

		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: 0027532

Facility Name: Manorcare at Normal

Address: 510 Broadway Normal 61761
 Number City Zip Code

County: McLean

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

HFS ID Number: 520886946006

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/2006 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 Normal

0027532 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 116

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

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

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

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

N/A

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

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

YES NO

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

YES NO

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

Date started 11/01/1981

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 116 and days of care provided 13,801

Medicare Intermediary HighMark Medicare Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>109</u>	Skilled (SNF)	<u>116</u>	<u>41,913</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>109</u>	TOTALS	<u>116</u>	<u>41,913</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>0</u>	<u>11,153</u>	<u>17,276</u>	<u>28,429</u>	8
9	SNF/PED					9
10	ICF	<u>6,200</u>	<u>261</u>	<u>3</u>	<u>6,464</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>6,200</u>	<u>11,414</u>	<u>17,279</u>	<u>34,893</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.25%

Facility Name & ID Number Manorcare at Normal # 0027532 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	176,178	20,308	53,942	250,428	2,455	252,883		252,883			1
2	Food Purchase		206,324		206,324		206,324	(1,376)	204,948			2
3	Housekeeping	121,838	28,931	4,378	155,147		155,147		155,147			3
4	Laundry	44,406	13,497	3,176	61,079		61,079		61,079			4
5	Heat and Other Utilities			148,069	148,069	5,754	153,823	(7,113)	146,710			5
6	Maintenance	39,186	20,545	44,319	104,050		104,050		104,050			6
7	Other (specify):* Med Waste			2,495	2,495		2,495		2,495			7
8	TOTAL General Services	381,608	289,605	256,379	927,592	8,209	935,801	(8,489)	927,312			8
	B. Health Care and Programs											
9	Medical Director			21,800	21,800		21,800		21,800			9
10	Nursing and Medical Records	2,095,143	192,674	65,763	2,353,580	3,889	2,357,469	(37,885)	2,319,584			10
10a	Therapy	318,136	14,371	565,725	898,232		898,232		898,232			10a
11	Activities	64,554	4,628	2,063	71,245		71,245		71,245			11
12	Social Services	105,364	69	1,348	106,781		106,781		106,781			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,583,197	211,742	656,699	3,451,638	3,889	3,455,527	(37,885)	3,417,642			16
	C. General Administration											
17	Administrative	98,821		381,784	480,605	(102,618)	377,987		377,987			17
18	Directors Fees											18
19	Professional Services			6,716	6,716		6,716	(6,716)				19
20	Dues, Fees, Subscriptions & Promotions			86,104	86,104		86,104	(53,435)	32,669			20
21	Clerical & General Office Expenses	221,952	46,319	188,354	456,625		456,625	(108,807)	347,818			21
22	Employee Benefits & Payroll Taxes			613,032	613,032	42,435	655,467		655,467			22
23	Inservice Training & Education			2,444	2,444		2,444		2,444			23
24	Travel and Seminar			37,839	37,839		37,839		37,839			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			108,873	108,873		108,873		108,873			26
27	Other (specify):*											27
28	TOTAL General Administration	320,773	46,319	1,425,146	1,792,238	(60,183)	1,732,055	(168,958)	1,563,097			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,285,578	547,666	2,338,224	6,171,468	(48,085)	6,123,383	(215,332)	5,908,051			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Manorcare at Normal #0027532 Report Period Beginning: 06/01/2006 Ending: 05/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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
	D. Ownership										
30	Depreciation			284,815	284,815	14,494	299,309		299,309		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			61,476	61,476	33,591	95,067	(406)	94,661		32
33	Real Estate Taxes			59,079	59,079		59,079	49,931	109,010		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			122,209	122,209		122,209		122,209		35
36	Other (specify):*										36
37	TOTAL Ownership			527,579	527,579	48,085	575,664	49,525	625,189		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		517,687	85,710	603,397		603,397		603,397		39
40	Barber and Beauty Shops			15,959	15,959		15,959		15,959		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			59,678	59,678		59,678		59,678		42
43	Other (specify):* IV Therapy		24,504		24,504		24,504		24,504		43
44	TOTAL Special Cost Centers		542,191	161,347	703,538		703,538		703,538		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,285,578	1,089,857	3,027,150	7,402,585		7,402,585	(165,807)	7,236,778		45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Manorcare at Normal

0027532

Report Period Beginning: 06/01/2006

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	(1,376)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,113)	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	(406)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	1,858	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(37,145)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(23,885)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,716)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(82,884)	21		24
25	Fund Raising, Advertising and Promotional	(53,435)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	49,931	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(4,636)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (165,807)		\$	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))	\$ (165,807)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Manorcare at Normal

ID# 0027532

Report Period Beginning: 06/01/2006

Ending: 05/31/2007

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Customer Reimbursement	\$ (3,876)	21	1
2	Transportation Revenue	(740)	10	2
3	Donations Revenue	(20)	21	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	(4,636)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Normal

0027532

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	(1,376)	0	0	0	0	0	0	0	0	0	0	(1,376)	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	(7,113)	0	0	0	0	0	0	0	0	0	0	(7,113)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(8,489)	0	0	0	0	0	0	0	0	0	0	(8,489)	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	(37,885)	0	0	0	0	0	0	0	0	0	0	(37,885)	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	(37,885)	0	0	0	0	0	0	0	0	0	0	(37,885)	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	(6,716)	0	0	0	0	0	0	0	0	0	0	(6,716)	19
20	Fees, Subscriptions & Promotions	(53,435)	0	0	0	0	0	0	0	0	0	0	(53,435)	20
21	Clerical & General Office Expenses	(108,807)	0	0	0	0	0	0	0	0	0	0	(108,807)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(168,958)	0	0	0	0	0	0	0	0	0	0	(168,958)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(215,332)	0	0	0	0	0	0	0	0	0	0	(215,332)	29

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Normal# 0027532 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	(406)	0	0	0	0	0	0	0	0	0	0	(406)	32
33	Real Estate Taxes	49,931	0	0	0	0	0	0	0	0	0	0	49,931	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):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	49,525	0	49,525	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)	(165,807)	0	(165,807)	45									

Facility Name & ID Number Manorcare at Normal

0027532

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	\$ 381,784	HCR Manor Care, Inc	100.00%	\$ 381,784	\$
2	V	Page					
3	V	8					
4	V						
5	V						
6	V	10a Therapy Management	25,931	Heartland Management Services	100.00%	25,931	
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 407,715			\$ 407,715	\$ *

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

Facility Name & ID Number

Manorcare at Normal

#

0027532

Report Period Beginning:

06/01/2006

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

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Manorcare at Normal

0027532 Report Period Beginning: 06/01/2006

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) 254-5495

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac	\$	\$	6,862,525	\$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	1,156,548	625,878	6,862,525	2,455	2
3	5	Utilities - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac	500,452		6,862,525	1,318	3
4	5	Utilities - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	2,089,736		6,862,525	4,436	4
5	10	Nursing - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac			6,862,525	0	5
6	10	Nursing - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	1,831,963	1,296,078	6,862,525	3,889	6
7	17	General & Admin - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac	41,206,110	32,327,667	6,862,525	108,552	7
8	17	General & Admin - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	80,368,229	42,462,992	6,862,525	170,614	8
9	22	Employees Benefits - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac	8,458,598		6,862,525	22,283	9
10	22	Employees Benefits - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	9,492,678		6,862,525	20,152	10
11	30	Depreciation - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac			6,862,525	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	6,827,559		6,862,525	14,494	12
13										13
14	32	Interest							33,591	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 151,931,873	\$ 76,712,615		\$ 381,784	25

Facility Name & ID Number

Manorcare at Normal

0027532

Report Period Beginning:

06/01/2006

Ending:

05/31/2007

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	Conv Sub Debentures		X	Facility			\$ 684,665	\$ 684,665			\$ 33,591	1						
2	National City Bank, Trustee						983,699	983,699			61,476	2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8									Interest Income		(406)	8						
9	TOTAL Facility Related						\$ 1,668,364	\$ 1,668,364			\$ 94,661	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 1,668,364	\$ 1,668,364			\$ 94,661	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.		\$ 7,483	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.)		\$ 57,414	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 49,931	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 59,079	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.		\$ 109,010	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	60,358	8
	2003	42,658	9
	2004	54,436	10
	2005	55,750	11
	2006	59,079	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 Normal COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0027532

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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>14-28-479-009</u>	<u>See Attached</u>	\$ <u>29,539.48</u>	\$ <u>29,539.48</u>
2. <u>14-28-479-009</u>	<u>See Attached</u>	\$ <u>29,539.48</u>	\$ <u>29,539.48</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>59,078.96</u>	\$ <u>59,078.96</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 Normal

0027532 Report Period Beginning:

06/01/2006 Ending:

05/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,293 B. General Construction Type: Exterior Masonry Frame Steel, Fire Resistant Number of Stories 1

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

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

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

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

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

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>1971</u>	<u>\$ 58,339</u>	<u>1</u>
2			<u>1993 & 2001</u>	<u>130,541</u>	<u>2</u>
3	TOTALS			\$ 188,880	3

Facility Name & ID Number Manorcare at Normal

0027532

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	90		1971	1962	\$ 506,817	\$ 8,195		\$ 8,195		\$ 1,162,792	4
5	9			1994	497,564						5
6	10			2001	588,325						6
7	7/1/06 Capital Rate Adj #1			2001	(54,815)						7
8	7			2006	480,167						8
Improvement Type**											
9	Building Improvements (Current Year Depreciation)										9
10				1979	60,522	154,483		154,483		1,985,119	10
11				1980	317,478						11
12				1981	50,351						12
13				1982	21,867						13
14				1984	16,946						14
15				1985	26,268						15
16				1986	18,155						16
17				1987	42,286						17
18	RETIREMENTS										18
19				1987	(29,830)						19
20				1988	207,264						20
21				1989	134,621						21
22				1990	46,332						22
23				1991	15,386						23
24	RETIREMENTS										24
25				1992	(3,110)						25
26				1993	44,829						26
27				1994	137,130						27
28				1995	72,481						28
29	RENOVATIONS-PATIENT ROOMS										29
30	CARPET/TILE & INSTALLATION										30
31	CAPITALIZED LABOR										31
32	WALL/VINYL/DRYWALL										32
33	SIGNS/BOARDS										33
34	INSTALL GRID/PANELS										34
35	CONCRETE WALK/RAMP										35
36	CABINETS										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare at Normal

0027532

Report Period Beginning:

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

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	CARPETING	1996	\$ 9,845	\$		\$	\$	\$	37
38	ROOFING	1996	24,474						38
39	ELECTRICAL/LIGHTING	1996	2,159						39
40	WALLCOVERINGS	1996	5,910						40
41	SIGNS/CORNERGUARDS/CHAIR RAIL	1996	2,433						41
42	INSTALL SHOWER TILE	1996	2,656						42
43	REPAIR COMPRESSOR	1996	900						43
44	CONCRETE WALK	1996	1,053						44
45	CR5/31/99 AUDIT ADJ - CAPITAL	1996	(7,272)						45
46	PAINTING & DECORATING	1997	15,688						46
47	ROOF REPLACEMENT	1997	3,345						47
48	WALLCOVERINGS	1997	1,788						48
49	TILE & INSTALLATION	1997	2,686						49
50	CARPET	1997	1,547						50
51	INSTALL COMPRESSOR	1997	2,583						51
52	ROOF WORK	1997	51,370						52
53	WALK-IN COOLER/FREEZER	1997	9,466						53
54	ALLOC. FAC. PLAN	1997	2,758						54
55	PLUMBING/BATHROOM WORK	1997	1,226						55
56	ELECTRICAL	1997	2,416						56
57	CR5/31/99 AUDIT ADJ - CAPITAL	1997	(2,758)						57
58	CR5/31/99 AUDIT ADJ - CAPITAL	1998	(1,702)						58
59	FINISH/STUD	1998	4,865						59
60	PAINTING/WALLCOVERINGS	1998	8,175						60
61	CARPETING	1998	6,460						61
62	PLUMBING	1998	1,456						62
63	ROOFING	1998	2,170						63
64	DOORS/WINDOWS/CASEWORK	1998	9,884						64
65	ELECTRICAL	1998	5,360						65
66	FLOORING/CEILING/COVE BASE	1998	13,283						66
67	GENERAL CONTRACTOR FEES-PATIENT ROOMS	1998	1,298						67
68	CORPORATE OVERHEAD-PATIENT ROOMS	1998	1,702						68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,491,226	\$ 162,678		\$ 162,678	\$	\$ 3,147,911	70

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

Facility Name & ID Number Manorcare at Normal

0027532

Report Period Beginning:

06/01/2006 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		\$ 3,491,226	\$ 162,678		\$ 162,678	\$	\$ 3,147,911	1
2	FURNISH & INSTALL STEEL DOORS	1998	2,439						2
3	MILLWORK	1998	1,166						3
4	INSTALL DUCTS	1998	327						4
5	REWORK FIRE/SMOKE DAMPERS	1998	632						5
6	RENOVATE PATIENT ROOMS	1998	5,233						6
7	WALKWAY	1998	7,267						7
8	ELECTRICAL	1998	8,111						8
9	ROOFING	1998	8,485						9
10	SIGNAGE	1998	13,529						10
11	DOORS/WINDOWS	1998	1,773						11
12	GENERAL CONTRACTOR FEES-PATIENT ROOMS	1998	2,507						12
13	MASONRY	1998	3,700						13
14	PAINTING/WALLCOVER	1998	251						14
15	FLOORING	1998	458						15
16	RENOVATE PATIENT ROOMS	1998	(2,520)						16
17	7/1/06 Capital Rate Adj	1998	2,520						17
18	GAZEBO	1998	2,495						18
19	7/1/06 Capital Rate Adj #2	1998	(2,495)						19
20	FLOORS	1999	2,990						20
21	DOORS	1999	18,097						21
22	FENCING	1999	4,343						22
23	SIDEWALK	1999	3,719						23
24	FIRE SPRINKLER	1999	6,270						24
25	WATER HEATER	1999	7,717						25
26	DOORS (adj yr per Capital Rate Adj #3)	1999	11,081						26
27	PAINTING (adj yr per Capital Rate Adj #4)	1999	28,868						27
28	FLOORS	2000	830						28
29	RENOVATION-ARCADIA ADDTN	2000	5,000						29
30	CONCRETE	2000	1,685						30
31	CARPENTRY	2000	3,179						31
32	DRYWALL/FINISHES	2000	15,397						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,656,280	\$ 162,678		\$ 162,678	\$	\$ 3,147,911	34

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

Facility Name & ID Number Manorcare at Normal

0027532

Report Period Beginning:

06/01/2006 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		\$ 3,656,280	\$ 162,678		\$ 162,678	\$	\$ 3,147,911	1
2	CEILING / FLOORING	2000	5,680						2
3	CAREPTING & PADS	2000	7,167						3
4	WALLCOVERING	2000	7,060						4
5	ELECTRICAL	2000	12,505						5
6	GENERAL OVERHEAD & MISC-ARCADIA ADDTN	2000	25,528						6
7	5/31/03 Audit Adjustment (See IDPH Pg.12 Schedule)	2000	(25,528)						7
8	INTEREST ON CONSTRUCTION-ARCADIA ADDITION	2000	5,447						8
9	5/31/03 Audit Adjustment (See IDPH Pg.12 Schedule)	2000	(5,447)						9
10	OVERHEAD COST-ARCADIA ADDITION	2000	43,193						10
11	5/31/03 Audit Adjustment (See IDPH Pg.12 Schedule)	2000	(43,193)						11
12	WATER HEATER	2001	9,350						12
13	8 REPLACEMENT WINDOWS	2001	5,812						13
14	MIXING VALVE	2001	3,397						14
15	CARPET & VWC	2001	24,531						15
16	7/1/06 Capital Rate Adj #5	2001	(21,937)						16
17	SOIL & CONCRETE TESTING	2001	2,905						17
18	WATER & SEWER, PERMIT FEES	2001	14,582						18
19	7/1/06 Capital Rate Adj #6	2001	(13,611)						19
20	SITWORK	2001	74,254						20
21	7/1/06 Capital Rate Adj #7	2001	(74,254)						21
22	LANDSCAPING	2001	2,270						22
23	ADDITIONAL COST SITEWORK	2001	371						23
24	7/1/06 Capital Rate Adj #8	2001	(371)						24
25	FRONT HALL & OFFICE WALLS / FLOORS (Cap Adj #9)	2001	10,290						25
26	FRONT HALL & OFFICE WALLS / FLOORS (Cap Adj #10)	2001	8,731						26
27	FRONT HALL & OFFICE WALLS / FLOORS	2002	29,012						27
28	FRONT HALL & OFFICE WALLS / FLOORS	2002	4,580						28
29	FLOORING BY GREASE TRAP	2002	753						29
30	FLOORING	2002	5,415						30
31	ADDITIONAL ARCHITECTURE ENG.	2002	65						31
32	ARCHITECTURE ENGINEERING	2002	350						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,775,187	\$ 162,678		\$ 162,678	\$	\$ 3,147,911	34

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

Facility Name & ID Number Manorcare at Normal

0027532

Report Period Beginning:

06/01/2006 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		\$ 3,775,187	\$ 162,678		\$ 162,678	\$	\$ 3,147,911	1
2	ARCHITECTURE ENGINEERING	2002	2,993						2
3	DIETARY HVAC	2002	82,214						3
4	7/1/06 Capital Rate Adj #11	2002	(21,512)						4
5	FRONT HALL & OFFICE WALLS/FLOORS	2002	7,395						5
6	7/1/06 Capital Rate Adj #12	2002	(7,395)						6
7	SMOKE SHELTER	2002	3,540						7
8	ALUMINUM SHELTER	2002	5,225						8
9	SIDEWALK	2002	2,375						9
10	FENCE	2002	975						10
11	RETROACTIVE ADDITION	2002	(10)						11
12	7/1/06 Capital Rate Adj	2002	10						12
13	LANDSCAPING	2003	7,887						13
14	DEVELOPERS COST - OVERHEAD	2003	10,184						14
15	7/1/06 Capital Rate Adj #13	2003	(10,184)						15
16	INTEREST ON CONSTRUCTION	2003	722						16
17	7/1/06 Capital Rate Adj #14	2003	(722)						17
18	CARPENTRY	2003	3,460						18
19	FLOORING	2003	7,040						19
20	PAINTING	2003	33,211						20
21	WALLCOVERING	2003	6,434						21
22	HVAC	2003	3,587						22
23	VWC	2003	754						23
24	HANDRAILS & INSTALLATION	2003	2,300						24
25	VWC	2004	922						25
26	BORDER	2004	56						26
27	PAINT, VWC & BORDER	2004	1,300						27
28	CABINETS AND COUNTERTOPS	2004	5,671						28
29	FLOORING	2004	2,288						29
30	FLOORING	2004	7,170						30
31	PAINT & VWC	2004	7,200						31
32	CARPET	2004	868						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,941,146	\$ 162,678		\$ 162,678	\$	\$ 3,147,911	34

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

Facility Name & ID Number Manorcare at Normal

0027532

Report Period Beginning:

06/01/2006 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		\$ 3,941,146	\$ 162,678		\$ 162,678	\$	\$ 3,147,911	1
2	OVERLAY ASPHALT PARKING LOT	2004	9,662						2
3	PARKING LOT CONSTRUCTION AND PAVING (Cap Adj #15)	2004	55,622						3
4	PAINT & VINYL WALL COVERING	2004	1,189						4
5	PAINT & VINYL WALL COVERING	2004	3,497						5
6	VINYL WALL COVERING	2004	219						6
7	DOOR WITH LOCK	2004	3,461						7
8	EXIT PANEL	2004	1,995						8
9	VINYL COVERED TILE	2004	640						9
10	PAINTING	2004	1,450						10
11	VINYL WALL COVERING	2004	432						11
12	ENGINEERING, OVERHEAD & INTEREST	2004	43,667						12
13	7/1/06 Capital Rate Adj #16	2004	(34,924)						13
14	ELECTRICAL WORK	2004	30,627						14
15	VINYL WALL COVERING	2004	56						15
16	VINYL COVERED TILE AND COVE BASE	2004	2,175						16
17	ADJUST ASSET #1851 (VINYL WALL COVERING)	2004	(56)						17
18	ELECTRICAL WORK	2004	4,342						18
19	ELECTRICAL WORK	2004	8,455						19
20	VINYL WALL COVERING	2004	1,279						20
21	13 PHONE LINES & JACKS	2004	3,520						21
22	ENGINEERING, OVERHEAD & INTEREST	2005	9,557						22
23	7/1/06 Capital Rate Adj #17	2005	(9,557)						23
24	VINYL WALL COVERING	2005	1,279						24
25	7/1/06 Capital Rate Adj #18	2005	(1,279)						25
26	VINYL WALL COVERING	2005	506						26
27	VINYL WALL COVERING	2005	526						27
28	VINYL WALL COVERING	2005	159						28
29	VINYL WALL COVERING	2005	257						29
30	VINYL WALL COVERING	2005	7,268						30
31	VINYL WALL COVERING	2005	2,749						31
32	VINYL WALL COVERING	2005	2,670						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,092,588	\$ 162,678		\$ 162,678	\$	\$ 3,147,911	34

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

Facility Name & ID Number Manorcare at Normal

0027532

Report Period Beginning:

06/01/2006 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		\$ 4,092,588	\$ 162,678		\$ 162,678	\$	\$ 3,147,911	1
2	VINYL WALL COVERING	2005	2,510						2
3	FLOORING VINYL	2005	1,980						3
4	KICK RAIL	2005	2,354						4
5	WINDOW TREATMENTS	2005	5,098						5
6	VINYL COVERED TILE & CARPET	2005	9,340						6
7	DOOR	2005	1,580						7
8	CEILING TILE	2005	29,500						8
9	OVERHEAD & INTEREST	2005	18,308						9
10	7/1/06 Capital Rate Adj #19	2005	(18,308)						10
11	ROOFING & SHEET METAL	2005	237,310						11
12	DUCT WORK	2005	6,802						12
13	SITE PREP, LANDSCAPING, UTILITIES	2006	52,007						13
14	SOIL & CONCRETE TESTING	2006	2,435						14
15	ELECTRICAL POWER SUPPLY	2006	2,295						15
16	ARCHITECT & ENGINEERING COSTS	2006	85,271						16
17	GENERAL OVERHEAD & INTEREST	2006	46,990						17
18	PLAN REVIEWS	2006	8,192						18
19	WALLCOVERINGS	2006	9,806						19
20	MILLWORK	2006	1,766						20
21	DINING ROOM RAILS	2007	2,950						21
22	DINING ROOM PAINTING	2007	3,950						22
23	ARCHITECT & ENGINEERING COSTS	2007	3,663						23
24	GENERAL OVERHEAD & INTEREST	2007	11,136						24
25	RESILIENT FLOORING	2007	780						25
26	WALLCOVERINGS	2007	17,334						26
27	CARPENTRY	2007	29,147						27
28	DOORS & FRAMES	2007	17,334						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,684,117	\$ 162,678		\$ 162,678	\$	\$ 3,147,911	34

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

Facility Name & ID Number Manorcare at Normal # 0027532 Report Period Beginning: 06/01/2006 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	\$ 1,432,180	\$ 122,137	\$ 122,137	\$		\$ 989,198	71
72	Current Year Purchases	216,148						72
73	Fully Depreciated Assets							73
74	Home Office Allocation			14,494	14,494			74
75	TOTALS	\$ 1,648,328	\$ 122,137	\$ 136,631	\$ 14,494		\$ 989,198	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,521,325	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 284,815	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 299,309	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 14,494	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,137,109	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Manorcare at Normal

0027532

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

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: \$ 122,209 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

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>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</u>	\$ _____

* 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	4493 hrs	\$ 140,121	7,883	\$ 197,083	\$ 1,143	12,376	\$ 338,347	1
2	Licensed Speech and Language Development Therapist	10a	999 hrs	31,167	1,794	44,845	196	2,793	76,208	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	4708 hrs	146,848	12,949	323,713	13,032	17,657	483,593	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				517,564		517,564	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): X-Ray, Lab, Inhalation	10, Col 3, 39				85,794	123		85,917	13
14	TOTAL			\$ 318,136	22,626	\$ 651,435	\$ 532,058	32,826	\$ 1,501,629	14

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

Facility Name & ID Number Manorcare at Normal# 0027532Report Period Beginning: 06/01/2006

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	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (1,384)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (182,427))	1,280,226		3
4	Supply Inventory (priced at)	46,013		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,822		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,327,677	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	188,880		13
14	Buildings, at Historical Cost	4,684,117		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,648,328		16
17	Accumulated Depreciation (book methods)	(4,137,109)		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)	\$ 2,384,216	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,711,893	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 79,375	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	303,070		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	59,079		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>	133,409		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 574,933	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	983,699		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 983,699	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,558,632	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,153,261	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,711,893	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,925,927	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,925,927	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,437,875	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,437,875	17
B. Transfers (Itemize):			
18	Change in Interdivision	(1,210,541)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (1,210,541)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,153,261	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare at Normal

0027532

Report Period Beginning: 06/01/2006

Ending: 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	\$ 6,642,812	1
2	Discounts and Allowances for all Levels	(789,857)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,852,955	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,343,175	6
7	Oxygen	16,734	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,359,909	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	354	12
13	Barber and Beauty Care	16,665	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	573,252	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18,922	19
20	Radiology and X-Ray	4,480	20
21	Other Medical Services	13,616	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 627,289	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	364	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 364	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	(57)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (57)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,840,460	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	927,592	31
32	Health Care	3,451,638	32
33	General Administration	1,792,238	33
B. Capital Expense			
34	Ownership	527,579	34
C. Ancillary Expense			
35	Special Cost Centers	703,538	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)*	\$ 7,402,585	40
41	Income before Income Taxes (line 30 minus line 40)**	1,437,875	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,437,875	43

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

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

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

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

Facility Name & ID Number Manorcare at Normal

0027532

Report Period Beginning:

06/01/2006

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	2,012	2,176	\$ 66,271	\$ 30.46	1
2	Assistant Director of Nursing	3,715	4,018	94,806	23.60	2
3	Registered Nurses	14,086	15,235	360,743	23.68	3
4	Licensed Practical Nurses	27,269	29,493	626,915	21.26	4
5	CNAs & Orderlies	74,503	80,579	911,739	11.31	5
6	CNA Trainees					6
7	Licensed Therapist	8,959	8,959	279,424	31.19	7
8	Rehab/Therapy Aides	1,187	2,385	38,712	16.23	8
9	Activity Director					9
10	Activity Assistants	4,998	5,421	64,554	11.91	10
11	Social Service Workers	5,571	6,038	105,364	17.45	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,597	19,058	176,178	9.24	15
16	Dishwashers					16
17	Maintenance Workers	1,931	2,095	39,186	18.70	17
18	Housekeepers	11,877	12,867	121,838	9.47	18
19	Laundry	4,776	5,169	44,406	8.59	19
20	Administrator	2,000	2,000	69,808	34.90	20
21	Assistant Administrator	1,301	1,301	29,013	22.30	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,726	15,084	222,000	14.72	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,985	3,233	34,621	10.71	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	198,493	215,111	\$ 3,285,578 *	\$ 15.27	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	21,800	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)		\$ 21,800		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

Facility Name & ID Number Manorcare at Normal

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 \$ 3,674, Alliance \$3,310
- (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 \$ 7,221
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 116
- (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. \$ 46,412 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 59,678
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$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.