FOR PATIENT FURNITURE	1999	121						10
11	Reclass to Equipment - 7/22/04 IDPH verbal Adj.	1999	(121)						11
12	PLUMBING PARTS, LABOR, SHOWER RENOVATION	1999	900						12
13	FABRIC FOR PATIENT FURNITURE	1999	674						13
14	Reclass to Equipment - 7/22/04 IDPH verbal Adj.	1999	(674)						14
15	PAINT, WALLPAPER, CORRIDOR	1999	8,471						15
16	FIRE-SMOKE DAMPERS	1999	(581)						16
17	REMODEL KITCHEN RECEPTACLES	1999	4,800						17
18	NEW SHOWER BASE	1999	6,870						18
19	DISCOUNT, CAIN'S ROOFING	1999	(2,221)						19
20	CERAMIC TILE - 2 SHOWERS	1999	2,718						20
21	FIRE & SMOKE DAMPERS	1999	9,527						21
22	PROCARE 1000 NURSE CALL	1999	17,494						22
23	ZSN REPAIR	1999	1,307						23
24	DRAIN REPLACEMENT	2000	875						24
25	DRYWALL REPAIR	2000	600						25
26	CONTROL PANEL REPLACED	2000	984						26
27	WIRING FOR CAMERA SECURITY SYSTEM	2000	6,979						27
28	WALLCOVERINGS	2000	364						28
29	VINYL WALLCOVERINGS	2000	1,662						29
30	WALLCOVERING	2000	1,566						30
31	CLOSET DOORS	2000	13,140						31
32	WALLCOVERING	2000	37						32
33	WALLCOVERING - DINING RM	2000	1,769						33
34	TOTAL (lines 1 thru 33)		\$ 2,521,510	\$ 96,098		\$ 96,098	\$	\$ 2,945,595	34

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

Facility Name & ID Number Manorcare at Champaign

0027581

Report Period Beginning:

06/01/2006 Ending: 05/31/2007

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		\$ 2,521,510	\$ 96,098		\$ 96,098	\$	\$ 2,945,595	1
2	WALL & FLOOR TILE - ARCADIA BATH	2000	3,780						2
3	CORNER GUARDS	2000	17						3
4	PAINTING & WALLCOVERING - CLOSET DOORS	2000	3,959						4
5	WALLCOVERING	2000	270						5
6	DEVELOPERS COST - ACTIVITY, LOUNGE RENOV	2000	4,708						6
7	C/R 5/31/03 AUDIT ADJ #1a - Developers Cost	2000	(4,708)						7
8	WALLCOVERING - ACTIVITY, LOUNGE RENOV	2000	6,102						8
9	VCT	2000	3,230						9
10	WIRING - ACTIVITY & REC RM	2000	1,412						10
11	ACTIV LOUNGE & BEAUTY SHOP REN	2000	1,520						11
12	PAINTING CLOSET DOORS	2000	8,000						12
13	SINK, FAUCET & PLUMBING	2000	1,985						13
14	ARCADIA HALL BATH	2000	3,933						14
15	CREDIT ON WALLCOVERING V#2072	2000	(1,566)						15
16	CLOSET DOORS	2000	7,640						16
17	SHOWER-CERAMIC TILE	2000	302						17
18	CLOSET DOOR - RETAINAGE	2000	1,460						18
19	ADDTL COST CERAMIC TILE - 2 SHOWERS	2001	203						19
20	2 NURSE STATIONS	2001	12,826						20
21	BORDER	2001	210						21
22	VCT	2001	1,130						22
23	GLASS DOORS (MAIN ENTRANCE)	2001	1,305						23
24	DOORS	2001	8,985						24
25	CARPET	2001	1,053						25
26	CEILING TILE	2001	28,650						26
27	SHOWER RENOVATION	2001	13,048						27
28	PAINTING	2001	765						28
29	COURTYARD RENOVATIONS	2001	4,775						29
30	COURTYARD RENOVATIONS	2001	5,120						30
31	DOORS	2002	746						31
32	CARPET	2002	995						32
33	WALL TILE FOR SHOWER	2002	1,840						33
34	TOTAL (lines 1 thru 33)		\$ 2,645,205	\$ 96,098		\$ 96,098	\$	\$ 2,945,595	34

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

Facility Name & ID Number Manorcare at Champaign

0027581

Report Period Beginning:

06/01/2006 Ending: 05/31/2007

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		\$ 2,645,205	\$ 96,098		\$ 96,098	\$	\$ 2,945,595	1
2	MILLWORK, ELECTRICAL	2002	14,351						2
3	CARPET	2002	1,686						3
4	Freight on Carpet	2002	73						4
5	VWC	2002	282						5
6	3 Heavy Duty Doors	2002	3,574						6
7	C/R 5/31/03 AUDIT ADJ #1b - Overhead & Interest	2002	(5,444)						7
8	Painting, VWC, and Flooring	2002	1,098						8
9	Painting, VWC, and Flooring	2002	524						9
10	Renovation - Electrical 5/31/03 Audit Adj #2a Change Year	2002	87,505						10
11	Arch Engineering Costs	2002	1,018						11
12	freight on vwc	2002	9						12
13	general construction	2002	1,169						13
14	Freight on Carpet	2002	112						14
15	Carpet	2002	1,170						15
16	border	2002	1,254						16
17	freight on vwc	2002	20						17
18	carpet	2002	953						18
19	carpet and installation	2002	16,878						19
20	VWC	2002	140						20
21	carpet	2002	953						21
22	paint, vwc, and flooring	2002	9,357						22
23	Retro Addition	2002	(231)						23
24	VWC	2003	2,980						24
25	Flooring	2003	445						25
26	Reno - Gen. fire, Doors&P Audit Adj #2b Change Yr 2001 & 2002	2003	60,845						26
27	C/R 5/31/03 AUDIT ADJ #2b - Overhead & Interest	2003	(60,845)						27
28	Renovation - 5/31/03 Audit Adj #2b Change Year 2001	2001	88,776						28
29	Renovation - 5/31/03 Audit Adj #2b Change Year 2002	2002	6,593						29
30	Arch Engineering Costs	2003	172						30
31	Arch Engineering Costs	2003	774						31
32	Carpet	2003	140						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,881,535	\$ 96,098		\$ 96,098	\$	\$ 2,945,595	34

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

Facility Name & ID Number Manorcare at Champaign

0027581

Report Period Beginning:

06/01/2006 Ending: 05/31/2007

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		\$ 2,881,535	\$ 96,098		\$ 96,098	\$	\$ 2,945,595	1
2	CARPET	2003	1,075						2
3	ELEVATORS - OVERHEAD AND INTEREST	2003	3,300						3
4	ELEVATORS CARPENTRY	2003	72,624						4
5	BORDERS	2003	127						5
6	VWC	2003	438						6
7	VWC	2003	4,080						7
8	VWC	2003	571						8
9	CARPET AND INSTALLATION	2003	4,190						9
10	SHOWER ROOM FLOORS AND WALLS	2003	6,901						10
11	SHOWER ROOM FLOORS AND WALLS	2003	289						11
12	DEVELOPERS COSTS - OVERHEAD	2004	17,971						12
13	DEVELOPERS COSTS - INTEREST	2004	1,099						13
14	CARPETING AND PADS	2004	7,249						14
15	WALLCOVERINGS	2004	46,392						15
16	EXTERIOR LIGHT POLE	2004	6,596						16
17	EXTERIOR LIGHT POLE	2004	687						17
18	CONCRETE SLAB	2005	3,115						18
19	VINYL WALL COVERING	2004	1,377						19
20	VINYL WALL COVERING AND PAINTING	2004	9,000						20
21	VINYL WALL COVERING	2004	938						21
22	VINYL WALL COVERING & PAINTING	2004	1,380						22
23	VINYL WALL COVERING & PAINTING	2004	3,420						23
24	COVE BASE	2004	2,160						24
25	DOORS	2004	5,893						25
26	CARPET	2004	4,275						26
27	INSTALL SECURITY DOOR	2005	2,910						27
28	FOURTEEN ARTWORK PIECES	2004	1,117						28
29	ELECTRICAL WORK	2005	5,926						29
30	STAIR TREDS	2005	5,640						30
31	OVERHEAD	2005	13,558						31
32	INTEREST	2005	805						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,116,638	\$ 96,098		\$ 96,098	\$	\$ 2,945,595	34

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

Facility Name & ID Number Manorcare at Champaign

0027581

Report Period Beginning:

06/01/2006

Ending:

05/31/2007

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 12E, Carried Forward		\$ 3,116,638	\$ 96,098		\$ 96,098	\$	\$ 2,945,595	1
2	FLOORING	2005	8,770						2
3	WALL COVERING	2005	8,050						3
4	CARPENTRY	2005	1,012						4
5	FENCE	2006	5,140						5
6	FENCE	2006	882						6
7	CERAMIC TILE SHOWER	2006	3,949						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	TOTAL (lines 1 thru 33)		\$ 3,144,441	\$ 96,098		\$ 96,098	\$	\$ 2,945,595	34

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

Facility Name & ID Number Manorcare at Champaign # 0027581 Report Period Beginning: 06/01/2006 Ending: 05/31/2007

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	\$ 1,343,689	\$ 116,575	\$ 116,575	\$		\$ 893,251	71
72	Current Year Purchases	65,693						72
73	Fully Depreciated Assets							73
74	Home Office Allocation			15,760	15,760			74
75	TOTALS	\$ 1,409,382	\$ 116,575	\$ 132,335	\$ 15,760		\$ 893,251	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)	\$	4,834,873	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	212,673	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	228,433	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	15,760	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	3,838,846	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	\$ 283,007	92
93			93
94			94
95		\$ 283,007	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 Champaign

0027581

Report Period Beginning: 06/01/2006

Ending: 05/31/2007

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>Not Applicable</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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 186,335 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>Not Applicable</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	4464 hrs	\$ 134,411	9,493	\$ 237,320	\$ 3,130	13,957	\$ 374,861	1
2	Licensed Speech and Language Development Therapist	10a	1510 hrs	45,479	4,313	107,816		5,823	153,295	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	6249 hrs	188,152	13,897	347,432	6,582	20,146	542,166	4
5	Physician Care		visits							5
6	Dental Care		visits			585			585	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescripts				381,941		381,941	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab, X-Ray, Inhalation	10, Col 3, 39				62,967			62,967	13
14	TOTAL			\$ 368,042	27,703	\$ 756,120	\$ 391,653	39,926	\$ 1,515,815	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 Champaign# 0027581Report Period Beginning: 06/01/2006

Ending:

05/31/2007**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 05/31/2007

(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	\$ 96,555	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (374,617))	1,657,015		3
4	Supply Inventory (priced at)	27,869		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,106		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,784,545	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	281,050		13
14	Buildings, at Historical Cost	3,144,440		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,409,382		16
17	Accumulated Depreciation (book methods)	(3,838,846)		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>	283,007		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,279,033	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,063,578	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 29,906	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	397,267		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	50,018		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>	154,908		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 632,099	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	280,211		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)	\$ 280,211	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 912,310	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,151,268	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,063,578	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 779,146	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 779,146	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	855,670	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)	\$ 855,670	17
B. Transfers (Itemize):			
18	Change in Interdivision	516,452	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 516,452	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,151,268	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare at Champaign# 0027581Report Period Beginning: 06/01/2006Ending: 05/31/2007**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	\$ 6,007,315	1
2	Discounts and Allowances for all Levels	146,661	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,153,976	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,510,105	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,510,105	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	1,298	12
13	Barber and Beauty Care	12,617	13
14	Non-Patient Meals	12,021	14
15	Telephone, Television and Radio	186	15
16	Rental of Facility Space		16
17	Sale of Drugs	426,846	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29,892	19
20	Radiology and X-Ray	7,380	20
21	Other Medical Services	4,819	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 495,059	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	(866)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (866)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,158,274	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,040,066	31
32	Health Care	3,832,162	32
33	General Administration	2,113,227	33
B. Capital Expense			
34	Ownership	669,815	34
C. Ancillary Expense			
35	Special Cost Centers	647,334	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)*	\$ 8,302,604	40
41	Income before Income Taxes (line 30 minus line 40)**	855,670	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 855,670	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 Champaign

0027581

Report Period Beginning: 06/01/2006

Ending:

05/31/2007

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	2,224	2,416	\$ 75,512	\$ 31.25	1
2	Assistant Director of Nursing	1,974	2,145	57,544	26.83	2
3	Registered Nurses	24,088	26,173	616,259	23.55	3
4	Licensed Practical Nurses	24,158	26,249	490,338	18.68	4
5	CNAs & Orderlies	78,219	84,991	930,027	10.94	5
6	CNA Trainees					6
7	Licensed Therapist	10,800	10,800	325,212	30.11	7
8	Rehab/Therapy Aides	890	3,192	42,830	13.42	8
9	Activity Director					9
10	Activity Assistants	5,795	6,308	66,708	10.58	10
11	Social Service Workers	12,737	13,801	203,110	14.72	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,823	22,661	242,419	10.70	15
16	Dishwashers					16
17	Maintenance Workers	3,179	3,453	64,472	18.67	17
18	Housekeepers	10,189	11,095	105,199	9.48	18
19	Laundry	4,725	5,141	60,086	11.69	19
20	Administrator	2,332	2,332	79,824	34.23	20
21	Assistant Administrator	542	542	10,819	19.96	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,829	13,227	214,373	16.21	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	5,424	5,897	80,702	13.69	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	219,928	240,423	\$ 3,665,434 *	\$ 15.25	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	25,000	Ln 9, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 25,000		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	231	2,523	Ln 5, Col 10	52
53	TOTAL (lines 50 - 52)	231	\$ 2,523		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	
Pamella Britt	Administrator	0	\$ 79,824	Workers' Compensation Insurance	\$ 34,149	IDPH License Fee	\$ 1,708	
Christine Kline	Assist Admin	0	10,819	Unemployment Compensation Insurance	60,328	Advertising: Employee Recruitment	18,407	
				FICA Taxes	262,692	Health Care Worker Background Check		
				Employee Health Insurance	303,924	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	285 5,690	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	6,919	
				Other Employee Benefits	16,823	Association Dues	6,621	
				Payroll Overhead Allocated	2	Advertising	50,092	
				401K	17,583	Public Relations/Marketing	(8,750)	
				Employee Uniforms	2,831	Less: Non-Allowable Assoc Dues	(11,199)	
						Less: Public Relations Expense	8,750	
						Non-allowable advertising	(45,271)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
\$ 90,643					\$ 744,470	\$ 32,967		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Home Office			\$ 404,209	Home Office Allocation		46,138	Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL (agree to Schedule V, line 22, col.8)				
\$ 404,209								
C. Professional Services								
Vendor/Payee	Type		Amount					
Michael T Mahoney, LTD	Legal		284				In-State Travel	13,845
Rossmann & Co	Accounting		2,542				Includes travel expense to the Home Office in Toledo, OH for regional meeting	
Theresa Rear	Consulting		490				Seminar Expense	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
\$ 3,316							\$ 13,845	

* 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. IHCA \$ 3,349 Alliance \$ 3,094
- (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 \$ 11,199
- (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. \$ 61,514 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. \$ 55,845
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ (12,021)
- (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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.